

Health Resources and Services Administration
Bureau of Primary Health Care
Introduction to UDS Clinical Measures
October 20, 2014 2 to 4:30 p.m. ET

Coordinator: Welcome and thank you all for holding. I would like to remind all parties that your lines on are on a listen only mode until the question and answer segment of today's conference. Also this call is being recorded. If you have any objections please disconnect at this time. I will now turn the call over to Alek. Sir, you may begin.

Dr. Alek Sripipatana: Thank you, operator. Good afternoon on the East Coast and good morning for those tuning in all parts west of the Rockies. Welcome to our Webinar on the uniform data systems or UDS's clinical measures. I'm Dr. Alek 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 of 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.

Before we go ahead and get started with our official presentation I did want to bring your attention to the left part of your screen. If you're interested in downloading the presentation slides I believe you would just right click and download from there.

Okay. So now onto the uniform data system. The UDS is an incredibly important activity of the Bureau of Primary Health Care. It provides empirically based information for strategic planning, It helps to direct resource allocation, It tracks quality of care to nearly 23 million patients served at health centers as well as highlights the terrific and innovative work

of health centers.

Using the UDS we've compared how health centers have met national clinical benchmarks like healthy people. In 2013 all of our health centers met or exceeded at least one healthy people target. This is not an easy achievement given the nature and complexity of health center patients.

Today's Webinar helps set the stage for the 2014 UDS. We at the Bureau appreciate the efforts that goes into these annual submissions and we are very strategic and judicious when it comes to making changes. The UDS is a robust data collection activity and can seem arduous at first glance. But don't be concerned. You're in good hands. We have an incredibly talented UDS team including my co-presenters as well as others who will be joining us for the question and answer portion including Dr. Laura Makaroff, our office's senior clinical advisor and our expert UDS consultant who many of you may already know Mr. Art Stickgold and Diane Lewis. So without any further ado let's begin our conversation of the 2014 uniform data system.

As an overview today's presentation we'll provide a review of the UDS's clinical measures, present changes to the clinical measure set that have been made to the UDS for the 2014 reporting year. Given that science surrounding the UDS clinical measures is fluid, the Bureau does expect to ensure that the clinical measures being collected reflects the most current science and aligns with vetted standards like the National Quality Form, meaningful use and healthy people.

Today's Webinar also includes strategies to ensure the accuracy of data being submitted into the UDS, reporting methods, helpful hints for successful reporting and UDS assistance resources.

In essence the purpose of this Webinar is to hopefully improve your understanding of the UDS clinical measures and provide strategies to ensure data quality and reliability. Identify clinical benchmarks for assessing clinical quality, for example health center trend data or national benchmarks. Finally, to provide a brief overview of the UDS clinical measures so that you have a better sense of what the Bureau is measuring over time and familiarize yourself with the UDS clinical measure language.

I do want to mention that this really is an overview of the UDS clinical measures and that they're all day long and structure led regional trainings. They're much more dynamic and they provide opportunities to flesh out issues with the UDS in a more individualized manner and in more detail. So with that I'm going to pass the presentation on to Mr. Art Stickgold.

Art Stickgold: We both did it, Alek. So yes thank you very much. This is Art Stickgold and we'll be talking today about the clinical measurements. We're going to be talking about what they are and assessing them and ways of identifying issues. Now those of you who are familiar know that there are a total of 12 tables involved in the UDS. Of those three 6A, 6B and 7 deal with clinical care persay. And it's those tables that we're going to be focusing on today as we talk about the Bureau of Primary Health Care's uniform data system clinical measures. The three tables that we're talking about are Table 6A, which reports selected diagnoses and services rendered, Table 6B, which reports a series of quality of care measures that are process measures and Table 7 which looks at intermediate outcome measures and disparities. The UDS clinical measures will continue to be revised when it is appropriate and we will continue to work to align the UDS measures with those that are published by other groups.

There are a number of changes in 2014 and we'll go into detail on all of them but let me just list them here so that you can see them. First on Table 6A we'll be making a change to add a variable that looks at the number of newly diagnosed HIV cases that you've seen during the course of the year. On Table 6B there are four changes. There are three new measures. One HIV linkage to care is going to tie into that measure that was on Table 6A. The second one, clinical depression screening and follow up and the third one which is a change in who reports things. Perinatal services are now going to be reported on by all health centers and that means that roughly 200 or so health centers who in the past have not filled out the perinatal sections of the clinical reporting are doing so this year.

We also have one tobacco use which was changed to drop one measure and combine the two measures into a single measure. So before we had one measure for screening and one measure for intervention. We will now have a single measure for screening and intervention placing this in the same sort of format that all the rest of the screening and intervention variables are presented in. Finally on Table 7 we'll be making a change which will be fairly easy. We're going to combine two columns. So instead of having three conforming reporting columns we'll have two. And again for perinatal those agencies that have not reported on outcomes, on deliveries and on birth weight will be doing so beginning this year.

So let's start with Table 6A, selected diagnoses. On Table 6A we report visits and patients for selected diagnoses and services. And let me emphasize the word selected. We know that health centers do far more than is listed on these tables. In fact at times when we reviewed it we've determined that as many as half or more of all the visits you have will not have one of these diagnoses. These are selected both because of their special interest to HRSA and because of their commonality in primary care programs. Table 6A permits us to

estimate prevalence rates for specific diagnoses. So are our patients sicker? How often do we see diabetic patients, for example, compared to our service area? And in the case continuity of care because we can see how many times, for example, that diabetic was seen. Were they seen once a year, 3.4 four times a year, eight times a year? And get a better idea of the extent to which our programs are actually doing comprehensive care for their patients.

