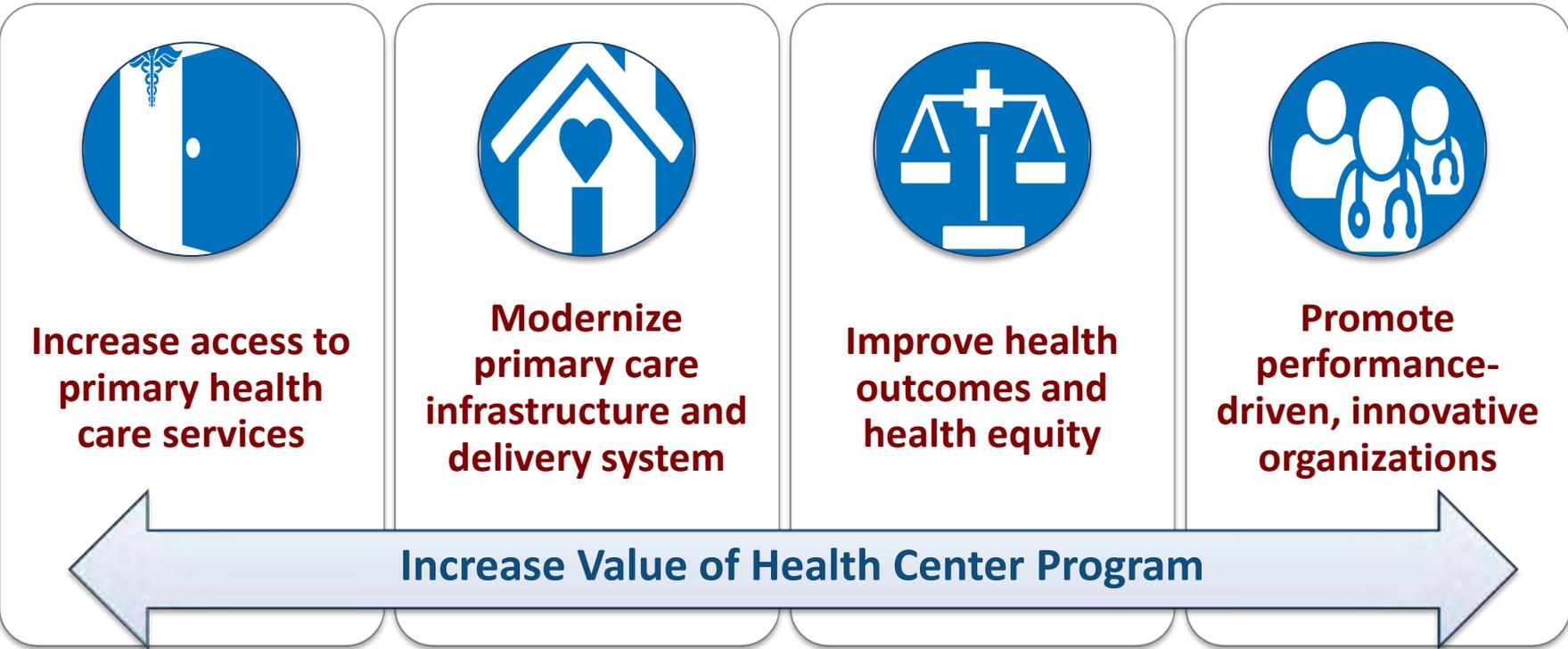


INTRODUCTION TO UDS CLINICAL MEASURES

**Bureau of Primary Health Care
December 3, 2015, 2-3:30 PM (EST)**

Primary Care Mission and Strategies

Improving the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.



Objectives of this Webinar



- Understand the framework of the clinical tables
- Identify ways to check data reliability
 - Quick methods are included for checking data accuracy
- Identify benchmarks for assessing clinical quality
 - BPHC's three-year health center trends (*where available*) and program averages
 - National benchmarks, including Healthy People 2020

Agenda



- Introduction to Uniform Data System (UDS) Clinical Tables
- Changes to 2015 UDS Clinical Tables
- Clinical Measures Overview
- Meeting the Measurement Standard
- Assessing Data Accuracy
- Data Reporting Methods
- Reminders, Strategies and References
- Questions

UDS

UNIFORM DATA SYSTEM



Introduction to UDS Clinical Tables and Changes for 2015

12 Tables Provide a Snapshot of Patients and Quality



| What is Reported | Table(s) |
|---|---------------------|
| Patients served and their socio-demographic characteristics | ZIP Code, 3A, 3B, 4 |
| Types and quantities of services provided | 5, 6A |
| Staffing mix and tenure | 5, 5A |
| The care delivered and quality of care provided | 6A, 6B, 7 |
| Costs of providing services | 8A |
| Revenue sources | 9D, 9E |
| Additional Reporting Requirement | Form |
| Electronic Health Record (EHR) capabilities and quality recognition | EHR Form |

Clinical Quality Tables



- Three UDS tables focus on clinical care
 - Table 6A: Selected Diagnoses and Services Rendered
 - Table 6B: Quality of Care Measures
 - Table 7: Health Outcomes and Disparities
- UDS clinical measures will continue to be revised to align with other national programs, such as Centers for Medicare and Medicaid Services' (CMS') Meaningful Use, the National Quality Strategy, and Healthy People 2020
 - Full alignment with the CMS' electronic specifications of the Clinical Quality Measures (CMS e-CQMs) is anticipated in calendar year 2016

