

**Health Resources and Services Administration
Bureau of Primary Health Care
2014 UDS Changes
April 09, 2014 2:00 to 3:30p.m. ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen only mode until the question and answer session of today's conference. At that time, to ask a question, press star 1 on your phone and record your name at the prompt.

This call is being recorded. If you have any objections, you may disconnect at this time. And now - I would now like to turn the call over to (Alek Sripipatana). Sir, you may begin.

(Alek Sripipatana) Great. Thank you. And thank you for folks participating. We had a little bit of technical difficulty today. If you were trying to log into the Web portion and weren't able to get in, please try again and hopefully you'll be able to log in.

That being said, good afternoon on the East Coast and good morning for those tuning in from all parts west of the Rockies. Welcome to our Webinar on the 2014 UDS or Uniform Data System.

I'm Dr. Alex Sripipatana, Chief of the data branch here in the Office of Quality and Data at HRSA's Bureau of Primary Health Care. First and foremost, I just want to thank you for all the great work that you do. Your work and services are a critical part of the first line of care for America's healthcare safety net, providing healthcare services to some of America's most vulnerable population groups.

Now on to the Uniform Data System, the UDS is an incredibly important activity of the Bureau of Primary Healthcare. It provides empirically based

information for strategic planning. It helps to direct resource allocation. It tracks quality of care to our 22 million patients as well as highlights the terrific innovative work of health centers.

Using the UDS data, we've compared how our health centers have met national benchmarks like Healthy People 2020. In 2012, all of our health centers met or exceeded at least one Healthy People objectives.

So today's Webinar helps set the stage for the 2014 UDS. We, at the Bureau, appreciate the effort that goes into these annual submissions and we're very strategic and judicious when it comes to making changes.

The UDS is a robust data collection activity and it can seem arduous at first glance. But don't fret. You're in good hands. We have an incredibly talented UDS team including my co-presenter, Ms. (Heather Nye), our contracting officer representative for the UDS, as well as Dr. Laura Makaroff, who's our office's senior clinical advisor, as well as those who will be joining us for the question and answer portion of this Webinar, our UDS consultants who many of you may already know - (Art Stickhold) and (Diane Lewis).

So without any further ado, let's begin our conversation of the 2014 Uniform Data System. So just a brief overview of what we'll be covering today. We'll talk about 2014 changes, the background and overview, as well as a table by table explanation of these changes, and providing available assistance and references for you.

Today's presentation will review the changes to 2014's data collection that are required to accurately provide UDS data analyses and submission on February 15, 2015.

The changes that we'll be discussing today include first time reporting of public housing patients, reporting of newly diagnosed HIV patients, addition or changes to five clinical quality measures, changes to (HR) capabilities and quality recognition questions.

Almost all of the changes we are discussing today relate to the clinical measures that are reported on the UDS and utilizing grants applications. They're not designed to change clinical practices, per se, the reporting is designed to establish a uniform method of measuring clinical performance.

Now, these UDS metrics are the (four). Health centers may establish additional performance guidelines for their own programs. Historically, these have included data analyses at the sites or provider level, special studies for targeted groups of patients. However, these must be in addition and may not substitute for required reporting.

So first, let's talk about how changes to the UDS are made for those of you that may not be familiar with this particular process. Changes to the 2014 UDS were published initially as a PAL, or Program Assistance Letter, on May 10th and revises another PAL in December.

They were also announced in the Federal Register. Comments and recommendations were solicited from health centers, primary care associations, PCOs and the general public. They were reviewed based on comments, received and modified. Package was approved by the Office of Management and Budget.

And they were also introduced in the 2013/2014 UDS training. Note that the changes are always announced as proposed early, prior to the year in which they take effect, and then finalized during the reporting year.

So today's presentation is designed to assist health centers understand the new and revised clinical measures, to help you understand some of the new demographic data that's added, as well as how to complete and submit data on these changes to Tables 4, 6A, 6B, 7 and the EHR capabilities form.

I think these particular (thoughts) will make more sense as we progress in our presentation. I did want to make a note that over the last several years, health center look-alikes have been aligning their reporting to that of grantee clinics. Most of the clinics are considering becoming grantees at some point in the future.

For many, look-alikes status are sort of the training wheel phase of learning the technical administrative aspects of the program. With these changes, all parts of the UDS are now being required of look-alikes with the exception, of course, of reporting their grant drawdowns.

Now I'm going to hand the presentation over to Ms. (Heather Nye) and she'll discuss more about our EHRs. (Heather).

(Heather Nye): Thanks (Alek). So as we review the 2014 changes today, we really want to stress the importance of using an EHR. And as you know, universal adoption of EHR with interoperability capabilities has the potential to reduce healthcare costs, enhance the capability of clinicians to serve their patients, improve the quality of care provided to patients, and ultimately improve patient health.

And we just want to take this opportunity to encourage health centers to continue expanding your HIT capacity, particularly as you are enhancing your HIT for the use - for use with UDS clinical measure of reporting. And as a

reminder, you know that you can use your EHR to report some or even all of your measures, depending on how ready you are. Next slide please.

And here're some facts about EHR use in health centers. Now, in 2012, we saw that 60% of health centers used an EHR for some electronic or some electronic data system for reporting one or more of the measures. So this is a great number so far but what we really want to do is continue to encourage you to strengthen and expand your HIT capacity.

We also saw that 79% of health centers indicated that they have an EHR installed and in use at all sites and all providers, and lastly, we saw that 44% of health centers are patient centered medical homes.

Let's go on to the next slide and now let's begin talking about the table by table changes of the UDS in 2014. The first that we'll review is in Table 4 under patient characteristics. Next slide please.

We see here the first change in Table 4 that we'll be describing is that of public housing patients, and as you know, homeless and agricultural worker patients have been reported in the UDS over the years. However, for the first time, we'll be collecting public housing patients as well on Table 4 on Line 26.

Now, how are these public housing patients defined? They are defined as residents in publicly supported multiple unit projects, either high rise or low rise, and this explicitly excludes scattered site Section 8 housing.

Now, targeted patients live in concentrations that could be served with a public housing primary care clinic site. Scattered site would not provide this opportunity. Most can be identified from a set of known addresses.

So, for instance, if there are housing projects in the community, their known addresses can be used to identify the patients that live there, and this can also be added as a characteristic to your registration form and there below in the slide, you'll see a depiction of how the line will look in the UDS itself.

So now I'm going to hand the call over to Dr. Laura Makaroff who will continue describing the clinical changes starting with Table 6A.

Dr. Laura Makaroff: Great. Thanks (Heather). Hi everyone. Thanks for joining us today. Like Heather, I'm Laura Makaroff. I'm a family physician by training and I am the senior clinical advisor here in the Office of Quality and Data at the Bureau of Primary Healthcare.

I'm happy to be with you today to go over the changes and revisions and some additions in the clinical quality measures. And, of course, we'll have time for questions and answers at the end so save any questions you have as we go.

And I also - before we get started, I just wanted to reiterate what (Heather) was speaking on about the importance of using your EHR for whole universe reporting, for the measures. The health centers - you've all done a great job of adopting EHRs like Heather presented.

Over 90% have EHRs in use in at least some of their sites. But we're seeing much less that are using their EHRs for full universe reporting. And we understand, here at the Bureau, the complexities of that and the challenges of making your EHR give you the reports you want. We just want to encourage you to keep working on that.

I will also tell you that, from our end, we're really trying hard to align our measures with NQF endorse measures and/or CMS meaningful use measures

so that there's less reporting burden and less having to report slightly different measures for different organizations.

So we work hard at that also and some of the changes we'll talk about today reflect that. Rob, can you advance the slides for me? It looks like I'm not able to. Great.

Okay, so the first change to discuss is in Table 6A. So there're two new HIV elements that have been incorporated into UDS 2014. Both of these are in response to the National HIV/AIDS Strategy. This first change is in Table 6A and is a recording of first time diagnosis of HIV, so newly diagnosed HIV patients.