The data requirements for Table 6A are really 2 different formats and there's really sort of two different tables pushed together here. The first part addresses specifically selected diagnoses. So in lines 1 through 20D each row has a name, for example diabetes, which is then further defined by one or more ICD9 codes listed on the table. And again for the most part it's those codes that you follow. Some codes have been intentionally excluded such as the code for gestational diabetes for example. So if you don't find the code there presume it's not to be included. If you think that makes no sense at all give a call to the help line and we'll give you that help line number at the end to verify it.

Every visit that has that diagnosis is counted. And if a patient comes in with multiple diagnoses during the visit then they're counted on each line. So for example the visit may address the hypertension, diabetes and obesity of a single patient and that will be counted on each of those three lines. The report on the number of visits for - sorry missed the button there. For the services on lines 21 through 34 again we're reporting on the number of visits with one or more of the selected services. Again each row has a name like childhood immunizations further defined by one or more CPT codes or in a few cases ICD9 codes and in the case of dental services ADA codes. Again some codes are intentionally excluded. So if the code is not there assume it is not supposed to be there or verify it with the help line.

Each visit with that service provided is counted. If a patient has more than one reportable service during a visit each one is counted. So if contraceptive services and a pap test were done in a family planning or a women's health visit then we will count that visit on each line. But note a quirk. Some of these lines have multiple procedure numbers on them and if on one line you did two of the procedures we only count it as one visit.

So, for example, if a DPT and an MMR were both given to the patient at the same visit we would count that as one visit at which childhood immunizations were given not one for each visit. It makes it a little bit harder for the programmers but they know it and they're all set to do it. And okay. We have a different one. I don't know what came up there but it's gone.

Okay. So data requirements. Again we're reporting on the number of unique patients who have the specific diagnosis and as defined. Okay assessing accuracy. So for each of these we're going to be talking about things to look at to see if the numbers you're presenting make sense. First, the patient count in column B should relate to a prevalence rate that makes sense with your community. If you've seen in your community that 13% of the patients have diabetes and you're reporting 5% or 29% you might want to take a look and see if that makes sense. Also look at the number of patients of visits per patient. If you're showing that your diabetic patients have had 13 visits a year that's not usual and you should be able to look at that and see if that makes sense.

This year the lookalikes will be completing this table for the first time. In fact this year the lookalikes now complete the entire UDS and we'll be seeing this throughout. This year we've also added a new variable, newly diagnosed patients with HIV. This is a variable which will be teamed with a Table 6B variable to help us look at the initiative that comes from the White House that

asks that federal programs work to rapidly move people who are identified with HIV into care to improve their outcomes and to reduce the probability of transmission. So we're going to ask you about the people that you diagnose with HIV for the first time during the year but when we say this we're being very, very specific. This is the first time that patient was ever diagnosed. We don't want you counting the patient that moved from Los Angeles to your town who had been diagnosed 20 years ago but it was the first time you're diagnosing them. No. It's the first time ever in their life.

So we want people who have never been diagnosed previously and we want only people who are being diagnosed for the first time at your health center. The diagnosis requires a confirming test not just a screening test. So we're talking about individuals who have had confirmatory tests. You'll note that there are no ICD9 codes for this. There is for HIV but of course that will capture everybody who has HIV. And while you could search to see if this person had ever been diagnosed with HIV before at your health center that wouldn't work because they might have been diagnosed elsewhere. So you're going to have to have either a modification to your template that allows you to capture this or if you're a health center that sees virtually no HIV patients this might well be one of those cases where we supplement our EHR with another recording system that allows us to keep track of the three or four or five patients which we guess most health centers will see in this category during a year.

Okay. Now we're going to move to Table 6B and talk about the rest. Six A was the easy one. This is the work. Six B has a set of process measures, a set of health care measures in the format of if the patient receives this timely care then we can expect improved outcome of health status. For most of these the improvement that we're looking for will occur either not until many years down the line or for many years down the line. So we're not asking you to

wait until we find out what's on the autopsy. We're saying we're going to presume these are well enough associated in literature that the intervention in and of itself assures us with better healthcare.

The first of these is timely entry into prenatal care. And the measure in and of itself is unchanged. We're going to ask that you estimate - you evaluate the number of patients who enter prenatal care during the course of the year or who are seen in prenatal care during the course of the year having answered in a prior year. When we talk about being in prenatal care we mean that the patient has had a complete obstetrical care visit. So we're not talking about when the patient had a pregnancy test. We're not talking about when they're received their vitamins or when lab tests were done. We're not talking about when you had an evaluation of their nutritional state or when they had a psychosocial evaluation. We're talking here about when they had that first visit with an NP or a PA or a CNM or a physician which was their complete obstetrical care visit and their entry into care.