Clinical Reporting Changes for 2015 UDS



- The ICD-10 transition affects Tables 6A, 6B, and 7
 - CMS required entities that bill Medicare to begin using ICD-10 codes on October 1, 2015
 - Because UDS data are reported for the entire calendar year, it will require the use of both ICD-9 and ICD-10 to report 2015 data
 - *Careful attention is required to ensure reported patient activity is unduplicated*
- EHR reporting in lieu of chart sample for Column B of Tables 6B and 7
 - Use *only* if at least 80% of all health center patient records are included in the EHR for any given measure

Additional Clinical Reporting Changes for 2015 UDS



- Table 6A
 - Line 1-2a, first time diagnosis of HIV, has been removed
- Table 6B
 - *New measure: Dental Sealants*
 - Percentage of children, aged 6 through 9, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period
 - *New flag: Prenatal care is provided by referral only*
- Table 7
 - Reported Hemoglobin A1c levels have been further reduced
 - Less than 8%
 - Greater than 9% or no test during the year

UDS

UNIFORM DATA SYSTEM



**Clinical
Measures
Overview,
including
Measurement
Standards
and Data
Accuracy**

Table 6A: Selected Diagnoses and Services Rendered

Table 6A: Selected Diagnoses and Services Rendered



NEW

| Diagnostic Category | Applicable ICD-9-CM Code | Applicable ICD-10-CM Code | Number of Visits by Diagnosis regardless of primacy (a) | Number of Patients with Diagnosis (b) |
|--|--|---|---|---------------------------------------|
| Selected Infectious and Parasitic Diseases | | | | |
| 1-2. Symptomatic / Asymptomatic HIV | 042 , 079.53, V08 | B20, B97.35, O98.7, Z21 | | |
| 3. Tuberculosis | 010.xx – 018.xx | A15- thru A19- | | |
| 4. Sexually transmitted infections | 090.xx – 099.xx | A50- thru A64- (Exclude A63.0), M02.3-, N34.1 | | |
| 4a. Hepatitis B | 070.20, 070.22, 070.30, 070.32, V02.61 | B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51 | | |
| 4b. Hepatitis C | 070.41, 070.44, 070.51, 070.54, 070.70, 070.71, V02.62 | B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52 | | |
| Selected Diseases of the Respiratory System | | | | |
| 5. Asthma | 493.xx | J45- | | |
| 6. Chronic obstructive pulmonary diseases | 490.xx – 492.xx | J40- thru J44- and J47- | | |

Purpose of the table

- Reports visits and patients for selected diagnoses and services
- Provides an estimation of prevalence for specific diagnoses and services
- Indicates continuity of care (average visits per patient by diagnosis)

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



- Reports on the number of visits of the selected **diagnosis**
 - Each visit during the year with the identified diagnosis is counted
 - If patients have more than one reportable diagnoses during a visit, each is counted
 - E.g., hypertension and diabetes and obesity
- Diagnoses are those made by a medical, dental, mental health, substance abuse, or vision provider, only

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



- Reports on the number of visits for one or more of the selected **services**
 - Each visit during the year with the service provided is counted
 - Count those services provided at the health center or by an in-scope contractor paid by the health center
 - If patients have more than one reportable service during a visit, each is counted
 - E.g., Pap test and contraceptive services
 - Multiple services in the same category at one visit are not counted
 - E.g., a DPT and an MMR immunizations given at the same visit

Data Requirements for Patient Count: Column B



- Reports on the number of unduplicated patients who had a specific diagnosis or received one or more of the selected services
 - Each patient who has had one or more visits with the designated codes is reported only once in column B
 - E.g., a patient seen five times for diabetes is counted only once as a patient in column B

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



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



Table 6B: Quality of Care Measures

Table 6B: Quality of Care Measures



- Purpose of the table
 - Evaluate the extent to which medical patients are receiving timely and appropriate preventive and chronic care services
- Trimester of Entry into Prenatal Care
- Childhood Immunization
- Cervical Cancer Screening
- Weight Assessment and Counseling for Children and Adolescents
- Adult Weight Screening and Follow-Up
- Tobacco Use Screening and Cessation Intervention
- Asthma Pharmacologic Therapy
- Coronary Artery Disease (CAD): Lipid Therapy
- Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy
- Colorectal Cancer Screening
- HIV Linkage to Care
- Patients Screened for Depression and Follow-Up
- Dental Sealants

Who Counts as a Prenatal Care Patient



- All health centers are to report on all pregnant *medical* patients who were provided any of the following required services:
 - Referral for prenatal care with no prenatal care provided by the health center
 - Some prenatal care and then transferred because of risk status
 - Some prenatal care and then referred out for late prenatal care and delivery
 - Some or all prenatal care and then referred for delivery
 - Full perinatal services including delivery by the health center

Trimester of Entry into Prenatal Care



- **Goal:** Timely entry into care
- **Evaluate:** Percent of prenatal care patients, including patients referred out for care, who enter treatment during their first trimester
 - Entry into prenatal care begins with a complete prenatal physical exam with a physician or NP, PA, or CNM
 - Does not include a pregnancy test, nurse assessment, etc.
 - Counting trimester of entry:
 - Women who initiated prenatal care elsewhere are reported in Column B according to the trimester they began with that provider
 - Women who were referred by the health center for all their prenatal care are counted in Column A
 - Women who began any prenatal care at the health center are reported in Column A

| Line | Trimester of Entry into Prenatal Care | Women Having First Visit with Health Center (a) | Women Having First Visit with Another Provider (b) |
|------|---------------------------------------|---|--|
| 7 | First Trimester | | |
| 8 | Second Trimester | | |
| 9 | Third Trimester | | |

Measuring Timely Entry into Prenatal Care Data



- **Measurement Standard:** Early (first trimester) entry into prenatal care
 - Include patients who began care with another provider
 - Include women whose only service with you in 2015 was their delivery
 - Include women who were referred to care, transferred, or were “risky out”, as well as women who were delivered by another health center’s provider