And as we know, screening and early diagnosis and treatment for HIV are all really important to decreasing the HIV related morbidity and mortality. So this measure will help us get a sense of how many newly diagnosed HIV patients are being cared for in the health centers.

So you'll see here, that this is the count of patients diagnosed with HIV for the first time in their lifetime. Note that this is not for the first time diagnosed in your clinic or the first time by your provider, but for the first time in the patient's lifetime.

Also note that it'll be important to carefully read the UDS manual instructions when those are available later this fall, on how to report those elements as this concept of newly diagnosed HIV is not specifically defined by only ICD9 codes.

Okay, well, now we'll move on to Table 6B and Table 7, so that's just one change in Table 6A for this UDS 2014. So this slide talks about the prenatal services measures, so Table 6B and 7.

The big change in this area is that all health centers are now required to report on both the early entry to prenatal care measure in Table 6B and the low birthrate measure in Table 7.

So if your health center does not directly provide prenatal care, it'll be important to develop referral tracking processes to track and document the date of the patient's first comprehensive prenatal care visit and the birth weight of the infant.

Many health centers have already been reporting on these measures. The measure definitions themselves have not changed. We're just now asking that all health centers report on both the early entry to prenatal care and the low birth rate measures.

The next change to talk about is the tobacco use screening and intervention measure. So as you know, historically these have been two separate measures, so we've had previously tobacco use screening as one measure and then another measure over on tobacco cessation intervention as a second measure.

These two measures were combined into one to reflect changes to the NQF endorsed measure. So in 2014, you'll only be reporting on one measure, and that is patients who were screened for tobacco use, who were not tobacco users, as well as those identified as tobacco users that received cessation intervention.

The next change, just following along on Table 6B, is a new measure around HIV linkage to care. This is the second new HIV element, as we discussed earlier. So the first one is the addition of newly diagnosed HIV patients of first-time diagnosis of HIV, and the second element is HIV linkage to care.

So this measure is looking at the percentage of the newly diagnosed HIV patients who complete a medical visit for HIV within 90 days of the diagnosis. Again, this is in response to the President's National HIV/AIDS Strategy which includes the goal of increasing the proportion of newly diagnosed HIV patients linked to care within three months of their diagnosis.

From our baseline nationally, it's 65% up to 85%. So that's part of the National HIV/AIDS Strategy. So note that if the follow up care is provided by referral or another provider, that the follow up must be completed within 90 days of diagnosis and not within 90 days of referral.

The next change, which is a new addition, is this new measure of clinical depression screening. This measure is aligned with the NQF measure and the number is 0418 in case anybody's interested in that.

The present screening measure is also part of the meaningful use stage two core measure set. Then the measure description is the percentage of patients, aged 12 and older, who are screened for depression with a standardized tool and had a follow up plan documented if screened positive.

We've gotten some question already around some of the definitions of what accounts as a standardized tool so this next slide, Slide 19, has a list of standardized depression screening tools that may be used to meet the measure definitions.

Okay, moving right along to the next change which actually is not a change. We're just continuing on with the old measure, but I'll explain what I mean by that. So this is the coronary artery disease and lipid lowering therapy measure.

So we've been collecting this measure for a couple of years as you're probably aware. The measure measures the percentage of patients aged 18 and older with a diagnosis of coronary artery disease with lipid levels that were determined to be high, so were prescribed a lipid lowering therapy.

So earlier in the year, through the PAL that has proposed UDS changes earlier last year, 2013, we had proposed to change this measure to align with the NQF endorsed LDL lipid lowering therapy measure.

But however, as you may also be aware, the clinical guidelines around cholesterol treatment and management changed late last winter or last fall. It was, like, the November/December timeframe.

When those guidelines came out that meant the clinical measures that were in use were no longer aligned. So in order to avoid confusion, we chose to just stick with our current measure, which is patients age 18 and older with a diagnosis or coronary artery disease who are prescribed lipid lowering therapy.

Once the measure developers and measure community comes out with a new measure and has consensus on that that reflects the current guidelines, we'll revisit this and we'll revise accordingly in the future.

So that was it for Table 6B. Now we'll move on and talk about Table 7 which is just one small change in the diabetes control measure. So historically, you'll remember that we have previously asked health centers to report diabetes control in four categories which would be hemoglobin A1C less than

7, hemoglobin A1C less than 8, between 8% and 9% and then hemoglobin A1C greater than 9.

As you can see here on the slide, the change for 2014 is that we'll no longer be requiring for health centers to report on hemoglobin A1C less than 7. Of course, as Alek mentioned in the beginning, this doesn't preclude you from doing any internal quality improvement that you'd like to do around that. It's just not a required measure for us any longer.

And again, this change is to reflect the NQF endorsed measures and hemoglobin A1C is not a measure that's part of the NQF endorsed measure set. So we chose to remove that. So there'll be only three categories for reporting on diabetes control - less than 8, hemoglobin A1C between 8% and 9%, and then A1C greater than 9 or no test during the year.

So that was a quick run-through of all of the different changes and as we move through this and get to the Q&A, I'm happy to answer any more specific questions. And I will hand the presentation back over to Heather.

(Heather Nye): Thanks Laura. So the very last change that we'll be talking about today is some minor changes in the ERH capabilities and quality recognition form at the very end of the UDS.

So on Slide 23, you'll see there, a link to the PAL 2014-01 that actually lists all the revised questions in that form. We revised them slightly from the previous year but, again, there're no major changes there and you can see that in Attachment 2 of the PAL which is - the link is provided there on the slide. And we will continue to collect information on patient centered medical home recognition and certification and accreditation.

Next slide please. So we'd like to just quickly review the available assistance and references for you. Slide 25 shows the phone numbers that you can call if you have any questions. The first is the UDS support line and there's the phone and email address for any questions related to the UDS content or any questions related to measures or clinical measures, specific questions can go to this phone number and email address.

The last bullet on the slide refers to the EHB support. If you have any questions regarding navigating through the Electronic Handbook as it relates to UDS, there are two numbers there, the first is the HRSA call center which links you to getting an EHB account. The second number there, it links you to the BPHC help desk which will help you navigate - once you're in EHB, it'll help you navigate the Electronic Handbook.

The other two points on this slide, first is technical assistance materials, anything related to UDS in terms of help sheets, quick reference sheets or links to archived presentations. All of those will be there on that - on those two Web sites.

And then there's a link to PALs. The first PAL is the 2013 PAL you'll see there and the second is the 2014 one as well. Next slide you'll see is references, these are just references you may want to consider looking at as you are programming your systems to collect these clinical measures we've been talking about you may find that these references would be useful. You've got references here to the National HIV/AIDS Strategy that Laura talked about and you have references here to help with People 2020, as well as NQF meaningful use and possible depression screening tools which may help as you collect data for the clinical depression screening measure.

And so finally, we want to take some questions from you all, anything related to anything we've talked about today. Please feel free to dial in. We'll need to take your questions by phone so if you are on the Web, please dial into the phone number that's listed in the notes box and the operator will queue for questions. So operator, we are ready for questions at this time.

Coordinator: Okay, thank you. We will now begin the question and answer session. To ask a question, please press star 1 on your phone, unmute your phone and record your name when prompted. One moment please for any incoming questions.

(Heather Nye): While we're waiting, we just want to remind folks that we will be archiving the presentation at the URL that's listed in your notes box, so you will be able to access the slides there.

Coordinator: And one moment here, I believe I have a question. I'm sorry, there's no recording on the name, so if you press star 1 your line is open. Yes, your line is open.

(Pam): Hi, this is Pam from Old Orchard and we just had a question about public housing patients. Is public housing and subsidized housing the same thing?

Woman: Art, do you have thoughts on that?