So that's the number we're looking at. If that occurred at your health center you'll report them in column A, first trimester, second trimester, third trimester. If that occurred at another health center and then they transferred into your health center you'll report them in column B and you'll tell us what trimester they started at the other health center. So if they started in the first trimester here in Los Angeles then moved to your town where you saw them in the second trimester you would report them on line seven for first trimester but in column B. All that's the same. What is changing this year is that those health centers who do not directly provide prenatal care themselves will be reporting on this as well. So if you refer out for prenatal care you're going to track that woman throughout her pregnancy. We want to know when she entered prenatal care at that referral source and you'll report it in column A.

And we want to know then later for Table 7 when she delivered and the birth outcome in terms of birth weight.

So we want those who started with you or those who started up with somebody else who then were served by you. We want to include all women who were seen in 2014 and that's going to include some women who started in 2013 and then delivered in 2014, some who started in 2014 and delivered in 2014 and some who've started in 2014 and were still pregnant at the end of the year. For the purposes of this table if the only service that patient had was that they delivered in 2014 we'll count them as well.

Again the patients who are started somewhere else and referred out will be reported as well as patients who had some prenatal care and then were transferred out because of risk or who had some prenatal care and then referred out routinely for late prenatal care and delivery. Or some of you do all the prenatal care and refer for delivery and some of you do the whole perinatal service. So all of those are going to get reported during 2014. All health center patients who received prenatal care services at the health center or referred elsewhere for prenatal care are to be counted.

We're going to look here at the number of prenatal medical patients by age and that's going to equal the number by trimester of entry. If it doesn't the computer is going to tell you that doesn't make sense and ask you to correct it. We're going to look at those entry into prenatal care from another source. If there are a lot that entered in the third trimester that usually doesn't happen. We'll ask about it. If there are none, if nobody came to your program after having been seen somewhere else that also doesn't make sense. We're going to ask about it. Nationally at community health centers 71.6% of women enter care in the first trimester doing almost up to the healthy people 2020 goal of 77.6%. So those are our perinatal visits.

Our second measure is childhood immunizations. Our goal of course is to see fully immunized children and we'll be evaluating the percent of children who were in fact fully immunized, in this instance before their third birthday. And as you know this has changed a couple of times and it now includes 11 diseases that are vaccinated against and you can see the list there in the footnote. This applies to all children that are seen in your medical program that turned three or more precisely two years, 364 days because technically the measure is before their third birthday.

A child who is immunized is of course counted as is one for whom you have evidence of the disease. So if you can see the child has had measles you do have to immunize. Or if they have a contraindication for the vaccine we can count it for that particular vaccine as compliant. If you did not do all the vaccinations yourself and that's not at all uncommon then as long as the medical record is complete indicating the name of the provider and the date for each vaccine you count that information as well. We do not count a parent telling us oh yes my kid had his measles shot and we do not count or we consider as non-compliant parents who refuse or who failed to bring in the patient even if in fact they are finding some - filing some sort of religious or conscience objection which might get them past rules for school admission. So immunized means immunized.

By the way for what it's worth clinically all these vaccines should be given by the time the child turns 18 months. So by saying by the time the child turns 36 months there's really a tremendously wide period during which you can catch up for a missed vaccination. Note thought that that means your system has to in some way be able to account for three years worth of immunization history. You can't just have the last year.

So we're going to look at the universe and we're going to compare that to the three year olds. It's different. But on Table 3A you report the total number of three year olds seen. Now of course some of those three year olds could be children who for example had just dental visits or vaccine only visits. So they're not going to get counted for the medical side but in general the number is going to be similar to that on Table 3A and of course the child has to have had a medical visit during the year. So we're not looking at people who are only dental patients. And that's any kind of visit. The idea is if you have had contact with that child you should be working to get that child fully immunized. And the fact that they may never have been in for a well child visit per se is not what we're looking at. Again health centers 76.4% immunized. The healthy people 2020 goal is 80% for the complete series.

Our third one is cervical cancer screening. This one was changed recently but this year there is no changes whatsoever. We want to know the proportion of women age 24 through 64 who were seen for a medical visit during 2014 who were appropriately screened for cervical cancer. That means they had a pap test during the measurement year or the prior two years or when they had that pap test they were first over age - they were age 30 or over and secondly had an accompanying HPV test. If that occurred then we want to know did that happen in the measurement year or the prior four years.

Note that the time period may have run out after the last visit. So a woman might be due for her pap test in September and was last seen in July. That means she's out of compliance if she did not get it. The fact that you never saw her when she needed it is not the point. The point is you as her physician were supposed to bring her back to the health center to get that test. We're looking for a copy of the test result either from your lab or another lab or a notation by your provider or the clinic staff that includes the provider, the test date and the result. We do not count a note that the patient was referred or that

the patient said they got a pap test but they don't have the results. And we also do not count a patient who refuses or who returned to - failed to return for the test. None of those are continued to be in compliance. And again unless you have a separate tracking system in your EHR you need three to five years of medical records to track all the tests that are in your system.

What are we looking at? We're going to check your universe to see if the number of women aged 24 to 64 is about the same as that on Table 3A. If you have women who come in just for dental care it'll of course be significantly lower than Table 3A or for mental healthcare or anything else. But that's the comparison we will make. They have to have had at least one medical visit in the measurement year. So if the patient may have been seen but not for a medical visit they're not in your universe. Note also that while we ask you on Table 6A to report how many pap tests you did because we're asking whether the pap test had been done in the last three or five years those numbers will not be the same. However you can't have more on Table 6A then you have on Table 6B. Health centers last year reported almost 60% were compliant with pap tests. The healthy people 2020 goal is 93%. We still have a way to go.