Assessing Accuracy of Early Entry into Prenatal Care Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Prenatal medical patients by age must equal prenatal patients by trimester of entry
 - Measurement Standard:
 - Large number of late entry into prenatal care with another provider or no entry into care with another provider suggests error
 - National Comparisons:
 - 2014 health center average: 72.2% of women entered prenatal care in first trimester
 - Healthy People 2020 goal: to have 77.9% of females receiving prenatal care in first trimester

Childhood Immunization



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

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

| Line | Childhood Immunization | Total Number of patients with 3rd birthday during measurement year (a) | Number Charts Sampled or EHR total (b) | Number of Patients Immunized (c) |
|------|---|--|--|----------------------------------|
| 10 | MEASURE: Children who have received age appropriate vaccines prior to their 3 rd birthday during measurement year (on or prior to December 31) | | | |

Measuring Childhood Immunization Data



- **Measurement Standard:** Number of children who, before their *3rd* birthday, for each and every disease, are (1) fully immunized, or (2) had evidence of the disease or (3) have a contraindication for vaccine
 - Medical records must indicate the name of the provider and the date for each vaccine
 - Parental refusal or failure to bring in patient means non-compliance
 - Current Advisory Committee on Immunization Practices (ACIP) guidelines recommend these vaccines be completed by 18 months of age
 - Requires 3 years of immunization history

Assessing Accuracy of Childhood Immunization Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes age three, not all patients three or younger
 - Includes those with at least one medical visit in measurement year - Includes any medical visit, not just well-child visits
 - Excludes dental-only or vaccine-only patients
 - Measurement Standard:
 - Will not equal the number of patients identified as having received ‘Selected Immunizations’ on Table 6A (line 24) because Table 6A includes other age groups and the Table 6B measure includes vaccinations given elsewhere
 - National Comparisons:
 - 2014 health center average: 77.2%
 - Healthy People 2020 goal: 80% for complete series

Cervical Cancer Screening



- **Goal:** Provide cervical cancer screening for women aged 24 through 64
- **Evaluate:** Percent of women aged 24-64 who had at least one medical visit in a health center clinic during 2015 screened for cervical cancer

Excludes patients with hysterectomy

| Line | Cervical Cancer Screening | Total number of Female Patients 24-64 years of Age (a) | Number Charts Sampled or EHR Total (b) | Number of Patients Tested (c) |
|------|--|--|--|-------------------------------|
| 11 | MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer | | | |

Measuring Cervical Cancer Screening Data



- **Measurement Standard:** Women who received one or more documented Pap tests (regardless of where performed):
 - During the measurement year or prior two years OR,
 - For women who were 30 or older at the time of the test, who chose to also have an HPV test performed simultaneously, if the test was done during the measurement year or during the four prior years
- A copy of the test result (your lab or another lab) or notation by your provider or clinic staff in the patient’s chart that includes the provider, test date, and result
- It is not sufficient:
 - To have a note indicating that a “patient was referred” or “patient reported receiving pap test”
 - When the patient refuses or fails to return for the test
- Look back into 3-5 years of medical records (based on age and tests)

Assessing Accuracy of Cervical Cancer Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Include the number of women aged 24-64 years
 - Unlikely to exceed total women aged 24-64 reported on Table 3A
 - Will be lower than Table 3A count if there are non-medical patients (E.g., those who receive only dental, mental health) at the clinic
 - With at least one medical visit in measurement year
 - Includes all medical visits, not just OB/GYN visits
 - Measurement Standard:
 - Will not be equal to ‘Pap test’ reported on Table 6A (line 23) because patients may receive Pap tests elsewhere and 6A includes other ages
 - National Comparisons:
 - 2014 health center average: 56.3%
 - Healthy People 2020 goal: 93.0%

Weight Assessment and Counseling for Children and Adolescents



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

Excludes pregnant patients

| Line | Weight Assessment and Counseling for Children and Adolescents | Total patients aged 3-17 on December 31 (a) | Number Charts Sampled or EHR Total (b) | Number of Patients with Counseling and BMI Documented (c) |
|------|--|---|--|---|
| 12 | MEASURE: Children and adolescents aged 3 until 17 during measurement year (on or prior to 31 December) with a BMI percentile, and counseling on nutrition and physical activity documented for the current year | | | |

Measuring Child and Adolescent Weight Screening and Counseling Data



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

Assessing Accuracy of Child and Adolescent Weight Screening and Counseling Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes children ages 3-17 on Table 3A
 - Number will be less when some children are seen just for dental or other non-medical services
 - With at least one medical visit in measurement year
 - Includes all medical visits, not just well child visits
 - National Comparison:
 - 2014 health center average: 56.6%

Adult Weight Screening and Follow-up



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

Excludes pregnant women and terminally ill patients

| Line | Adult Weight Screening and Follow-Up | Total Patients Aged 18 and Older (a) | Number Charts Sampled or EHR Total | Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c) |
|------|--|--------------------------------------|------------------------------------|--|
| 13 | MEASURE: Patients aged 18 and older with (1) BMI charted and (2) follow-up plan documented if patients are overweight or underweight | | | |

Measuring Adult Weight Screening and Follow-Up Data



- **Measurement Standard:**
 - Measure BMI
 - BMI must be recorded at last visit or within 6 months of last visit
 - Just recording height and weight is not adequate – BMI must be visible in chart or on template
 - Measurement standard is also met if adults are within normal BMI range and have BMI recorded in medical record
 - Document a follow-up plan if:
 - Under age 65: BMI was ≥ 25 OR < 18.5 or
 - Age 65 and older: BMI was ≥ 30 OR < 23