(Art Stickhold): All public housing is subsidized housing but not all subsidized housing is public housing. There is a program known as the Section 8 program, or the scattered site program, where vouchers are given and people are able to use that voucher at any number of apartment buildings scattered throughout the city. And those are not individuals who we would be counting for this particular measure in the UDS.

Coordinator: And I'm sorry, were we ready for the next question?

(Art Stickhold): I'm sorry, yes.

Coordinator: Okay, Rafael Andrati, your line is open.

(Rafael Andrati): Hi. Thanks. I would like to ask you what do you recommend about sliding new HIV patients?

Woman: Can you repeat that question?

((Crosstalk))

Woman: Yes, the question would be, how do you recommend an EHR system to flag a patient so that UDS reports can differentiate if the HIV diagnosis is a first time ever or a diagnosis that is just entered because the patient is seen for the first time. So what do you recommend for an EHR to be able to pull the data into this new measure, into the Table 6A?

Dr. Laura Makaroff: Yes, that's a great question. This is Laura Makaroff. You know, I think you'll probably just need to talk to your EHR vendor about any approach that they may suggest to that. From my clinical experience, I think it will probably have to be flagged somehow through the lab tests.

Because you're right, if I see a new patient today and I type HIV into their problem list and it shows up for the first time today, that doesn't mean that that's their first time diagnosis. That just means that's the first time I put it in their problem list. So I understand the complexities of that. It seems like your vendor may be able to help you develop some kind of report that can pull information from your lab testing but that may be...

((Crosstalk))

Woman: Because (unintelligible) for the first time...

Dr. Laura Makaroff: I don't know. Art, do you have other things to add on that?

(Art Stickhold): Yes, the - all of these techniques are good for identifying HIV patients but, be it a lab test or a diagnosis. Identifying it as first time is not going to happen that way.

Let me suggest that the vast majority of our health centers, those that are not also Ryan White programs, that do not have a large HIV population, the event of identifying a new HIV infected patient is one which is meaningful and significant in the life of the clinicians. They are aware when it occurs and it may just be necessary to keep a paper or a computerized log of these events in a secure environment. We looked at the number of people who are diagnosed HIV positive from Table 6A and tried to figure out how that changes over the years, and it looks like the average clinic is going to have under a dozen such incidents during the year. So maintaining this in an offline parallel system, if necessary, will work. For those of you who do have Ryan White programs or who do have significant HIV populations, you will need, as Laura said, to identify a mechanism to identify those patients.

Most likely it will probably have to be an element in the template that you use to identify the basic backgrounds of your patients, so a template element added in that, of course, has all the risks associated with it, namely, upgrading and the data disappearance. So use caution and work with your vendor as Laura suggests. Okay?

Coordinator: Thank you. Our next question comes from Kathy Amato. Your line is open.

(Kathy Amato): Yes, thank you. I have a question on how often do we need to ask our patients if they're having, like, symptoms of depression. Do we need to ask every time they come in or just once a year or what are you recommending?

Dr. Laura Makaroff: This is Laura Makaroff again. That's a great question also. So the - as you probably know the US Preventive Services Taskforce clinical guidelines are not totally clear on how often the person's screening should be done. In our case of what we're hoping for with the UDS measure is we're expecting that it would be done once per calendar year. Does that help?

(Kathy Amato): Yes. Thank you very much.

Dr. Laura Makaroff: Sure.

Coordinator: Thank you. Our next question comes from Amanda Lewis. Your line is open.

(Amanda Lewis): Hi. Could you please go over the perinatal measures when a health center already does the perinatal care themselves?

((Crosstalk))

(Art Stickhold): What exactly - so very briefly - there are essentially three different measures that are in there. On Table 6A -- sorry, on Table 6B -- there is a question as to the age of your prenatal patients, your perinatal patients, and then there is also a question which is linked to an indicator, as to when they begin prenatal care.

And that is very cleanly defined as when they have their first comprehensive perinatal or prenatal care visit. So it's not when they're defined as being

pregnant, not when the pregnancy test is done, not when the nurse does the health history or when the health educator does background or when vitamins or tests are ordered, but when they have that first comprehensive perinatal visit. So that's the Table 6A - sorry, 6B. On Table 7, we ask about deliveries and the birth weight of the child. And the women who are reported on, on Table 7 will be a subset of the women who were perinatal patients because, obviously, a significant portion of your patients will still be pregnant on December 31st. So we'll be looking for a smaller number on 7 than on 6B. And there's been a confusion which we hope to resolve by being more explicitly - instructions in the future. This data on Table 7 is requested in terms of race and ethnicity and where the deliveries are counted, where the mother is counted, we want the race and the ethnicity of the mother. Where the birth weight is reported on the child, we want the race and ethnicity of the child and since there is generally somebody else involved besides the mother, it is entirely possible for the race and ethnicity of the child to be different than that of the mother.

(Amanda Lewis): Okay, I've been doing that for a few years with those definitions but my question is, what is changing for 2014? I'm unclear about what's different from 2013 to '14.

(Art Stickhold): For the agency that has already been reporting them, nothing.

(Amada Lewis): Okay, good. That's what I wanted to hear.

(Art Stickhold): What's changing is that those - there used to be a box at the top of Table 6B and at the top of Table 7 that said if you do not provide perinatal care, check here. That box will be gone. All grantees are required to provide perinatal care either directly or through referral and as of this year, those who are

providing it for some or all of their patients by referral must provide comparable data.

(Amanda Lewis): Okay, thanks Art.

Coordinator: Thank you. And our next question comes from Sally Oswald. Your line is open.

(Sally Oswald): Hi. Thank you. I was wondering if you could comment on what you consider a positive depression screen.

Dr. Laura Makaroff: Sure. This is Laura Makaroff. I think it depends on what tool you're using, so whatever standardized tool you choose to use in your health center should have instructions on what is considered positive on that screening tool.

So, for example, if you use the PHQ2, then if either one of those questions is positive, you move on to the PHQ9 and then that will tell you what's positive from there. So does that help?

(Sally Oswald): Thank you.

Coordinator: Thank you. Our next question comes from Yvonne. Yvonne, your line is open.

(Yvonne): Hi there. It's a question on the public housing reporting, the new requirements. So we don't report anything that's Section 8 or scattered site or high rise according to the PAL letter. What exactly is meant by high rise?

(Art Stickhold): I want to say if you've got it, you'd know it. What is being excluded is publicly supported housing which is not in a concentration. Concentrated

housing in the east tends to be apartment buildings that tend to be from 4 to 12 stories high and that's what we refer to as high rise.

As you go further west, you are more and more likely to find public housing being low rise, one or two stories, almost townhouse-like arrangements but they are conce- they - everybody in that area is a resident of public housing.

(Yvonne): Okay, so then...

((Crosstalk))

(Yvonne): So then you are really referring - yes, because I'm in Texas and - yes, yes. I mean, I don't know if you meant two stories, three stories.

(Art Stickhold): It - the idea is that it's concentrated. It might be 52 story- here in Los Angeles, we have places where there are 150 two story buildings. That's concentrated, okay?

(Yvonne): And it's also a high rise.

(Art Stickhold): Yes, it's not high rise but it's concentrated, and there is a slight glitch. When you go to the east, you may find Section 8 being used in high rises.

(Yvonne): Yes.

(Art Stickhold): Again, the key is concentration. The key is tell us about how many patients you have who live in a concentrated environment of public housing that might be the location for a public housing primary care grant where those could be made available.

(Yvonne): Okay.

Woman: Okay, thank you. And our next question comes from Linda Lovelife. Your line is open.

(Linda Lovelife): Hi. My question revolves around the HIV. My question was, on the October to September timeframe that you're talking about, is October - is that 2013 or 2014? And then a follow up to that question, is there any requirements if the patient is seen at least two times before - within the measurement year or is that not a requirement?

Coordinator: And I believe her line must've hung up accidentally. Should we go on to the next question or was there a response?