Our fourth measure addresses child and adolescent weight screening and counseling. This has never changed. It's always been the same. We're looking at children and adolescents aged through 3 until 17 and the question is have they had a BMI percentile charted during the year and counseling for nutrition, not just diet, and counseling on physical activity, not just exercise, during the measurement year. So all three of those things must have occurred during the year and it's the BMI percentile that must be there.

Now that we're moving into an EHR period or perhaps now that we are in an EHR period many systems do not ask anyone to physically enter a BMI percentile. And that's fine as long as when the clinician looks at that sheet that

describes the patient and their status the BMI percentile is displayed. So if it's calculated on the fly and displayed when the clinician looks at the report that's considered compliant. Again just recording that a well visit was - a well child visit was done does not meet the requirement. Certainly this is a requirement of a well child visit but it can be done many other ways and it is also quite possible to do a well child visit and not have done everything that should have happened. So we need the criteria, all three of them, reported.

Data checks, again Table 3A tell us how many children and adolescents aged three through 17 were seen during the year. We know that some of them may have been seen for mental healthcare or for dental care. But that with stand - notwithstanding we should be able to compare those numbers and see a logical relationship. When your editor looks at your data in this and all these other areas where we talk about age what we'll do is guess. We know from Table 5 what proportion of your patients are actually medical patients.

So we'll guess that the proportion of 3 to 17 year olds who are medical patients is the same as it is for the entire clinic. Of course if you say - if none of your 3 through 17 year olds see the dentist, only adults see the dentist then we'll have underestimated the population. And if you only have (pediatric) and do not see adults we'll have overestimated. But nonetheless we look at those numbers for comparisons. Nationally, 51.8% of health center patients in this age range have been screened for weight and counseling.

Okay our fifth one, adult weight screening and follow-up. Again no change. This - we are looking at whether weight was assessed and whether follow-up was provided if needed. So our evaluation is to see what percent of medical patients aged 18 and over had their BMI -- we're no longer talking percentile - had their BMI recorded at their last visit or within six months of that visit and if their BMI was outside the normal parameters if a follow-up plan was

documented. So BMI recorded, note we say just recording height and weight is not adequate. That is unless your EHR calculates BMI on the fly and presents it to the clinician when they're looking at the chart. The measurement is also met if adults within normal BMI range have been screened and we're also looking now for follow-up if the BMI for persons under age 65 was less than and equal to 25 - sorry greater than and equal to 25 or less than 18.5. And slightly different standards for persons over age 65. Again we can look at the numbers. Again we have national comparisons.

Note we have two variables here. We're asking about did they have their weight screened and if they were out of compliance was there follow-up? There are a number of measures here that you'll see including the next one that have the same structure. And in each of them the universe is everybody who meets the age or the age and visit criteria. The - so that is going to be our variable in column A. In column A, total patients. In column B you're going to look at sample of either 70 or all of them and in column C we will count those patients that you reviewed who had a BMI that was normal and those who had a BMI outside the range who did have follow-up. So we see a lot of people get confused and think that we're only asking you to evaluate those patients who are outside the range. No. Either in the range or outside the range with a follow up document.

And so we go into number six. And this is in the same format and it's changed from prior years. So in prior years we had two questions. First were they screened and second if they were tobacco users was follow-up provided. Now we have put them together in the same format as adult weight and others. So we want to know the proportion of patients, medical patients aged 18 and over, who had two or more medical visits ever and at least one in the medical - in the measurement year who were queried at any time at least once within the 24 months of their last visit. So because it's within 24 months of the last

visit and the last visit could have been in January we really need three years worth of data to find all the information.

So one were they queried and two if they were found to be tobacco users did they receive tobacco cessation counseling intervention and/or pharmacotherapy as a result or were they determined to be receiving it. So the change it's one measure. Patients 18 and over found to be users. Were they provided with the information - with the intervention, the follow-up intervention, that is prescribed by your protocols? And we no longer have the two separate measures. Medical patients queried for tobacco use and not smoking by the way tobacco. Anyone can do the query as long as it's recorded and received tobacco use cessation services, received an order for cessation medications or found to be on the medications.

Next number six asthma treatment. Again this is not changed. We know something about the total universe of patients. We can look at that and see how many patients are in the age range. Whoops. I went backwards. Sorry. We know how many there have been in the past and we know how many are use - are diagnosed with asthma. And we want to know for those who are diagnosed with persistent asthma were they provided pharmacotherapy meaning inhaled cortical steroids or an approved alternative medication and those all proved - approved alternatives are listed in the manual or evidence that the patient was on one of these medications. We all know that persistent asthma is not one of the diagnoses that have an ICD9 code. So you need to look through further information unless you are using CPT2 codes which will permit you to find them easily.

We want to look at the year prevalence. The Bureau prevalence in the last year was about 5%. Are you way above or way below? That could happen, but you should know why. Patients on Table 3A are going to be compared - are

going to be used as our basis. And this is not going to equal the number of patients identified as having asthma on Table 6A though we should see some similarity. But of course Table 6A does not first ask about persistent asthma; and second, limit us to the age range that is used here. So the numbers will not be the same.

