UDS Sampling Methods, including Randomizer.org

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Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen-only mode until the question and answer session of today's conference. At that time to ask a question press the star 1 on your phone. Today's call is being recorded. If you have any objections you may disconnect now. I would now like to turn the call over to Alek. You may begin.

Dr. Alek Sripipatana: Great, thank you John. Happy holidays and good afternoon on the east coast and good morning for those tuning in from all parts west. Welcome to our webinar on sampling methods for the uniform data system or UDS. I'm Doctor Alek Sripipatana, the Chief of the Data Branch at the Office of Quality and Data at HRSA's Bureau of Primary Healthcare.

Before we begin first and foremost I want to thank you all for the great work that you do. You're a part of an esteemed group of healthcare providers that is the health center program family. 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. So thank you, thank you, thank you to the UDS.

The UDS is an incredibly important activity of the Bureau of Primary Healthcare. It provides empirically based information for strategic planning and decision making. It also helps in directing a resource allocation. It provides data to track quality of care to our over 21 million patients as well as highlight the terrific and innovative work of health centers - your work.

Using the UDS we've compared how health centers have met national benchmarks like healthy people 2020 and 2012 - all of our health centers met or exceeded at least one healthy people objective. This is - this sort of achievement is not easy given the complex nature of our patient population.

UDS is a robust data collection activity and can appear intimidating at first glance but don't fret. You're in very good and capable plans. We have an incredibly talented UDS team including our presenter Art Stickgold. So without further ado, Mr. Art Stickgold.

Art Stickgold: Thank you Alek and good morning to everybody here from the west coast. My apologies for my voice. It seems that after 16 hours of straight lecturing, it left. So today we're going to be talking about the UDS and about specifically the clinical measures and where and how to use sampling in lieu of the survey of the complete universe of your patient population.

So we'll be looking at the clinical measures and for each of these we'll describe what the universe is and then talk about how you might be sampling in lieu of actually querying the entire universe in your UDS and in your EHR. We'll be talking about when sampling is preferred or necessary. We'll talk about when sampling is prohibited and we'll discuss some of the issues to take into consideration when you are doing a chart review.

So why - why sampling? The theory was going to be that once we got an EHR everybody was going to be able to get all their information off the EHR. We would never again have to look at a chart and I think that's still the goal that we're shooting for.

For 2013 there are over 1300 health centers that are going to be reporting on 14 clinical measures. These clinical measures are selected to govern all lifecycles and to address both prevention and treatment and the treatment of both chronic and acute conditions. The centers have different abilities to capture and report these data. Some health centers have EHR's.

In fact in 2012 950 of the roughly 1200 health centers reported that they did have an EHR in place which probably would have some or all of the information necessary to respond to the clinical measures without doing sampling but clearly there are a number who do not yet have them in place and others whose EHR is new enough that they don't have enough data in place.

Add to this the fact that some of the BPHC measures are somewhat different than the meaningful use measures or other national benchmarking measures that may be programmed into the EHR and that there are changes to the clinical measures which are being made constantly in which the EHR's may not be tracking. So in those instances reporting is still required and sampling is the methodology that will be used.

So we're going to look into each one of the clinical measures. There are two reports that - two tables that report on the combined 14 clinical measures. On table 6B we report on eleven qualities of care measures. On table 7 we deal with three health outcome and disparity measures. We also collect data on table 6A but these are not used for clinical measures so we don't have to worry about sampling on them.

When we talk about the quality of care measures we're really talking about measures of - we're talking about process measures - measures in the format of saying if patients receive timely intervention then they can be expected to

improve health status. These are all based on med studies on studies of research studies where we can see a high correlation between an intervention and an outcome.

To actually measure the outcome we would have to be able to track the patients for years if not decades. But because other researchers have done that for us already, we can simply move in, look at the intervention and know that to the extent that we are successfully intervening with our patients we will be successful in improving the quality of life.

So for example we know that if children are routinely screened on weight and on counseling and if they and their parents get counseling then we will see less obesity, less diabetes, less hypertension later on in life.

Table 7 looks at a set of intermediate outcome measures. In these measures we can go one step further. We can look at the extent to which medical patients receive clinical interventions and then by using intermediate proxy measures we can actually see the impact of the intervention that they have received. So if this measureable intermediate outcome is in the desired range then the negative outcomes will be less likely.