Dr. Laura Makaroff: This is Laura. I can address that question. So the - on the HIV question, the (unintelligible) year for the HIV would be October of - let me think about this for a second. Art, can you help me on this? It's October 2013.

(Art Stickhold): Sure, this is - it's going to be October 1 of the prior year to September 30th of the measurement year. And we're doing that to sync it up with the data that we're going to collect on Table 6B that is going to ask you about how many people were seen within 90 days.

So the universe of people who might have been seen within 90 days that we're going to look at on Table 6B for all of 2014 will include those people who were first seen in 2013 but within 90 days of 2014.

Dr. Laura Makaroff: Great. Thanks Art. I had a busy morning so I was - my brain was not working very well for that one.

(Art Stickhold): Yes, you've been being a doctor.

Dr. Laura Makaroff: I was.

(Art Stickhold): What an interruption.

Dr. Laura Makaroff: Yes. So and then the next part of that question, I think the question was around whether the measure required two visits but I'm not sure which measure the question asker was referring to, so if you want to call back in and ask that question again, I'm happy to answer it.

(Art Stickhold): But I think we can say at this point, there's no two visit requirement except that which is implicit of a patient coming in once and to be diagnosed and then a second time to be treated. But this does not have to be a patient who you have seen at least two times during the calendar year.

Dr. Laura Makaroff: Right. Thanks for the clarification.

Coordinator: Okay, thank you. And our next question comes from Gail Fede. Your line is open.

(Gail Fede): Hi there. My question is regarding Table 6B, the new clinical depression screen measure. So I get the positive screening. What - how do you prove that you have a follow up plan documented? There's not really a CPT code that you could electronically search. What would you recommend?

Dr. Laura Makaroff: Yes, that's a great question. So a couple of things. The - like I mentioned this - so the clinical depression screening measure is an NQF endorse measure. It also has E measure specifications.

So there are E specifications that will - that you can show - share with your vendor, your EHR vendor. And there may be some way on the backend for them to help you figure out how to do that.

The follow up plan, and sort of what that means and how to document it, we'll probably just require some kind of - I don't know, sometimes I've seen used kind of like a fake CPT code or something like that to allow for that or there's something happening, sort of underneath the hood of the EHR that allows for that information to be captured.

So if you go - probably the best way to find that, the E measure specifications for this particular measure is through the National Quality Forum Web sites and then you can search for the measure and - on the right-hand side it will give you - you can click on the E measure specifications.

(Gail Fede): I guess - can I ask a follow up to that?

Dr. Laura Makaroff: Your vendor should be able to understand all of that.

(Art Stickhold): Let me mention that we now have had three of these questions. We have a question, were people screened for tobacco use? And if so, was there follow up treatments or a treatment plan?

We have were they screened for weight gain and was there follow up? And now we're adding were they essentially screened and found positive for HIV and is there a follow up?

So in all of these instances where there is a follow up required, there is a similar mechanism. So hopefully if you figured out how to do it for the other two, you'll have figured out how to do it here too.

(Gail Fede): Well, there's a CPT for the other two. That's my question, is - can you do a chart audit, so can you...

(Art Stickhold): Absolutely.

((Crosstalk))

(Gail Fede): Versus a chart sampling audit or is that not appropriate?

(Art Stickhold): No, you can always do a sampling when EHR cannot - that's why (Heather) pointed out the - for each of the clinical measures, you have the option of either doing a chart audit or a universal search through an EHR or through an (I track) or some other system.

The issue is that you will need to be able to identify the universe electronically no matter what you do. So as long as you can find all those individuals who were identified as having a depression problem that needs a follow up, then you can go ahead.

(Gail Fede): Okay, thank you.

Coordinator: Thank you. Our next question comes from Dori. Your line is open.

(Dori): Hi. Part of my first question was answered on the housing with the Section 8 answer that Section 8 does not have to be counted, as a real life practicality in areas where we don't have those easily identifiable high rises but there might be a small concentrated public housing project, how would anyone suggest we phrase that question on our registration or intake form so that patients know what we're asking and that we don't offend them?

(Art Stickhold): Well, first of all, be clear that there will be a lot, maybe a majority of all the health centers reporting, who will not have any numbers for this question. I mean, they just simply will not have public housing in their communities.

That's okay. After that, if you - the question that - the reason that it stipulates that if you know the addresses, you can use the address, is to avoid having to ask people the question.

Our fear has been that many people won't even know that what they're in is public housing, that the right word won't have been used. We'll say, "Are you in public housing?" And no, they're not in public housing, they're in East Side Manor which, if they were to bury - look through the funding, you would find was public housing but they're not aware of the term. So I guess what I want to say is if you don't know that it exists, it probably doesn't and it's probably going to be a zero.

(Dori): Okay and the next part of my question was on the prenatal. So we have to answer all of the questions even if the service that we provide to the patient is the pregnancy test and the referral to an OB or a doctor that provides delivery care.

We need to follow up and find out when their first actual prenatal visit was and then however many months later it is, we need to have the tracking mechanisms in place to find out about their baby's delivery and their birth weight. Do I kind of have that down?

(Art Stickhold): You certainly do, and if you think about it for just a moment and see how clearly it links to quality of care, if you're referring women who are pregnant to somebody and never finding out whether they're completing that referral

and actually obtaining timely prenatal care, you're not doing the job that a community health center's supposed to do, and on the other end, if you're not finding out when that child is born, then we're not a family medicine program, we're not a patient-centered medical home. We're looking for that child to come back. And by the way, that child's going to have four or five fully insured visits during the first year which should more than cover the cost of tracking them.

(Dori): Thank you.

Coordinator: Thank you. Our next question comes from Vicky Wenz.

(Vicky Wenz): Since the ICD10 has been postponed until 2015, are we still going to be expected to use ICD10 diagnosis codes for 2014 reporting?

(Art Stickhold): We took out the slide but we forgot to take out the reference in one spot on one of the other slides.

Woman: (Alek), do you have any thoughts on that?

(Art Stickhold): As you said, the President has now signed the law and the ICD10 program has been put on hold for one year and so we are back into the holding pattern. We will not make ICD10 changes for this calendar year.

(Vicky Wenz): Great. Thank you.

Coordinator: Thank you. Our next question comes from Donna Lewis. Your line is open.

(Donna Lewis): Yes ma'am. I was looking at the PHQA which is the adolescent depression screening. The first one I saw was well over 100 questions. The one I got from

the (SAMSA) (HRSA) Web site is one with about 13 questions. Which one are you wanting us to use?

Dr. Laura Makaroff: This is Laura. Either one is fine. Probably the 13 question one is (going to make) more sense but the PHQA is a standardized tool and either one is fine.

(Donna Lewis): Okay. All right. Awesome. Thank you. That's it. Everything else had been answered.

Dr. Laura Makaroff: Okay, great. Thank you.

Coordinator: Thank you. Our next question comes from (QA Robinson). Your line is open.

(QA Robinson): Hi. I apologize if you've already covered this but I was wondering what your suggestion is for using electronic health records to monitor the public housing piece, especially since - the example you gave is a good one, you know, you may ask someone if they live in public housing but they don't necessarily understand the term and they give a name of a unit. Do you have any specific suggestions for how to manage that?

(Art Stickhold): Yes, any registration form that you create is going to be unique to you and you have certain variables that you can add and subtract on that registration form. And it's going to be a variable that's placed on the registration form. It should be a variable that is somehow linked to your address.

Almost every health center will confirm the address of a patient when they first come in to ensure they have the correct address on file. And if it's also noticed that they were public housing, then you can ask a follow-up questions. But for an EHR, that's a registration field and just like age and date of birth and sex and race and ethnicity, public housing becomes one.

If you are using an EHR that is one of those that says in its guarantee to you that all modifications to the system necessary to produce the UDS are included as a part of your normal system maintenance, your hardware and software maintenance, then your vendor should already have placed that field into the registration form. And if they haven't, get them to.