Last year health centers reported that 77.7% of the patients with persistent asthma were being provided pharmacotherapy. Number 7, cost for all cholesterol treatment for coronary artery patients and this can really be thought about in terms of your coronary artery patients who are hyperglycemic. Because you'll see that this specifically excludes individuals whose last LDL lab tests was less than 130 milligrams per deciliter.

So we want to know about the percent of coronary artery disease. And we include in this category patients who have had a heart attack, a myocardial infarction, or have had cardiac surgery, age 18 and over, two or more medical visits, one during the measurement year, who were prescribed lipid lowering therapy.

You can look back a couple of years to identify all those patients. We don't want to miss the patients that in fact were coronary artery disease patients but didn't get that treated during the current year. They don't need to have had a coronary artery disease diagnosis in the current measurement year as long as that is on their current problems or on their problem list or the current diagnosis list, they would be in the universe.

Data accuracy, well this is not a population that we see a lot of in the health centers. In 2013, roughly 2% of the estimated adult medical patients had this diagnosis. So it's a small population and health centers are quite successful in

treating them with 75.1% documenting that they have a cholesterol treatment in the record.

Staying with the cardiovascular world, we look at what is called heart attack-stroke treatment. Treatment for patients who have IVD, ischemic vascular disease, as well as patients who have been discharged after a heart attack, after a bypass graft, or after stenting, coronary bypass graft, percutaneous transluminal cardio angioplasty, anyway, in the prior year, aged 18 and older with at least one medical visit which had documentation of the use of aspirin or any other anti thrombotic which was prescribed.

So for that population group there must be evidence that they were prescribed, dispensed or that the patient was using aspirin or another anti thrombotic. Note that when it's an OTC drug, you will very likely not have evidence of a prescription or of dispensing it per se. But you should still be documenting that the patient is using it.

We're going to look at estimated prevalence. And again, somewhat more common than the coronary artery disease, we have 3% of the estimated adult population had a diagnosis of ischemic vascular disease or one of the hospitalized incidents.

Nationally, health centers just about three-quarters of the patients were in fact being provided with appropriate anti thrombotic medications. Measure Number 9 relates to colorectal cancer screening.

We want patients aged 50 through 74 with at least 1 medical visit to have had appropriate screening for colorectal cancer. There are three different tests that can be applied to identify appropriate screening. The least likely to be seen and the longest lived is colonoscopy.

Did they receive it in the measurement year or within the nine years prior to the measurement year? For a Flex Sig, it's the measurement year or the prior four. And for a fecal occult blood test, including fecal immunochemical tests, during the reporting year.

And again, just as with the pap test, that doesn't mean if they were due for a test at the last visit, was it ordered, it means did they have it during the year. If the last time you saw the patient was in March of 2014 and they didn't need a test at that time.

And you did not succeed in getting a test from them by December 31 then even though they were compliant when you saw them, the record is not compliant at the end of the year. The patient needs to have had the test during the year.

Then we'll compare the number of adults on Table 3A in the age group to what you're reporting as the universe. And nationally, well, 32.6% of patients in that age range were provided with colorectal cancer screening. The healthy people 2020 goal is a little over 70%. We've got a good way to go.

Now, new, Number 11, HIV cases with timely follow-up. Remember on Table 6A we asked you how many newly diagnosed patients you've seen. Well, here we want to know how many of the newly diagnosed patients you have seen in a one-year period were successfully provided with treatment within 90 days of the diagnosis.

Because it's within 90 days, we're going to backup the timeframe. So this is patients who were first diagnosed between October 1, 2013 and September 30, 2014. That's a one year period. And we want to know -- that's your universe in

Column A -- how many of them in fact were provided with treatment for their condition within 90 days.

So that treatment will have occurred within 90 days after the diagnosis. It's conceivable that some of that treatment may have occurred in 2013. We can compare this to the patients who had a medical diagnosis on Table 6A to see if they're in the same ballpark. And then we want to know again, medical visit with the health center provider or a visit with a referral resource.

But if it's a referral, compliance means not that the patient got the referral form. Not that the patient got to the referral site and they drew blood for a follow-up test. It is that the patient was in fact starting treatment.

The universe we're talking about are people who have been definitively diagnosed. So if all they have had is a reactive initial test, a screening test without confirmation by a positive supplemental test, they are not in your universe.

If, on the other hand, the patient was referred to you after that reactive test for the confirmatory test, then you would include them in your universe. We have no comparison data yet. This is new to us. So we'll be finding out what this number looks like this year.

And finally our last, and again a new clinical measure, screening for depression and follow-up. The goal is for all patients aged 12 and older to be screened for depression using a standardized tool. And if the screening is positive, to have a follow-up plan documented.

So this is another one of those screening and follow up. Our universe is everybody aged 12 and older who was seen for medical care. So there are

millions of these in the system and thousands if not tens of thousands at your health center.

And we want to know of those that you are looking at either the universe or a sample, did they have the screening. If it was that they had the screening and it was negative, they are counted as a success. If they had the screening and it was positive and you had follow-up for them then that is considered a success.

We're going to compare it to the total number of patients you have. But we don't have any national comparison numbers. So we'll be looking at it for the first time with you.

So those are all of our process tests. Those are all measurements where we look to see if you intervened in an appropriate fashion which should prevent adverse outcomes. Now we're going to look at the group of intermediate outcomes.

We're going to look at measures where we in fact do have not only clinical intervention but also have a measurable outcome. We're going to look at birth weights. We're going to look at blood pressure. We're going to look at hemoglobin A1C scores.