So for example for diabetes our concern is not really to get the hemoglobin A1C into a certain number range. Our concern is to prevent blindness, to prevent amputations, to prevent organ failures. But we do know that that hemoglobin A1C number is highly correlated to reducing loss of limb, blindness, etc. And so since we can measure it, we can look at the outcome of our intervention and predict our success.

So the who, what and how of reporting clinical measures. As we go through here we're going to be defining the universe for each of the clinical measures -

the individual patients who meet the criteria to be included in the population evaluated.

The fact that you may use sampling does not mean that you can skip finding the patients. In fact you will still need to use your EHR or your practice management system or some other set of systems in order to insure that you find all the patients that meet the criteria that we are looking for. After that the universe which we identify can be queried but we must be able to include all patients across all sites that have the specified age, which have the specified medical visit or visits, which have the specified conditions or exclusions. And on table 7 we need to be able to look at what is their race and ethnicity.

So one way or another, clinics will be dependent on looking at their computers to at least identify the universe. But once the universe is defined then either a sample or the universe will be evaluated to determine the number of records that meet our measurement standard. For 12 of the 14 measures health centers will report on whether or not they met that standard using either a sample or the universe. We say 12 because two of these measures - one on table 6P and one on table 7 both relating to perinatal care. Our old measures have always used the universe in where the sampling option is not available.

Before the others we will ideally use the universe but it's not always possible. When it's impossible to query the entire universe for the data we need, we will be using a sample. And the sample can include results that are pulled from an incomplete EHR or other automated system or from the review of actual paper charts. We want to emphasize that for each of the measures the choice of using a sample or the universe is made independently. You can use the universe on the first three, the sample on the fourth, the universe on the fifth, the sample on the sixth and seventh and so on.

There are two different formats that are used for reporting. On table 6B a standardized format is used and that format shows first the universe in column A. That means that for whatever the measure is we need to know how many people fit into that category. If our universe is going to be all children who are just before the age of three then we need to be able to find every single one of them regardless of what computerized systems are set up and in column A you'll tell us how many there are.

In column B you will either choose to run the test on every single one of those patients that are in column A in which column B will have the same number as column A or you will decide to do a sample. In that case the sample will be a sample of 70 and we in all instances use samples of 70 regardless of how many individuals are in the universe.

And then in column C - whatever the number you put in column B - whatever the number of cases that we're going to review be it the universe or 70 - in column C you'll report how many of those that are reported in column B were actually in compliance.

A different format is used for table 7. It's relatively similar in that we're going to ask you to tell us how many are in the universe, how many you review - either the same as the universe or a sample of 70 - and then how many meet the compliance standards.

However on table 7 we will also ask you to break down these patients by race and by ethnicity. All the Hispanic and Latino patients will be reported in the top section by their race. All the non-Hispanic non-Latino will be reported in the second section by race and then if people reported neither their race nor their ethnicity there is a separate line - line H - which addresses them. Again

you can do the hypertension one way and the diabetes the other way or you can do them both the same way.

So what are our options? When do you report the universe? Well it's very simple. You'll report the universe if you can meet all of these requirements. First if your electronic health record or - if you're using it - a chronic disease management system or any other electronic system includes every single patient who meets the selection criteria. That means that all your sites have to be on the - in the system - that all your providers must be in the system and that your system has to have been in place long enough.

So if the criteria is that somebody has received a service over the last year or two years or five years or ten years then your system must be able to report for the multiple years. Your system also needs to be able to identify individuals who should be excluded from the universe. So if you're going to report on the universe you need to be able to find and exclude all patients who are to be excluded on the measure. For example with PAP tests women who have had a hysterectomy are excluded from the universe. And then of course the data must be appropriately linked.

So even if you can find all of the patients, you still need to be able to find the success criteria we're looking for - for example be able to find out what the last hemoglobin A1C actually was.

So the other side of this is when to use a sample. If the systems cannot report the universe and for the universe those who meet the measurement criteria, you have to use a sample. For example if what we are looking for is something you don't code for, you'll need a sample. The common one is that since persistent asthma does not have an ICD9 code if you do not have some

surrogate in your system to identify those patients then you'll have to use a sample.

You need to use a sample if you have two of your five or three of your five or four of your five sites but not all five of your five sites. If you've expanded and added a new site and the new site is not yet on the EHR then you'll need to use a sample which permits you to include the patients from the new site as well as those from all the other sites.

And of course if for some reason you have not included all your patients in the EHR you'll use a sample. Some health centers for example have started out putting pediatrics in the EHR then move to women's health then move to adult medicine. If you don't have adult medicine in there yet well of course you'll need to use a sample.