Coordinator: Okay. Our next question comes from Rhonda Hobbs. Your line is open.

(Rhonda Hobbs): Hi. I'm, this is a public housing questions again. Sorry. I understand that you're looking for concentrations of housing. My question is do you care at all where the source of the public housing comes from?

So if it's Head housing or Department of Agricultural or Rural Development, are those okay to include. So that's my first question. My second is related to the prenatal question and that is for those of us that offer free pregnancy testing to get woman in early but they only come here for pregnancy testing but go other places and we do provide prenatal care, you still want us to track the women who choose to go elsewhere even though they could have chosen to come here?

Art : So on the first question, we looked around and recognized that there is some agricultural public housing but very, very little. But yes, if there is public subsidized housing, we presume that that would be included too and we're almost certain that somewhere they'll say there's a city that has subsidized housing and they're going to get built in there by accident. And that's fine because again, we're looking for concentrations of persons who could be in need of community health center type services.

So far as the tracking for programs that do pregnancy testing, the draft manual pages that we're still working with that will come out later in the year essentially say persons who sought prenatal care and we want to be very careful to exclude those individuals who got a pregnancy test and then ran screaming out the door or those who said this is wonderful. I have an OB and I'll go to her right away as well as those who looked at you and in some way or another managed to communicate the fact that they weren't going to carry this child to term. And so no, the, if you are doing pregnancy testing, the next question is if you are referring them for care, you track them. If they turn down that offer of referral to care, you won't track them.

(Rhonda Hobbs): Great. Great answer. Thank you.

Coordinator: Thank you. Our next question comes from (Yvonne). Her line is open.

(Yvonne): Yes. Okay. Thanks. I have a, three questions. One, on the depression screening, you might have mentioned this before but can you please let us know what kind of, what this metric is based on but is it NCQA? Or where, if you could email that out or let us know. We did email the Help Desk and they didn't know.

And two, related to that, is what kind of compliance rate are you all expecting to see?

Woman: Laura, I don't know if you want to answer that?

Okay. The clinical depression screening is NQS-418 and that's, we will be posting the slides up shortly with more information on that. Laura, do you want to address the second question?

Laura Makaroff: That's the one around what kind of compliance are we looking for. Is that right?

(Yvonne): Yes.

Laura Makaroff: Wasn't, I think we're looking for all of the clinical quality measures, the goals and purposes for quality improvements. So this is our first year collecting it and probably it could be the first year that a lot of health centers are working on it although some health centers may have already been doing depression screening and follow-up with a measure collection already.

So I think we'll just sort of have to see where we're at the base planning and kind of go from here. So as sort of national benchmarks, just a couple of healthy people, 20/20 objective related to depression screening but it's a little bit different, the definition, so I don't think we have a clear national (date) plan to kind of go (unintelligible).

Man: We'll let you know next year.

(Yvonne): Okay. Yes. And I have a couple of other questions real quick. So on the manual; normally we get the manual I think for the reporting period. Last year we got it in January, late January. Is there any way we can have it earlier especially in anticipation of next year when ICD-10 comes out. We'll have to recode a lot of those diagnosis codes.

So is there any kind of plans to release the manuals early this year?

Art: We had a plan in place for this year, believe it or not. We're all laughing at ourselves a little now. And the plan was that if in fact ICD-10 goes live October 1, 2015, we will have by mid-year a set of alternative ICD-10 codes

to use as well as instructions for programs as to how to use the combined ICD-9 or ICD-10 or the translated ICD-9 or the translated ICD-10.

So yes we will. You would have seen this glorious plan unfold in a few months if it were not for the Medicare Act and it will unfold in the summer of 2015. So you will have adequate time for that.

(Yvonne): Right. Thank you.

Laura: I just wanted to announce we're still taking questions even though the Adobe connection seems to have gone down. So please continue to ask questions, if you have them.

Coordinator: Okay. Thank you. And our next question comes from Katie. Your line is open.

(Katie): Hello. I'm calling from a health center which is also a Ryan White provider and provides HIV and other screening out in the community. So we diagnose HIV both with our medical providers as well as with testing counsellors. Should we count both HIV diagnosis for this UDS report or only that done by our medical providers?

Art: Laura, that one's yours.

Laura Makaroff: Let me make, this is Laura. Let me make sure I'm understanding your question. So you do HIV testing out in the community, correct?

(Katie): Correct, with testing counsellors.

Art: But using non-licensed, non-physician, non-measurable staff.

Laura Makaroff: Well I think this has, actually we'll go back to how we'd define a patient within the UDS. So if the, if a patient is, meets the definition of a patient as we've defined in the UDS, then they would be counted. If they don't, then they would not be counted.

So like for example, if you're doing like an immunization fair and you are vaccinating you know lots of kids who are not actually health center patients, I don't believe those are included as part of UDS or the immunization counts. So it would be sort of the same thing.

(Katie): Okay.

Laura Makaroff: Do you have anything to add to that Art? Did I explain that correctly?

(Art Stickhold): No I think that's perfect.

Laura Makaroff: Okay.

(Katie): Wonderful. So although we are Ryan White provider and they may be referred to us for care because it was a non-visit, non-encounter at which they were diagnosed, we do not count those diagnoses.

Laura Makaroff: Right. Correct.

(Katie): Okay. Thank you.

Laura Makaroff: Sure.

(Art Stickhold): Let me add onto that issue because it's, what we've talked about also is the recipient. The Ryan White supported agency that receives a patient who has been diagnosed by a community health center elsewhere, they, that entity, the Ryan White entity is not doing the first diagnosis and so they would not recount the referrals that they got from other community health centers in their community.

Coordinator: Okay. Thank you and our next question did not provide their names. If you pressed star 0, or I'm sorry, if you pressed star 1 and did not record your name, your line is open.

Woman: That me?

Coordinator: Yes.

Woman: Hi. I have two questions and I think that you've already answered them but I just want to verify. For the prenatal, if our patients come in, they get their pregnancy test. It's their third baby. They have their OB/GYN. They're all set. Our providers aren't making a referral. We don't have to count them.

If they're patients that need case management and help then we count those.
Correct?

(Art Stickhold): I'm not going to take your full, the second scenario. The first scenario, yes. They have their own OB. They're happily off to see her. You don't count them.

The second one you diagnosis and they say they need referral. Even if you give them a piece of paper that has the name and address of three clinicians in the community, you have referred them so you added into it that you're going

to provide case management and formal services. And that's great. That's a really fine way of providing the care. But it's not required for this measure.

Woman: Okay, All right. And my second one is about the public housing. If we have a housing complex with, you know, 200 units, even if they accept Section 8, those would be counted because it's a concentration? Or they're not counted because they're Section 8?

(Art Stickhold): If it is essentially a Section 8 apartment building or apartment complex, yes, you would count it because it's a concentration.

Woman: Okay. So you're only, you only don't count the Section 8 that they get a voucher and they go and find their only little place.

(Art Stickhold): Correct.

Woman: Those are the Section 8's you don't count. But if it's a multi-dwelling complex with 50, 100, you know...

(Art Stickhold): Section 8. Yes. You're from Texas or New Jersey or one of the places that uses Section 8 that way. Yes.

Woman: Okay. Thank you very much.

Coordinator: Thank you. Our next question comes from Rafael Andrati. Your line is open.

(Rafael Andrati): Hi. We have a question again regarding HIV patients. And with the, what, can you tell us what constitutes acceptable follow-up with a newly diagnosed HIV patient?

Laura Makaroff: Sure. This is Laura. That's a great question. So the details of this will be in the manual but I'll tell you where we're at right now. We're still working through sort of the draft, the specifications of exactly.

But what sort of constitutes an HIV, a follow-up visit for HIV would be a medical visit with HIV as a diagnosis provided by a provider who provides comprehensive HIV care.

Does that help? So does it necessarily mean that they have to be referred to infectious disease? You may have a primary care provider who provides HIV care and provides that kind of comprehensive HIV care. That could be it.