Assessing Accuracy of Adult Weight Screening and Follow-Up Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Adults on Table 3A need to be adjusted by non-medical patients seen
 - And further adjusted for pregnant women
 - Measurement Standard:
 - Must include assessed adults whose BMI is within normal parameters AND those with BMI outside range with documented follow-up plan
 - National comparison:
 - 2014 health center average: 56.1%

Tobacco Use Screening and Cessation Intervention



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

| Line | Tobacco Use Screening and Cessation Intervention | Total patients aged 18 and older (a) | Number Charts sampled or EHR total (b) | Number of patients assessed for tobacco use and provided Intervention if a Tobacco User (c) |
|------|--|--------------------------------------|--|---|
| 14a | MEASURE: Patients aged 18 and older who (1) were screened for tobacco use one or more times in the measurement year or the prior year and (2) for those found to be a tobacco user, received cessation counseling intervention or medication | | | |

Measuring Tobacco Use Screening and Cessation Data



Measurement Standard: Documentation must evidence that

- **Medical** patients were queried about tobacco use by any staff
 - Query for tobacco use - not just smoking
 - Include query by any staff – E.g., medical, dental, vision
 - Query was in the measurement year or within 24 months of last visit which means three years of data are needed
- **AND** if found to be a tobacco user
 - Received tobacco use cessation services *or*
 - Received an order for a smoking cessation medication (prescription or over-the-counter) *or*
 - On a smoking cessation agent

Assessing Accuracy of Tobacco Use Screening and Cessation Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Number is compared to adults age 18 and older on Table 3A adjusted for non-medical patients seen
 - Would not be the same universe as reported for the adult weight measure
 - Measurement Standard:
 - Must include assessed adults who are not tobacco users AND tobacco users with cessation services
 - National comparison:
 - 2014 health center average: 81.0%

Asthma Pharmacologic Therapy



- **Goal:** Asthma patients should be on appropriate pharmacologic therapy
- **Evaluate:** Percent of patients who had a diagnosis of persistent asthma, aged 5 through 40 with two or more visits ever (at least one medical during the year), who received or were prescribed corticosteroids or acceptable pharmacological agent
Excludes patients with allergic reaction to asthma medications and those with intermittent, mild asthma

| Line | Asthma Pharmacologic Therapy | Total Patients aged 5 - 40 with persistent asthma (a) | Number Charts Sampled or EHR Total (b) | Number of Patients with Acceptable Plan (c) |
|------|--|---|--|---|
| 16 | MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan | | | |

Measuring Asthma Pharmacologic Therapy Data



- **Measurement Standard:** Documented treatment for persistent asthma patients as evidenced by prescription or use of
 - Inhaled corticosteroids being prescribed or given *or*
 - An acceptable pharmacological agent, specifically: inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines
- Look back into patient records for history of persistent asthma, ideally over at least three years
 - ICD-10 codes will help to better define persistent asthma

Assessing Accuracy of Asthma Therapy Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes patients on Table 3A adjusted for non-medical patients
 - Will not be equal to the number of patients identified as having 'Asthma' on Table 6A, Line 5 because of differences in age, severity, and visit criteria
 - Estimated Prevalence: 2014 BPHC average indicates 4%
 - National Comparison:
 - 2014 health center average: 80.8%

Coronary Artery Disease (CAD): Lipid Therapy



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

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

| Line | Coronary Artery Disease (CAD): Lipid Therapy | Total Patients aged 18 And Older With CAD Diagnosis (a) | Number Charts Sampled or EHR Total (b) | Number of Patients Prescribed A Lipid Lowering Therapy (c) |
|------|--|---|--|--|
| 17 | MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy | | | |

Measuring CAD: Lipid Therapy Data



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

Assessing CAD: Lipid Therapy Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes adults on Table 3A adjusted for non-medical patients
 - Estimated Prevalence: 2014 BPHC average indicates 2% of estimated adult medical patients had a diagnosis of CAD
 - National Comparison:
 - 2014 health center average: 78.4%

Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy



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

| Line | Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy | Total Patients 18 And Older With IVD Diagnosis or AMI, CABG, or PTCA Procedure (a) | Charts Sampled or EHR Total (b) | Number of Patients With Aspirin or Other Antithrombotic Therapy (c) |
|------|--|---|---------------------------------------|--|
| 18 | MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy | | | |

Measuring IVD: Aspirin or Antithrombotic Therapy Data



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

Assessing IVD: Aspirin or Antithrombotic Therapy Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes adults on Table 3A adjusted for non-medical patients
 - Estimated Prevalence: 2014 BPHC average indicates 3% of estimated adult medical patients had a diagnosis of IVD
 - National Comparison:
 - 2014 health center average: 76.9%

Colorectal Cancer Screening



- **Goal:** Patients screened for colorectal cancer
- **Evaluate:** Percent of patients aged 50 to 75 with at least one medical visit who had appropriate screening for colorectal cancer

Excludes patients who have had colorectal cancer or a colectomy

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

| Line | Colorectal Cancer Screening | Total Patients 51 through 74 Years of age (a) | Charts Sampled or EHR Total (b) | Number of Patients With Appropriate Screening For Colorectal Cancer (c) |
|------|--|---|---------------------------------|---|
| 19 | MEASURE: Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer | | | |

Measuring Colorectal Cancer Screening Data



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

Assessing Accuracy of Colorectal Cancer Screening Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes adults on Table 3A adjusted for non-medical patients
 - Age 51 through 74 is being assessed, not age 50 through 74
 - National Comparisons:
 - 2014 health center average: 34.5%
 - Healthy People 2020 goal: 70.5% screened for colorectal cancer