Using a sample you can produce accurate results with a reasonable confidence limit and we feel confident that your data based on a sample of 70 will in fact give us good data. The sample can also limit and reduce the data analysis burden on those centers that are not fully automated. And of course this still complies with OMB's mandate to the bureau that if a sample is to be used there should be 70 in that sample size.

To be very clear, using a sample when you have problems in finding the universe of patients who meet the reporting criteria doesn't mean that you don't have to find the universe. You still need a way to find all the patients that meet the criteria for the measure. So it may be that you can find all your asthmatic patients but not find which ones have persistent asthma. You need to be able to find a way to identify the persistent asthma patients.

So we're going to start talking then about table by table and we're going to go through each one of the tables in table - each one of the measures in table 6B and table 7 and talk about what the universe is and what you're going to be sampling.

The first one on table 6B addresses childhood immunization. Actually the first one addresses early entry into prenatal care but as I mentioned there is no option to sample that. So for our first measure - childhood immunization - if you have lots of information but if lots of your immunizations are being done by others and if this is not routinely entered into your EHR you may very well have to do a sample.

For example if the county or some other organization is doing immunizations and what you have in your records are paper copies of or scanned in copies of evidence of vaccination then you'll need to go in and look at a sample of 70. Right now we're asking you whether you have - we're asking about children who are turning three in 2013.

Since these children could have been immunized in any of the last three years you actually need to know about 2010, 2011, 2012 and 2013. So you're going to add to that line 2010 because you need to be able to look at the records for those children three years prior to their turning three. That means that if you only have the last two years' worth of immunizations online then you'll have to use a sample.

For the cervical cancer measure again if some or all or a large number of your patients are getting their PAP tests done through another resource, through a family planning program, through a county health department - even if they are bringing in copies of their results - unless those are in a searchable format in your EHR, you'll not be able to rely on the EHR.

And because today we are looking at women who may have gotten a PAP test and HIV test as much as five years prior to the measurement year, we really need you to have 2009, 2010, 2011, 2012 and 2013 data in your system or an alternate way of collecting that information. And note it is possible to use a template to record that you have evidence of a PAP test or a PAP plus HPV in prior years and not actually have all those data in your own system.

Your EHR also has to be able to identify patients who have had a hysterectomy so that you will be able to delete them from the population where you are questioning whether or not they have had a PAP test.

We have two measures that address weight - one for children and one for adults. The one for children requires that your EHR have recorded their BMI percentile or - this is becoming more common - have the capability of calculating that on the fly any time the provider clicks on the BMI percentile tab. And your EHR must specify whether the required counseling has been provided. And note it's not just did the patient receive counseling. It's did they receive counseling on nutrition and did they receive counseling on activity.

And again because it's rather useless to say that a pregnant adolescent is "overweight" it has to be capable of identifying adolescents who are pregnant and removing them from the universe before it asks about whether or not all of the records are in compliance.

For adults we have a multistep process. So first your EHR must determine and must be able to demonstrate whether or not there is a recorded BMI for a patient and indeed for every patient in the sample that's all adults. And then if their BMI is outside the norms, your EHR must be able to be queried to

determine whether or not a follow-up plan has been entered into the record. And of course you need to be able to exclude pregnant women. The fact that they're heavier than normal is not relevant. And it needs to be able to exclude the terminally ill. The fact that they are underweight is unfortunate but not a part of this particular measure.

With tobacco we have combined - we have two different measures that together address tobacco use. First we want to know whether or not you are assessing the tobacco use. So for the first measure we want to know whether or not the patient has used tobacco - not just smoking but tobacco. And because the criteria says that they have it within 24 months of their last visit and their last visit could have been in January of 2013. We need your EHR to be recording this information and have it available to be queried for 2011, 2012, 2013.

And note the complexity of what we're talking about here and elsewhere. When there are multiple years and you have brought some of your sites online later than others then if you can't query all your sites for three years, you're going to be using a sample.

The first of these measures asks about whether or not they are queried. The second measure asks about your tobacco users and asks whether or not you were provided cessation counseling or medications. And again we need the three year span and again we lack codes that would necessarily tell us this. So unless you have clear codes for them we'll be using a sample.