For birth weights, our goal of course is newborns with a normal birth weight. And we're evaluating the percent of children. But actually the name of this is low birth weight children. So you'll see it frequently listed as what percent do not have normal birth weight.

But obviously our Column 1D, Live Births, is the, one, live births with a birth weight of greater than or equal to 2,500 grams is what we're looking for. Again, the important distinction is that we are now measuring that for all

prenatal patients who are known to have delivered even if the delivery was done by somebody else, even if all of the care was provided by somebody else.

So now it's required that you must track those referrals and report on them. This was always required of health centers that had a perinatal program. Now those who do not have a perinatal program per se, must report on them.

We have reports on Table 7 by race and ethnicity. And we will compare the numbers by race and ethnicity to those on Table 3B which means that if you have a small minority group those numbers have to make sense.

So, if for example, you served a total of ten native Hawaiians you can't really report that 20 of them delivered this year. So we do make comparisons between the race and ethnicity that you report on this table and that on Table 3B.

We also compare the number of deliveries on Table 7 to the number of women being provided prenatal care on Table 6B. Of course Table 6B is going to be bigger because basically if we're admitting women in the first trimester then everybody who was admitted from July 1 through December 31 is still pregnant at the end of the year.

But there is a ratio that we're expecting. And we will look to make sure that it makes sense. Just definitionally, multiple births is one delivery but multiple children. A still birth one delivery, zero children.

In a large prenatal care program it is unlikely that the number of births will equal the number of deliveries because of the way we're counting. So if you have 400 women and 400 babies, it's probably wrong. And by the way

because the question comes up frequently enough, deliveries, number of women who delivered, we want the race and ethnicity of the mother.

Birth weights for the children, we want the race and ethnicity of the child. It is usually but certainly not always the same. So we don't expect those lines to add across.

Next blood pressure control, we want to know, of your hypertensive patients aged 18 to 85, who were diagnosed prior to June 30 for the first time ever, and who had two medical visits or more, how many of them had controlled blood pressure? We don't leave out the pregnant women and those who have end stage renal disease.

But we want to know was their blood pressure less than 140 over 90. So if there was no blood pressure reported on a hypertensive patient that you saw twice during the year that's not likely. But if that's the case that patient is out of compliance.

But what happens is we simply report the number that are in compliance. So no evidence means out of compliance. We want all hypertensive patients even if their hypertension was never diagnosed during the measurement year. So if the patient is known to be hypertensive but didn't have a specific hypertension diagnosis during the year, if that's on their problem list, if that's on their ongoing diagnosis list then they're included in the universe.

We compare the numbers, 3A and 3B. We compare to the prevalence of patients being reported on Table 6A for having hypertension. Note, it won't be the same. That's the one thing we know. Because the age is restricted on Table 7B but not Table 6A.

And you have to have had two visits on 6B but not on 6A. They're going to be different. But the exact nature of that difference is not something that is proscribed. Twenty four percent of adult health center patients in 2013 were identified as hypertensive.

And by the way, nationally the number is 32, so 32%. So actually our hypertension rates may be a little bit lower. We're going at 18; this is at 20 years.

Note some organizations use disease tracking systems. That's fine. But it has to include 100% of the hypertensives being served not a restricted number that are being targeted.

Nationally 63.6% of the hypertensives were in fact found to have their blood pressure in the appropriate range. The target for healthy people 2020, 61%, essentially we're there.

And then the third issue, diabetes control, we want to know diabetic patients aged 18 to 75. And for this one there is no question about whether it was diagnosed before June 30. Unfortunately for this one, if you diagnose this on December 31, we want to know whether their hemoglobin A1C was under control so all diabetic patients aged 18 to 75 who have been seen twice.

And we have this year, three categories, two compliance and one noncompliance as opposed to last year's three. So last year we had a category for less than 7, between 7 and 8, and then between 8 and 9.

This year, we have one category, hemoglobin A1C less than 8%. A second category, hemoglobin A1C between 8% and 9% and a third category,

hemoglobin A1C greater than 9%. And if they did not get a test during the year, they go in that over 9% category.

So again, this is preventive care. If the patient, when you saw them in March had had a test last year in December and you didn't think it was necessary to test them again. That's fine but that patient should be back for further care and should have had a test at the end of the year. If they didn't, it's a noncompliant record.

So for this, we lump the two categories together. All patients with a hemoglobin A1C less than or equal to 9 are considered to be compliant. Charts of diabetics with no documented are not. And again, even if they were not treated for diabetes, if they were known to be diabetic they are in your universe.

We can look at the number of patients on Table 6A who were reported as having a visit for diabetes. But notice on Table 6A, it could be any age and only one visit whereas on Table 7, there must have been two visits. There's a constrained age range. So the numbers will be different but close.

Last year, 13% of all adult patients so defined by the Bureau system had diabetes; nationally 12% is looked at. For health centers, last year 70% of them were in compliance. The healthy people 2020 goal is 84%.

So let's talk about options, okay. There are some options on how you report. On Table 6B, you, of course, report the universe no matter what you're doing. So under any circumstance we need to know how many people fit that category.

But in Column B you can either report on all of those patients in which case the number in Column B is going to be equal to the number in Column A. And you're going to look at all those records to see if they comply.