HIV Linkage to Care



- **Goal:** Initiate HIV medical care for patients newly diagnosed with HIV within 90 days of diagnosis
- **Evaluate:** Percent of medical patients diagnosed with HIV for the first time ever between 10/1/14 and 9/30/15

| Line | HIV Linkage to Care | Total Patients First Diagnosed with HIV (a) | Charts Sampled or EHR Total (b) | Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c) |
|------|---|---|---------------------------------|--|
| 20 | MEASURE: Patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis | | | |

Measuring HIV Linkage to Care Data



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

Assessing HIV Linkage to Care Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes patients referred to the health center after a reactive, initial test done elsewhere where you run the supplemental test
 - Excludes persons who have only a reactive, initial test without confirmation by a positive, supplemental test
 - Should be less than the number of patients with HIV reported on Table 6A since Table 6B is limited to newly diagnosed
 - National Comparison:
 - 2014 health center average: 77.29%

Patients Screened for Depression and Follow-Up



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

Excludes patients participating in on-going treatment for depression and those with an active diagnosis for depression or bipolar disorder

| Line | Patients Screened for Depression and Follow-Up | Total Patients Aged 12 and Older (a) | Charts Sampled or EHR Total (b) | Number of patients Screened for Depression and Follow-Up Plan Documented as appropriate (c) |
|------|--|--------------------------------------|---------------------------------|---|
| 21 | MEASURE: Patients aged 12 and older who were (1) screened for depression with a standardized tool <i>and</i> if screening was positive (2) had a follow-up plan documented | | | |

Measuring Patients Screened for Depression and Follow-Up Data



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

Assessing Patients Screened for Depression and Follow-Up Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes patients age 12 and older adjusted for non-medical patients
 - Measurement Standard:
 - Must include those screened during the reporting year for depression whose test result was negative AND those screened positive for depression who had a follow-up plan documented
 - National Comparison:
 - 2014 health center average: 38.83%

Dental Sealants



- **Goal:** Children at moderate to high risk for caries receive a sealant on a first permanent molar
- **Evaluate:** Percent of dental patients aged 6 through 9 at moderate to high risk for caries who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year

Excludes children for whom all first permanent molars are non-sealable

| Line | Dental Sealants | Total Patients Aged 6 through 9 Identified as Moderate to High Risk for Caries (a) | Charts Sampled or EHR Total (b) | Number of patients with Sealants to First Molars (c) |
|------|---|---|------------------------------------|---|
| 22 | MEASURE: Children aged 6 through 9 years at moderate to high risk of caries who received a sealant on a permanent first molar tooth | | | |

Measuring Dental Sealants Data



- **Measurement Standard:**
 - Received a sealant on a permanent first molar tooth in the measurement year

Assessing Dental Sealants Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Includes dental patients age 6 through 9 documented as having a moderate to high risk for caries
 - Includes only dental patients receiving services directly by the health center or by paid-referral
 - National Comparison:
 - Healthy People 2020 goal: 28.1%



Table 7: Health Outcomes and Disparities

Table 7: Health Outcomes and Disparities



- Purpose of the table
 - Evaluate the extent to which medical patients are receiving clinical intervention using measurable outcomes for good long term health outcomes
 - If these measurable outcomes are improved, then later negative health outcomes will be less likely
 - Measurable process outcomes are evaluated
 - Low Birth Weight
 - Controlled Hypertension
 - Poorly Controlled Diabetes

Low Birth Weight



- **Goal:** Fewer newborns with low birth weight
- **Evaluate:** Percent of children born whose birth weight is *below normal* (*Note: Negative measure*)
Exclusions: Still-births or miscarriages

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

Measuring Low Birth Weight Data



- **Measurement Standard:** Number of babies born with a birth weight of 2,499 grams or less
 - Report birth outcomes for all prenatal patients who were known to have delivered during the year, even if some or all of the prenatal care (including the delivery) was done by another provider
 - Include the weight for each baby born of a multiple birth
 - Include births of women whose only prenatal service in 2015 was their delivery
 - Births are reported by race and ethnicity

Assessing Accuracy of Birth Weight Data



- Strategies for Checking Data Accuracy:
 - Universe and Measurement Standard:
 - Is reported by race and ethnicity
 - Comparison to patients' race and ethnicity reported on Table 3B
 - Of prenatal patients (Table 6B) is compared to women delivering (Table 7)
 - Not all women deliver in same reporting year or carry to term
 - Comparisons of births to women delivering are made (both Table 7)
 - Multiple birth = one delivery, multiple children
 - Stillbirth = one delivery, no children
 - National Comparisons:
 - 2014 health center average: 1.3% VLBW, 6.0% LBW, 7.3% combined
 - Healthy People 2020 goal: 1.4% VLBW, 6.4% LBW, 7.8% combined

Controlled Hypertension



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

Excludes pregnant women and patients with end stage renal disease

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

Measuring Controlled Hypertension Data



- **Measurement Standard:** Patients with hypertension whose blood pressure (BP) at last visit during the reporting year was less than 140/90
 - If there was no documented BP during the reporting year, record fails to meet the measurement standard
 - Look back into 3 years of patient records to identify patients with hypertension

Assessing Controlled Hypertension Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Is compared to adults (adjusted for non-medical patients) on Table 3A and patients by race and ethnicity on Table 3B
 - Prevalence is compared to patients reported as having hypertension on Table 6A (line 11) – (note age and inclusion criteria are different)
 - Estimated Prevalence:
 - 2014 BPHC estimate: 23% of adult (age 18-84) medical patients have hypertension
 - Other national prevalence: 32.5% of adults age 20 and older have hypertension
 - National Comparisons:
 - 2014 health center average: 63.68%
 - Healthy People 2020 goal: 61.2% of patients with hypertension to have blood pressure control