It doesn't have to, it could be an NP or PA who does HIV care also.

(Rafael Andrati): Okay, but if it were a referral to an infection disease specialist or say to the County who does HIV care and case management, that would also be acceptable.

Laura Makaroff: Yes. Yes. Absolutely.

(Rafael Andrati): And if we did a referral like that, then we would be required to track that to make sure...

(Art Stickhold): So it will be the 90 days that you're going to count for Table 6B are going to be to the completion of the referral. Like if you made the referral and the County said great, we'll give them an appointment in four months, you failed.

(Rafael Andrati): Okay. So we want to be sure that if we make a referral that it is completed in 90 days so we would track at least that long.

Laura Makaroff: Right.

(Art Stickhold): I want to say that we hope that you would track that patient until you knew that patient was in treatment.

(Rafael Andrati): Exactly. Well that's what I mean, that they would, that they were established with care with the, say the infectious disease specialist.

Laura Makaroff: Right. And then in the whole concept of sort of the care coordination in the medical neighborhood, you know, I think being able to work on whatever referral relationships you have to ensure kind of information is sharing back and forth on both sides because the patient may go for their HIV care but may also have primary care needs and you want to be able to share information. So hopefully it would be a longer term relationship and kind of ongoing but I think you'd (give it) just...

(Rafael Andrati): Correct.

Laura Makaroff: ...the measured definition.

(Rafael Andrati): Thank you.

Laura Makaroff: Sure.

Coordinator: Thank you. Our next question comes from Marilyn Wesmiler. Your line is open.

(Marilyn Wesmiler): Yes. My question is that we have a walk-in service and sometimes we see patients who come in, you know, they're not established patients of ours. They're in the area. They come in for a sore throat. Never, you know, we

never see them again. Yet we're required to count them for preventative health care measures. Is that accurate? You know, if they come in, if they come in for a sore throat, we're required to count on whether they've had a mammogram or PAP or...

(Art Stickhold): Not a mammogram but a PAP, yes. This is, so somebody asked earlier what sort of number we're looking for. We're looking for excellence. We also know the community health centers are more than just medical homes. That they also are providers of just last resorts. They also are, they provide the care of those who come through the community or those who have lost their insurance, and so we know that the numbers that you get aren't going to be 100%. That doesn't change the criteria for who's in your universe. But it does provide an explanation for why you aren't at 100% and I was thinking your own internal quality assurance.

You want to be coding your failures. You want to know which of those failures are true failures that you need to redesign your system to address and which of those are simply patients who although they meet the criteria, you're never going to be able to address and not worry about them. They left this country, you know.

(Marilyn Wesmiler): Yes, we're currently doing that. But it was just, you know, we always want to have that 100%. So that answered my question.

(Art Stickhold): I want to say, I want to say that when we see 100% on the UDS, we immediately start worrying about your data collection.

Coordinator: Thank you. Our next question comes from (Anna Sadona). Your line is open.

(Anna Sadona): My question's been answered. Thank you.

Coordinator: Thank you. Then we'll move to (Tarsha Jackson). Your line is open.

(Tarsha Jackson): Thank you. Our question was answered.

Coordinator: Thank you. (Donna Lewis), your line is open,

(Donna Lewis): Yes Ma'am. I want to make sure I understand the prenatal because the way I understood it initially because we do provide prenatal care but it's for a particular group, a particular population of pregnant folks.

There are patients that come in just for verification of pregnancy tests. And then they're, they know that they call, they call up a number to begin care somewhere else. Does that count as part of our prenatal? I thought we counted everybody that came in with a positive pregnancy test, the way that I understood it.

So what should I be thinking about these patients that are coming in? Which ones should I track because I'm totally confused now?

(Art Stickhold): You're moving it to an area that you're going to have to define carefully for yourself. The distinction between, we see they're positive and then they go off and get taken care of, and we say they're positive and we give them a list of places where they can get it take care of, there's almost no difference between those, and so what we're trying to say is as a community health center, you will be required to provide pre-natal care to all those women in your practice, in your community who use you for their medical home and if you do some or all of that by referral, then you need to track the referrals.

And the question is was that second women you were describing referred by you or did she have her own OB beforehand that she's going to? I don't think that we're going to get clearer than that because it's going to have to be on a case by case basis and you're going to be the one that decides it.

But you understand the goal of the Bureau. Women that are your patients, you have a responsibility to ensure that they provide, get prenatal care, sliding discounts and all the rest of that stuff, as needed. And if you're facilitating that care in any way, then we expect you to track them.

(Donna Lewis): Okay. I think that we're going to track all positives. That way, this makes a lot easier. Thank you.

(Art Stickhold): Thank you.

Coordinator: Okay. Our next question comes from Laurie Garland. Your line is open.

(Laurie Garland): Hi. We're just wondering. We have some confusion. When is the ICD-10 coming into effect?

(Art Stickhold): As of today. October 1, 2015. No. Did the law say when it would come into effect or did the law simply say it would be deferred for a year?

Man caller: The law says that it would be deferred to at least October 1, 2015.

(Art Stickhold): Yes, I, it could be deferred even later but the law specifies that it can be no earlier than October 1, 2015. Do you understand that was an AMA law. That was the law that the AMA promoted to make sure that doctors weren't thrown out of the Medicare System because of the reimbursement rate and not doing ICD-10 was an AMA initiative, and so we have no more idea than you do as

to whether it might get deferred beyond October 1, 2015 but we know it might occur before then.

(Laurie Garland): Okay. Thank you.

Coordinator: All right. Our next question comes from Julie Colbert. Your line is open.

(Julie Colbert): Hi. My question is related to the HIV measure. Could you give us a description of the numerator and the denominator and then what would be the national benchmark?

Laura Makaroff: Sure. Excuse me. This is Laura. I might cough again. So you're talking about the HIV linkage to care measure?

(Julie Colbert): Yes.

Laura Makaroff: Sure. So the description of the measure itself is the percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of their first ever HIV diagnosis. So that correlated...

(Julie Colbert): What's the numerator?

Laura Makaroff: ...with the measure in Table 6A or the number or count in 6A, I should say.

((Crosstalk))

(Julie Colbert): And the denominator?

Laura Makaroff: So the numerator for the HIV linkage to care is number of patients in the denominator who had a medical visit for HIV care within 90 days of first ever HIV diagnosis.

And the denominator is the number of patients first time diagnosed with HIV between the prior-year through September 30 of the current measurement year. And that sort of weird dating is the reflection of trying to capture those who were referred into care within the 90 days on both sets, both ends of the calendar year.

So all of this will be clearly specified in instructions in the UDS manual also.

(Julie Colbert): Okay. And the national benchmarks that you had mentioned was...

Laura Makaroff: Yes. So the HIV linkage to care measure is not something that I don't think there is a national benchmark at this point. This measure is part of the Secretary of Health and the President's national HIV strategy. But it's not something that's been in widespread use up to this point so it's not, I don't think it has a national benchmark at this point.

(Julie Colbert): Okay.

Man: But it was part of an effort, a departmental wide metrics alignment around HIV aids.

Laura Makaroff: Right. Yes. Excuse me. So I think what I was mentioning in the presentation was around national HIV aids strategy in general, the percentage. Just trying to increase the percentage of people who are linked to HIV care after their diagnosis.

(Julie Colbert): Okay. Thank you very much.

Laura Makaroff: Sure.

Coordinator: Thank you. Our next question comes from Sheena Logan. Her line is open.

(Sheena Logan): Hello. Yes. I just wanted some clarification and I apologize if this is repeated. My session ended so I had to call to get the number to come in. But anyway, I just wanted clarification on the prenatal. So we have to collect the race and the ethnicity of the baby? Is that, you know, am I correct in that assessment?

(Art Stickhold): Yes. That's correct.