Or, you can look at a sample of 70 randomly selected patients but not for prenatal care where the universe is required but on all the rest. In Column C is going to be the number of records that are reported in Column B that were in compliance.

So B is always equal to A or equal to 70. And C is never greater than B. When we're on Table 7, we have the same situation. For diabetes and hypertension but not for perinatal, you first report the total number of patients with diabetes or with hypertension by race and ethnicity.

But you then can either report on whether or not they met the criteria, each and every one of them, report on the universe or, on a sample of 70 randomly selected patients. For both 6B and for Table 7, you can decide for each measure whether it's appropriate for you to use a sample or for you to use the universe.

If you have the universe in your EHR and if you have all the data needed to evaluate the patient in the in your EHR, you're strongly encouraged to use the EHR both because it's simpler and because it should be a more accurate tool.

But if you don't, if the EHR is not installed at every site, if the EHR does not have enough years of service, you will have to go to a sample. For those of you who are going to be looking at a sample, it's always a sample of 70, okay.

So it's not ten per doctor or 20 per site. It's 70. With 70, the sample should be able to produce sufficiently accurate data with a reasonable confidence limit for us to be able to work with it and to comply with OMB's mandates to us.

I should also mention that we're going to be having a Webinar specifically addressing sampling methods on November 6. So that's already been announced in the BPHC Weekly News. And you can find all the information there.

So with that, let me toss it back to Alek for some remarks about additional resources. And then we'll open it up for questions. So if you do have questions, get ready to call those in or to respond to them. Alek.

Dr. Alek Sripipatana: Great, thanks a lot, Art. I'm sure some of your heads are spinning about now as that was a fairly large amount of material we just covered in a very aggressive timeline.

With that being said, I'm going to provide some strategies and available assistance for the UDS clinical reporting.

A starting point is to understand the critical dates in the UDS process. Now certainly it's easier said than done but to prepare in advance for the timeline. The earlier you prepare the more likely you'll have a smoother submission process.

So critical dates in the UDS process, your UDS report is due February 15 of every year, February 15, February 15, February 15. You'll be able to start entering your data into the electronic handbook or EHB beginning January 1.

If you are new to the EHB, you should refer to the online training available at the Technical Assistance website which you will learn about on the next slide. The EHB also includes a Help function which you can access in the application for assistance.

The expectation is that you will submit a complete and accurate report by February 15. The due date happens to fall on a Sunday this year. But you're still expected and must submit a complete and accurate UDS report on or before February 15.

Please do not submit a partially vetted report on February 15 just to meet the deadline. You'll need to plan ahead and start your data entry early so that you have time to review your submission and address any potential problems before the February 15 deadline.

To assist you with making sure your report is complete and accurate, over 1000 edits are built into the EHB. These edits are designed to flag when there appear to be problems or questions with your data.

It's important to review these edits and address them by either correcting your error or commenting on why the UDS data is correct as reported.

Okay. So strategies for successful reporting. This Webinar was intended to give you a high level overview of key issues related to your UDS clinical reporting. Since we cannot cover all the content included in our day-long training in two hours, it's important that you prioritize attending a day-long training for step-by-step instructions for reporting your UDS.

A strategy for successful reporting is to work as a team. Hopefully this review has made it clear that the UDS tables are interrelated. For most organizations,

multiple people are involved in completing the table, including IT, finance and clinical staff.

In order to successfully complete your report, please consider working as a team to complete the various sections of the report. Check your data before submitting. Check data trends. Look at relationships across tables. And compare benchmarks. Excuse me.

And overall, work with your reviewer. Your reviewers are there to help assist you through the process. I can't stress the importance of communication with your reviewer.

It's very important the data in the UDS are accurate. As highlighted earlier, we take several measures to try and ensure the accuracy and validity of UDS data. But don't feel like you're going it alone.

There are several resources available to help you complete an accurate UDS report. In addition to this Webinar, there are regional in-person trainings held in 45 states in partnership with state primary care associations.

Please refer to the Bureau of Primary Healthcare Training website for a complete list of training dates and locations. There are also a series of online training modules which you can download.

The UDS manual is forthcoming and UDS factsheets that provide step-by-step instructions for completing your UDS tables. There is also an archive of previous UDS Webinars.

Additionally there is a helpline which is available year round. The UDS helpline can assist you with questions about where to report your data, clarification of UDS definitions and interpretation of edits.

If you're having trouble accessing the EHB or if you have problems with the system, you can contact the HRSA Call Center. The number is located towards the bottom of this screen.

So as you're digesting all of this material and as we begin to open up for questions and answers, I've left some resources on your screen with regard to UDS clinical measures. And again, I want to reiterate the fact that there are going to be in-person trainings held all over the country.

And these are really terrific opportunities to work with other folks who are involved with the same process as you are and to work with experts in our UDS.

So with that, we'll begin to open up for questions.

Coordinator: Thank you. At this time, if you would have a question, please press Star 1 and record your name when prompted; Star 1 please and just a few moments for the first questions to register.

Art Stickgold: While we're waiting for that first question, let me just point to one of the strategies which we've just added ten years too late. Those of you who submitted UDS reports last year, if you'll pull out the letter that you got from your - the email that you got from your reviewer and take a look at the problems that occurred then.

One of the most common responses we get when we ask a question is that's exactly what I reported last year. And of course the answer is yes; it was wrong last year. Take a look at what we said then. So find that email and take a look and see where you were vulnerable last year.