Uncontrolled Diabetes



- **Goal:** Fewer patients with uncontrolled diabetes
- **Evaluate:** Percent of patients with a diagnosis of Type I or Type II diabetes aged 18 to 75 who had two or more medical visits during the year whose hemoglobin A1c (HbA1c) was greater than or equal to 9% at the time of the last reading in the measurement year *(Note: Negative measure)*

Excludes those with a diagnosis of gestational diabetes or steroid-induced diabetes

| | | | |
|--|---|---|---|
| Total Patients with Diabetes (3a) | Charts Sampled or EHR Total (3b) | Patients with Hba1c <8% (3d1) | Patients with Hba1c >9% Or No Test During Year (3f) |
|--|---|---|---|

Measuring Uncontrolled Diabetes Data



- **Measurement Standard:** Patients with diabetes whose most recent hemoglobin A1c level during the measurement year is $> 9\%$ or did not have a test or had a missing result
 - Look back a minimum of 3 years of patient records to identify all patients with diabetes
- **2015 Change:** Note that the reporting categories have been reduced to HbA1c $<8\%$ (Column 3d1) and $>9\%$ or No Test During Year (Column 3f), although the additional HbA1c levels could still be used for internal tracking

Assessing Uncontrolled Diabetes Data



- Strategies for Checking Data Accuracy:
 - Universe:
 - Is compared to adults (adjusted for non-medical patients) on Table 3A (age) and race and ethnicity on Table 3B
 - Compares prevalence to patients reported as having Diabetes Mellitus on Table 6A (line 9) – (note age and inclusion criteria are different)
 - Estimated Prevalence:
 - 2014 BPHC estimate = 13% of adult (age 18-74) medical patients have diabetes
 - Other national prevalence: 12.3% of adults age 20 and older have diabetes
 - National Comparisons:
 - 2014 health center average: 31.22% with HbA1c >9%
 - Healthy People 2020 goal: Less than 16.1% with HbA1c >9%

UDS

UNIFORM DATA SYSTEM



**Data
Reporting
Methods**

Reporting Table 6B



- Prenatal care – Health centers must report details of all women in the prenatal care program – no modifications or options provided
- All other measures on this table:

- **Column A:** All patients who meet the reporting criteria
- **Column B:** All those in EHR or a sample of 70 patients

Three options are available (health center may select method independently for each measure):

- If Column A < 70: Column B must equal the universe (column A)
- If Column A ≥ 70: Column B may equal:
 - A universe count from the EHR greater than or equal to 80% of Column A (*and must not* be restricted by any variable related to the test measure) OR
 - A random sample of 70 charts (from column A)
- **Column C:** Number of charts (from column B) whose clinical record indicates that the measure rules and criteria have been met

| Line | Childhood Immunization | Total Number of patients with 3rd birthday during measurement year (a) | Number Charts Sampled or EHR total (b) | Number of Patients Immunized (c) |
|------|---|--|--|--|
| 10 | MEASURE: Children who have received age appropriate vaccines prior to their 3 rd birthday during measurement year (on or prior to December 31) | Universe | Sample or Universe | Records meeting the measurement standard |

Reporting Racial and Ethnic Disparities Table 7



| | | | |
|---|----------------------------------|-----------------------------------|---|
| Prenatal Care Patients Who Delivered During the Year (1a) | Live Births: <1500 grams (1b) | Live Births: 1500-2499 grams (1c) | Live Births: ≥ 2500 grams (1d) |
| Total Hypertensive Patients (2a) | Charts Sampled or EHR Total (2b) | | Patients with HTN Controlled (2c) |
| Total Patients with Diabetes (3a) | Charts Sampled or EHR Total (3b) | Patients with Hba1c <8% (3d1) | Patients with Hba1c >9% Or No Test During Year (3f) |

- **Columns 1a, 2a, and 3a:** All patients who meet the reporting criteria
 - 1a: women who delivered
 - 2a: patients with hypertension
 - 3a: patients with diabetes
- **Columns 1b-1d:** All delivery and birth data of women who delivered (1a)
- **Columns 2b and 3b:** All those in EHR or a sample of 70 patients
 Three options are available (health center may select method independently for each measure):
 - If Column A < 70: Column B Must equal the universe (column A)
 - If Column A ≥70: Column B may equal:
 - A universe count from EHR greater than or equal to 80% of Column A (*and must not* be restricted by any variable related to the test measure) OR
 - A random sample of 70 charts (from column A)

Reporting Racial and Ethnic Disparities Table 7



| | | | | |
|---|----------------------------------|----------------------------------|-----------------------------------|---|
| Prenatal Care Patients Who Delivered During the Year (1a) | | Live Births: <1500 grams (1b) | Live Births: 1500-2499 grams (1c) | Live Births: ≥ 2500 grams (1d) |
| Total Hypertensive Patients (2a) | | Charts Sampled or EHR Total (2b) | | Patients with HTN Controlled (2c) |
| Total Patients with Diabetes (3a) | Charts Sampled or EHR Total (3b) | Patients with Hba1c <8% (3d1) | | Patients with Hba1c >9% Or No Test During Year (3f) |

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

- **Column 2c:** Number of charts (from column B) whose clinical record indicates that the measure rules and criteria have been met
- **Column 3d1 and 3f:** Number of charts (from column B) whose clinical record is within the specified range
- Data must be reported by race and ethnicity for all Table 7 sections: Births, Hypertension, Diabetes
 - Care must be taken to ensure that race and ethnicity data across Tables 3B and 7 align