(Sheena Logan): Okay. Was that supposedly, was that something that changed or just if...

(Art Stickhold): No, that's something that we thought was clear for years.

(Sheena Logan): Oh.

(Art Stickhold): Decades actually. Because the measure predates the UDS. But we recently were made aware that there is a way of reading ambiguity into it.

(Sheena Logan): Okay. So, okay. Thank you.

Coordinator: Our next question comes from Yvonne. Your line is open.

(Yvonne): Oh no. I don't have a question anymore. Thanks.

Coordinator: Okay. And again, if you'd like to ask a question, please press star 1 on your phone. Unmute your phone and ask your question when prompted. We have a question from Tom Churman. Your line is open.

(Tom Churman): Yes. We have a multi-practice this year. We've got a regular internal med practice plus an OB practice at our, at three different sites. Now if, well a site, we have a family practice site and an OB site.

Now if we, if we are counting prenatal at the OB site and also the prenatal at the family practice site, most of our family practice patients that test positive for pregnancy are referred over to our OB site.

Now how do we eliminate the duplicates?

(Art Stickhold): Well now you're back to talking about how your EHR is set up. Assuming that both of those sites are in scope in your...

(Tom Churman): They're both in scope yes.

(Art Stickhold): (Unintelligible) program, then you're EHR is supposed to be set up to avoid duplication. And if it's not set-up to avoid duplication here, why then you're in a world of hurts and all the other places that you were supposed to be un-duplicating patients.

So the requirement of the reporting is that you're providing unduplicated number of patients and that means that that same patient, when they go from site to site, and there are a lot of health centers that have their prenatal care specialized at one of their multiple sites.

Then you need to make sure that you are never...

(Tom Churman): Yes it may be, it may be that that is the case. I'm not sure. But we've been reporting on our, on our OB sites at this point in time.

(Art Stickhold): Again, you're dealing with your scope of project and, so maybe you need to talk with your Project Officers as to whether they're in or out.

(Tom Churman): Okay. All right. Very good. Thank you.

Coordinator: Thank you. Our next question comes from Saita from Family Healthcare. Your line is open.

(Saita): Hi yes. We're a look-a-like and have never done the prenatal counting or live birth rate. From all the questions, I think I have a grasp on the prenatal and referrals, but my question is about the birth rate.

So I know many of our patients will have their child and go, prefer to go to a pediatrician instead of use the services here. So how many of them, or how should be go about the process of recording the weight of this incident?

(Art Stickhold): So here's one of the unique areas. There are actually only two of them in the UDS where we say it's okay for you to ask the mother the weight of the infant. Turns out mothers remember that number. Long after my mother forgot what my name was, she remembered my birth weight. And I think we can, I think we can go ahead and assume that the mother is going to continue to be a patient of yours and get the information from the mother and at the same time, offer her the services of the health center for her pediatric care.

(Saita): Okay so it doesn't have to be a document from the hospital that has the weight recorded. It can just be a verbal statement of the child's birth rate.

(Art Stickhold): We, this is, very few places in the UDS that allow it but it is allowed here.
Yes.

(Saita): Okay. And then also we're asking race and ethnicity of that child also?

(Art Stickhold): Yes.

(Saita): So those three pieces need to go along with when we're asking Mom specifics about the infant she gave birth to.

(Art Stickhold): Unless she's presenting with the child for prenatal care and then you have your full range of registration data.

(Saita): Okay. Now, because I haven't seen, I don't know how this is put in on the UDS. Are we recording, how has this broken down as far as the weight? The live birth rate?

(Art Stickhold): That's broken down to national standards - 25 hundred grams and above is normal, 15 hundred to 2499 is low birth rate. Below 15 hundred is very low birth rate and you're reporting in those three categories.

(Saita): Okay. Three categories. Okay. Okay, that answered my question. Thank you.

Coordinator: Okay. Thank you. Our next question comes from (Jim Beaumont). Your line is open.

(Jim Beaumont): Thank you. We're a target population program embedded within a larger safety net facility with clinics. And so the question on public housing is, our scope is almost the migrants. There might be other safety net patients within

the overall clinic systems that are public housing that are not migrant, in this case.

Are we going to be required to count them or are we only counting the people that are otherwise, patients that are otherwise within our scope?

(Art Stickhold): Only those that are within your scope.

(Jim Beaumont): Thank you Art.

Coordinator: And our next question comes from Emily from Keystone Health. Your line is open.

(Emily): Yes, thank you. I just had a question on the race and ethnicity for Table 7, birth weight. Now that is not the race and ethnicity of the mother then? That is the race and ethnicity of the child along with the child's birth weight?

(Art Stickhold): Correct.

(Emily): Okay. And then the other, my other question was with the HIV, we also do HIV testing out in the field. If we have a positive test and they're the non, they're like case managers. Not the medical professionals.

If they have a positive test out in the field and then that person does come into the health center, becomes a health center patient, would you consider that the health center performing the test and having it as the positive.

I mean when the test was done they weren't necessarily a patient of the health center but if they do come into the health center for the follow-up?

(Art Stickhold): Laura, do you want to talk about follow-up tests and two tests and, or...

Laura Makaroff: Sure. Sure. That's a great question. You know, that's just an interesting scenario and I totally get it. And I love to hear it. It's great work you're doing. That's something I think we probably need to further define on our end here.

So at his point I would say in that case where you have a health center employee providing the initial screen test in the community, then that initial screening test leads to a referral or connection to your health center. And then the patient gets sort of the formal positive HIV test at that time, then you would count them.

(Emily): Okay.

((Crosstalk))

Laura Makaroff: As soon as the UDS Manual's released, we will try to make sure that we include some detailed instructions around that specific kind of scenario.

((Crosstalk))

(Art Stickhold): For all practical...

(Emily): Oh I'm sorry Ma'am. Say that again.

Woman: All right. Go ahead.

(Emily): I know our clinical case manager, when they're in the field and they do have a positive test, if the person does not come into our health center, they do

follow-up and track that person to make sure that they're getting care somewhere and at some point.

Those ones, if they're not coming into our health center and they don't ever become a patient of ours, then we would not count that as a positive test for us.

(Art Stickhold): So let's talk about all of Table 6B and all of Table 7. Those Tables all have as a part of the definition of the denominator medical patients who, and if that patient was never a medical patient, if they were a case management patient or even a dental patient but they were never a medical patient, then they wouldn't be included.

Ultimately, if they are a medical patient, I suspect you'll have a great deal of difficulty in determining a screening test in the field prior to the first test back at the health center with the dates. I think you'll include them but for no other reason than it will be impossible to exclude them.

(Emily): We actually do do the ORHA, the 20 minute test out at remote locations.

(Art Stickhold): Right.

(Emily): So that would be the first positive test before they actually come into the health center.

Woman: Right.

(Art Stickhold): And I think what we're saying is if that person becomes your patient, okay, we're going to count him.

(Emily): Okay. Thank you very much.

Laura Makaroff: And Ma'am, if you have any further questions on that in your specific case, feel free to reach out to the UDS team or your Project Officer and they can get in touch with us and we can talk more offline about your specific circumstances too.

(Emily): Okay. Thank you.

Laura Makaroff: Sure.

Coordinator: Thanks. Our next question comes from Jim Beaumont. Your line is open.

(Jim Beaumont): Yes, I called in before. Again, a public housing question. We have a migrant public housing project. So those people will be counted in both, the public housing line and the migrant line. Is that understood and agreeable?

(Art Stickhold): Understood and agreeable.

(Jim Beaumont): Same for homeless patients who happen to find housing during the year but they're still counted as homeless?

(Art Stickhold): Our definition of a homeless person is a person who was your patient when they were homeless and then for a period of one-year after the last time you saw them as a homeless person.

(Jim Beaumont): Right.

(Art Stickhold): So if they walk in and they have housing and they say, you know, I used to be homeless, no.