Coordinator: Our first question today comes from Jeff Gephardt, your line is open.

Jeff Gephardt: Hi. You mentioned with the change to all centers reporting OB data for 6B, you wanted all patients even if they weren't in a prenatal care program. If they just walked into your center and delivered.

For Table 7 for deliveries, you didn't mention that you wanted prenatal patients that delivered. I'm just trying to reconcile the two because then those numbers would not match.

Art Stickgold: So let me make it three things and include your two in one. What we said is the patient who comes to you looking for prenatal care which you do not provide is to be referred and tracked, okay.

If you actually are located in a place where deliveries are done and they walk in crowning, ready to deliver, and they've never been your patient before, that's an inpatient service and that's not really what we're counting on this.

So if you're first interaction with that patient was to deliver the patient, that's not who we're talking about. But if you referred them because you do not provide prenatal care, yes, we want you to talk about those. Does that clarify it?

Jeff Gephardt: Yes, I think so; thank you.

Art Stickgold: Okay.

Coordinator: Next we have Geeta, your line is open.

Geeta: Thank you. Hi, my question is for the prenatal care as well. You did mention in the slide patients should be counted only once if they have a physical exam with a provider or np and others, my questions is should we include patients who have a pregnancy test as well the reason that I am asking this is last year we went back to the UDS help desk and they mentioned we should track everybody which is different than what we are hearing today. Just wanted to get clarification on that.

Art Stickgold: Laura do you want to pitch in here?

Geeta: Sorry

Art Stickgold: I'm sorry

Laura Makaroff: Yes sure. Hi everybody my name is Laura Makaroff and I am the clinical advisor.

(Audio cuts off at this point and picks up with Art answering the question)

Art Stickgold: Follow up, I rather screen and follow up, column b is the number of records you reviewed, column c is every record you reviewed where the patient was within the standards that is had normal weight, plus all those whose weight was outside the standards and who had follow-up recorded.

Geeta: Okay so and so for those who have normal BMI, we still have to do the follow-up plan for them?

Art Stickgold: No, no. It's two conditions, normal BMI or abnormal BMI with a follow-up.

Getta: Okay. Okay. I got it.

Art Stickgold: So the ones that are out of compliance either those who never had a screening or those who had a screening but didn't have a follow-up. And that's a good point because we can't tell whether the problem that you exhibit if you do is that you are failing to screen your patients. Or that you're screening patients but failing to follow up with them.

We can't tell that but you certainly can. And so when you talk about developing corrective action plans or a change in a healthcare plan to address the issue, you certainly know which it is that you have to address. But we can't tell that from looking at your UDS.

Getta: Okay. Can I have a copy of the presentation emailed to me?

Art Stickgold: Well it was in the upper left-hand corner of the screen was the address. And you'll be able to go the Bureau's website under the Training section and it will be available there.

But if you look at the upper left-hand corner of your screen, you'll see a dial-in pass code and then the link to where to go to get the slides.

Getta: Thank you so much.

Coordinator: Our final question comes from Jennifer Johnson-Jofield. Your line is open.

Jennifer Johnson-Jofield: Hi, can you hear me?

Art Stickgold: Yup.

Jennifer Johnson-Jofield: Oh great. So my question was about the asthma measure. We're struggling with the universe report on that what would be 6A column because in our system asthma as a diagnosis, obviously as you point out, is not separated by persistent asthma. So we get thousands and thousands of hits that are not genuine.

Art Stickgold: Right.

Jennifer Johnson-Jofield: So how are we supposed to, I mean do I really have to go through all of that...

Art Stickgold: Well let me give you three answers okay.

Jennifer Johnson-Jofield: Okay.

Art Stickgold: The first answer, look in Appendix C in the manual. Last year's manual has it as well. Second answer, start using the CPT2 codes which do allow you to code for persistent asthma.

The third answer, though we will go over it again in the sampling seminar, if you pull a sample but you can't pull a sample of 70, my experience you'll need a sample of about 200 to 300.

Go through and if it's not persistent, set it aside. If it is persistent, include it. And just keep going through until you get a total of 70 that are persistent.

Jennifer Johnson-Jofield: We can get the 70 but you're right it takes about three to four times that amount of chart edits to get it.

Art Stickgold: And you want to know what that ratio is because you can use it backwards.

Jennifer Johnson-Jofield: Okay.

Art Stickgold: If you had to look at 280 charts before you found 70 then you know that 25% of your patients with asthma have persistent asthma. So for Column A you're going to give 25% of those with asthma and report that as your number with persistent asthma.

Jennifer Johnson-Jofield: Okay. Thank you.

Art Stickgold: Again, it's spelled out in Appendix C of the manual.

Jennifer Johnson-Jofield: Great, thank you.

Art Stickgold: Okay well again, thanks everybody for participating. There were a lot of you on the call today and we hope you were able to get what you need. You do have those resources.

There are, I think 40 training sessions scheduled around the country beginning or actually beginning next week. And those will be posted on the Bureau's website as well.

And if you have further questions, detailed questions, do call the helpline, 866-UDS-HELP. And you'll speak with somebody there who will have the answer or who can get the answer. Thanks a lot.

Dr. Alek Sripipatana: Operator that concludes us.

Coordinator: Thank you. That does conclude today's presentation. Thank you all for joining. You may now disconnect.

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