EHR Reporting



- Reasons to report using EHR
 - Performance measurement standard can be obtained from EHR for at least 80% of all health center patient records for the given measure
 - Must not be restricted by any variable related to the test measure
 - Health centers who have added capacity (NAP or change of scope of site previously excluded) whose EHR has not yet followed the expansion
 - Data can be extracted from EHR for all patients in the universe
 - BPHC encourages use of an EHR for reporting on the full universe of patients served by health centers

Sample Reporting



- Reasons to report using a sample of 70 records
 - Automated systems cannot generate the number meeting measurement standard (e.g., exclusions cannot be removed)
 - Multiple sites have not been on the system for the entire measurement period
 - Fewer than 80% of all health center patient records for the given measure are included in the EHR
 - Population excluded from EHR has unique characteristics related to the variable being measured
- Sample can
 - Produce accurate data with a reasonable confidence limit
 - Work where automated systems do not contain required data
 - Comply with OMB mandate of 70 for sample size

UDS

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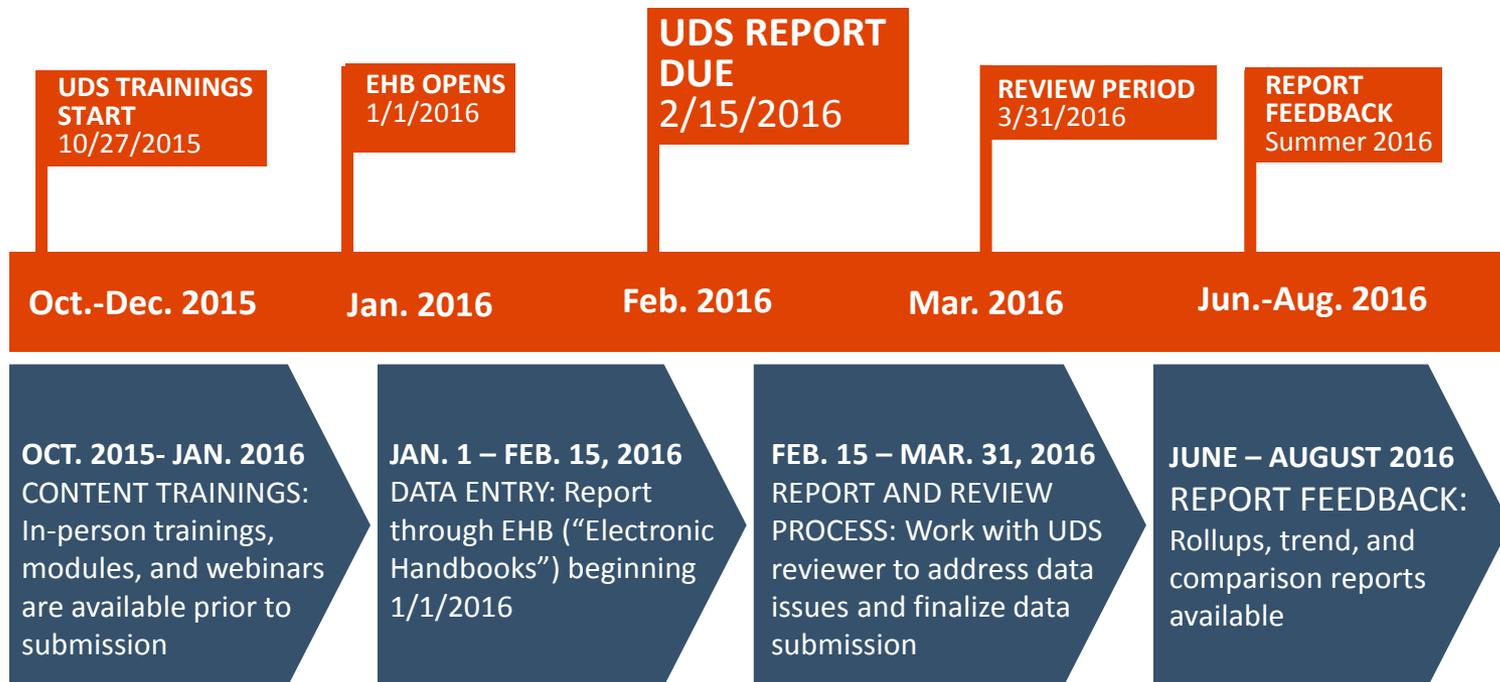


**Reminders,
Strategies,
and
References**

Critical Dates in UDS Process



2015



2016

Training Opportunities can be found at: [Health Center Data and Reporting](#) and [BPHC Training Website](#)
 UDS Support at: 866-837-4357 or udshelp330@bphcdata.net

HRSA Electronic Handbook can be accessed at: <https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx>

EHB Resources: EHB training available through HELP in application and online training module
 EHB incorporates hundreds of edits to alert you to possible problems that require follow-up
 EHB assistance is available through:

- HRSA Call Center for EHB account access and roles: 877-464-4772 or [HRSA Electronic Handbooks Contact Center](#)
- BPHC Help Desk for EHB system issues: 301-443-7356

Strategies for Successful Reporting



- Work as a team
 - Tables are inter-related
- Adhere to definitions and instructions
 - Refer to the manual, fact sheets, and other resources and apply definitions
- Check your data before submitting
 - Check data trends and relationships across tables, last year’s reviewer’s letter, and compare data to benchmarks
 - Address edits in EHB by correcting or providing explanations that demonstrate your understanding
 - “Number is correct” is not sufficient
 - Report on time, but do not submit incomplete reports
- Work with your reviewer