(Jim Beaumont): (Unintelligible) your period or even during the year that they were first homeless, they would count and that's, you understand that might be a duplication of what's in the homeless line.

(Art Stickhold): You know, people live with more than one identity sometimes.

(Jim Beaumont): Okay.

((Crosstalk))

(Jim Beaumont): You know, we're going through the whole on duplicated issues so I just wanted to make sure, you know, that those lines could end up with people being counted multiple times.

(Art Stickhold): Yes.

(Jim Beaumont): Okay. Another question.

Emily: Oh, I'm sorry. One more question. For the, you know, for the Table, 6, 7, for Diabetes and Hypertension, one of the criteria there is that if they had been ever diagnosed ever like if with a Diabetes, if they were your patient or a Hypertension and then, you know, what they're rated at currently.

We've always had problems with this because, you know, there's some of our, for example, that were diagnosed as Diabetes that were diagnosed a couple of years ago, like three years ago, and we still, you know, kind of count them because that's that the criteria said. But they don't have any kind of tests anymore because, you know, they don't really have the Diabetes.

So how do you, is there like a timeline of when you say they were Diagnosed Ever? Is it like two years ago or if they're not, having never been diagnosed with Diabetes since then, we don't count them anymore? What's the deadline or what's the cutoff so that they don't count?

(Art Stickhold): Well you're stumbling around the very problem that this attempts to address. What this, what that language is taking into consideration is the assumption that you don't get cured of Diabetes.

So that's why it says Diabetic Ever. The, and then if you say well they were identified as a Diabetic three years ago but we haven't been treating their Diabetes, then in fact that is showing us a failure. If you're not testing them on an annual basis, that is correctly being identified as a failure according to the theory that we're dealing with here that Diabetics remain Diabetic and they should have at least an annual check to determine the Hemoglobin A1C.

If you, on the other hand, say you know what, this was high blood sugar. It wasn't Diabetes, we erroneously identified them as Diabetic three years ago but they never were, well then they never were. And...

((Crosstalk))

(Art Stickhold): ...then they would not be included.

Emily: Yes, and it would, just kind of was a mistake (notice). But the problem with us for every year is that then our Table 7 numbers get, tend to be higher than our 6A number for Diabetes and so our reviewer always asks us why is that the case?

It's because we find a whole bunch of people that were kind of diagnosed, wouldn't count currently as being diagnosed as diabetic because they were maybe like misdiagnosed. So I don't know how to answer that to our reviewer and it comes up every year, like our numbers are off, you know.

(Art Stickhold): Well the answer to your reviewer is that those patients are not being seen for their Diabetes during the year and we know that. Your reviewer just wants to make sure that the numbers are correct.

Your QI program, those are the people who want to know why you're not treating them for their Diabetes but that's totally outside the purview of the UDS. That's internal to your own quality assurance process where we would hope that your QI team looks at issues like that. But that's not, you know, that's your internal activities.

So you'll tell the reviewer we know this and our QI team is looking at it and that's the way it will go.

Emily: Okay. Great. It's just because that happened for the past few years. So thank you.

(Art Stickhold): Mm-hmm.

Emily: I just wanted to make sure that there was nothing wrong with that. Okay.

Coordinator: Okay. Thank you. And our next question comes from (Yvonne Nesmith). Your line is open.

(Yvonne Nesmith): Good afternoon (Art). This is not a question. I'm just trying to reach (Art Stickhold). I want to thank you (Art) for being so informative and the rest of you all also. (Art) is there a number that I can reach you at? I know.

(Art Stickhold): I want to say call me afterwards and I'll give it to you.

(Yvonne Nesmith): Okay. That's fine.

(Art Stickhold): Yes.

(Yvonne Nesmith): (Unintelligible) email so if you can call me, I would appreciate it.

((Crosstalk))

Healthier: (Unintelligible) UDS Help Line and then we can address them that way.

(Art Stickhold): Excellent, 866-UDS-HELP. And they can refer you directly to me.

(Yvonne Nesmith): Okay. Thank you.

(Art Stickhold): Thank you.

Coordinator: And our next question comes from Natalie Drake. Your line is open.

(Natalie Drake): Hi. I have a question about the clinical depression. In the manual, are there going to be CPT codes for that to let us know about the follow-up that we can, so we can document that? Or do we just go on our EHR and find some Category 2 codes and document it that way?

(Art Stickhold): I think you're going to be stuck with the latter given the fact that acceptable follow-up is going to include referral elsewhere, is going to include return for another visit. There are any number of activities that will never produce something that is codeable.

Yes you may find a medication code that, if you determine that this individual is in need of medication but that's going to be only some portion of them and you can't rely on it.

(Natalie Drake): Okay. I have another question about the homeless. We have a homeless and a public housing grant so if we are, if we have a patient in the current year that is homeless and then they advance to the program and now they have public housing, do they count on both grants?

(Art Stickhold): The patients that you, that you saw as homeless is continued in your homeless population for a period of one-year after your last visit with them as a homeless patient. Not one-year after they got their housing but one-year after you last saw them.

And that's to ensure continuity of care because one of the things that we know about our homeless as patients was their cycle in and out of housing. And we don't want to say you got housing, you're cut off now, only to have them come back in six-months later.

So it's actually in the law that they have that one-year period and that means they might in fact end up being in two different populations that we serve and that's fine.

(Natalie Drake): Okay. Thank you.

Operator. Okay. Thank you. And again, if you'd like to ask a question, please press star 1 on your phone. Unmute your phone and record your name when prompted. And we do have a question from Kyle Vas. Your line is open.

(Kyle Vas): Thank you. With the Tobacco Manager, I know many of these are aligning to the meaningful use measures, and the meaningful use measure as far as I'm aware of goes down to age 13. Is there any plan to lower the age from age 13 to further align with meaningful use?

Laura Makaroff: This is Laura. And that's a great question. And I would sort of answer that with a general yes. I mean we're always working to align more so we'll definitely take that under consideration. Thanks for letting me know about that.

(Kyle Vas): Sure thing.

(Art Stickhold): You all should be aware by the way that in some instances there are many measures that are proffered by NQF and others as alternatives for individual organizations to select that best meets their practice. And so you will often find that if you go back to the NQF data source, 3, 4, 5, 6 different measures and one has been selected and if it remains a measure it is much less likely to be changed than if the measure itself gets changed, if the old one gets removed.

Coordinator: Okay. Thank you. Our next question comes from John Ansoldo. Your line is open.

(John Ansoldo): Yes. My question is, is public housing reporting required whether or not we, currently we see public housing grant?

(Art Stickhold): Yes. The, we have always obtained information from those who have public housing grants so this is if you will, uniquely opened for the first time to those who do not have public housing grants.

(John Ansoldo): Thank you.

Coordinator: Thank you. Our next question comes from Kelly Robinson or Kiley Robinson. Your line is open.

(Kiley Robinson): I'm sorry. My phone has been kind of cutting in and out. So I apologize if this was covered but we will be getting a copy of these slides. Is that correct?

Heather: Correct. The slides will be posted on the URL that was available on the Webinar in that little note box but we will be putting in on the UDS Technical Assistance Web page.

(Kiley Robinson): Great. Thanks.

Coordinator: And I'm showing no further questions at this time.

Alec Sripipatana : Well thanks and thank you very much. Thank you for such a fruitful conversation and discussion. Again, the UDS team is all here to help support our health centers in the reporting process and make sense of these metrics.

I also want to thank our colleagues and presenters. Please be on the look-out for in-person trainings on the 2014 UDS in the fall as well, you know, many of the questions that have been discussed on this Webinar are likely to be addressed either in the UDS manual and/or in these in-person trainings.

Again, I just want to thank everyone's participation. We look forward to seeing the great, you know, the health and services that you all provide reflected in our UDS. So with that, I will close the Webinar. Thank you very much for your participation.

Coordinator: Thank you for your participation. This concludes today conference call. You may disconnect at this time.

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