Available Assistance



- Regional trainings: <http://www.bphcdata.net/html/bphctraining.html>
- On-line training modules, manual, fact sheets, webinars, and other technical assistance materials, including PALs available:
 - <http://bphc.hrsa.gov/datareporting/index.html> or <http://www.bphcdata.net>
 - PAL 2015-01: <http://bphc.hrsa.gov/datareporting/pdf/pal201501.pdf>
 - PAL 2015-05: <http://bphc.hrsa.gov/programrequirements/pdf/pal201505.pdf>
- Technical support from a UDS reviewer during the review period
- Primary Care Associations
<http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html>
- Telephone and email support line for UDS reporting questions and use of UDS data: 866-837-4357 or udshelp330@bphcdata.net
- EHB Support
 - HRSA Call Center for EHB account access and roles: 877-464-4772 or <http://www.hrsa.gov/about/contact/ehbhelp.aspx>
 - BPHC Helpline for EHB system issues: 877-974-2742 or <http://www.hrsa.gov/about/contact/bphc.aspx>

Performance Measures

References



- Million Hearts Hypertension Control Change Package
 - http://millionhearts.hhs.gov/Docs/HTN_Change_Package.pdf
- Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Health Solutions for resources related to depression screening and follow-up
 - <http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression>
- National Quality Forum
 - <http://www.qualityforum.org/QPS/QPSTool.aspx>
- CMS Meaningful Use Clinical Quality Measures
 - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html
- United States Health Information Knowledgebase (USHIK)
 - <https://ushik.org/QualityMeasuresListing?system=mu&stage=Stage%202&sortField=570&sortDirection=ascending&resultsPerPage=100&filter590=April+2014+EH&filter590=July+2014+EP&enableAsynchronousLoading=true>

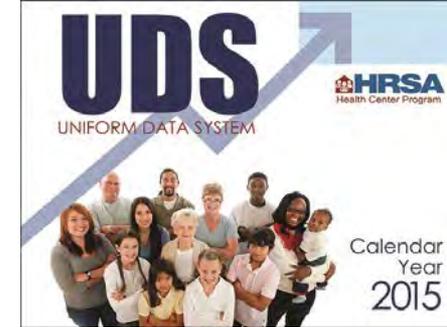
Performance Measures

References



- Healthy People 2020
 - <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8>
- US Preventive Services Task Force
 - <http://www.uspreventiveservicestaskforce.org/>
- State Tobacco statistics
 - http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/map/index.htm
- State Diabetes statistics
 - <http://www.ncsl.org/issues-research/health/diabetes-state-rates.aspx>
 - CDC National Center for Health Statistics State Facts
http://www.cdc.gov/nchs/fastats/map_page.htm

Webinars



Upcoming Webinar

- **Using UDS Data and Reports for Program Evaluation and Quality Improvement**
- **Date, Time:** December 15, 1-2 PM ET
- **Webinar and conference call information**
- **Adobe Connect:** <https://hrsaseminar.adobeconnect.com/udsqiwebinar/>
- **Conference call:** 1-888-469-0691
- **Participant passcode:** 5255999

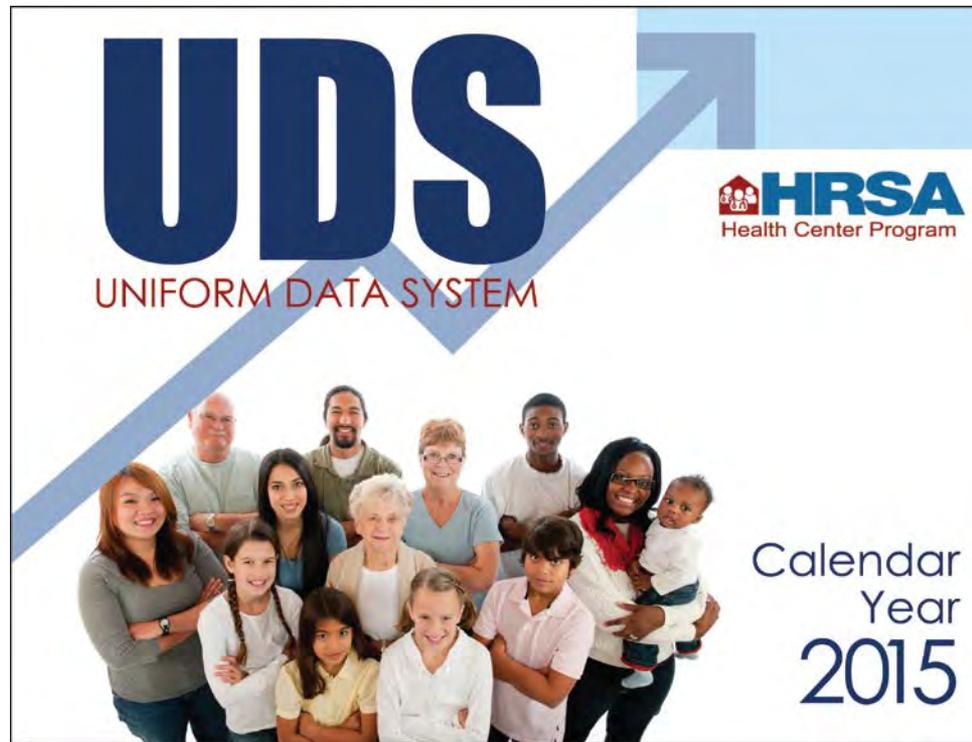
Past Webinar

- **Preparing for and Understanding Your UDS Submission**
- **Date Aired:** November 16, 2015

Webinars will be archived on [HRSA's BPHC Health Center Program website](#)

Questions?





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

Ongoing questions can be addressed to

UDSHelp330@BPHCDATA.NET

866-UDS-HELP