For asthma we have a special problem and it's been hitting a lot of the health centers. For asthma the criteria is for patients who have persistent asthma and persistent asthma is not an ICD9 code. Note we're not talking about severe asthma. A person could have persistent, severe persistent, moderate persistent

mild asthma. So we need to be able to identify all patients with persistent asthma and if we cannot do that then we will be using a sample.

And of course the data system must also be able to identify whether or not patients have had a medication prescribed or dispensed or whether the medication is being used and by the way that's or the medication is being used. So if you have evidence that the data - the drug has been dispensed you do not also have to have evidence that the drug is being used.

We have two measures for cardiology and relating to heart attacks. The first deals with coronary artery disease patients and that means that your system must be able to identify all current coronary artery disease patients as well as those patients who have had a heart attack or who have had cardiac surgery.

And then if we can identify all of those you need to be able to say whether or not the medications have been given or taken. And most importantly you have to have your lab data easily accessible so that you can exclude patients whose last LDL lab test was less than 130 milligrams per deciliter.

Our other cardiology measure - our other heart attack measure is - deals with extreme vascular disease. And very simply you need to be able to identify all those individuals who show extreme vascular disease on the problem list who show it as an active diagnosis and also be able to tell for all of those patients whether they are indeed taking aspirin or some other antiflambotic drug. And we're looking for not only those with extreme vascular disease but also for those who have had a heart attack, a bypass or stunting between January of 2012 and November of 2012. And those very same states are in fact stipulated in the measure.

And then finally among this group of measures - colorectal cancer screening. Here we need to know not only all patients who are age 50 to 74 who are our patients but also we need to be able to determine whether they have had either a colonoscopy in the last ten years or a flexible sigmoidoscopy and Flex-CID within the last five years or much more commonly whether they've had a (unintelligible) blood test in the last year. But that means that we need to be able to tell for every single patient age 50 to 74 whether they have had one of these three forms of cancer screening.

Then we go to table 7. Hypertension and diabetes - again we need to be able to identify every single patient who has been diagnosed as hypertensive and have a system that can see their most recent blood pressure. This by the way - we think almost all L centers with a fully operable EHR will be able to do. For diabetes we need to be able to look at what their most recent hemoglobin A1C test was or note that they haven't had one this year and being able to determine that for every one of your active diabetic patients.

Now we do have some changes that are going on and the transition to an EHR is not necessarily smooth in every instance. So while sampling may still be necessary, we are urging every health center to make sure that their EHR will in the future be able to measure the criteria that we're looking at.

You'll notice that for several of the 330 variables - 330 clinical measures - the clinical measure is not the same as the meaningful use measure. So you'll need to look very carefully at what your vendor has programmed into your system and then make sure that you can get what you need for the clinical measures for the 330 program.

For example this year the vaccination measure has changed and is no longer the same as the meaningful use measure. While you still may need to use the

meaningful use measure for your meaningful use reimbursements, you will have to be able to also have programmed into your system the BPHC clinical measure for vaccinations.

Your vendors are always encouraged to attend the UDS training sessions. Most of those are done now but in the future these are discussed at the sessions and you and your vendors are invited to call the UDS helpline at 866-UDS-HELP if you have questions about what is in those measures. Not that before you do that you should take a look at the PAL that the bureau has released defining all of these measures and once it is posted towards the end of the year - the manual - as I said the complete UDS manual will be on the Bureau's website in the next week or so.

There are a couple of changes coming in 2014. We just want you to make a note of them so that if you're working to get your EHR capable of doing the reporting, you're aware of these too. Two of them went on table 6A and then again on table 6B ask you to report about individuals who have been diagnosed for the first time with HIV AIDS.

Also on table 6B and 7 there's a new requirement that all health centers report on perinatal measures including those who refer for perinatal care. So beginning in 2014 even if you are referring for prenatal care you need to keep track of the outcomes to report on table 7.

Table 7 next year is going to merge the tobacco screening and cessation measures. That'll make it a little easier and it's going to add a depression screening measure - a no go - have they had screening or have they not.

There was a clinical measure webinar conducted a few weeks ago that is on the website. It is available to play back if you'd like to go back and listen to

that. So let's talk about what to do when you're doing a random sample and the first thing is to recognize what a random sample is. A random sample - in our case a random sample of 70 is a group of 70 patients where every single one of your medical patients who meets the criteria for that measure has an equal chance of being included among the 70.

So if your new site is not in the EHR and the children of that site have no chance of being included in the 70 who were looking at vaccinations on all four then you'll have to use the universe. All sites, all services - the entire grant funded program must be available to be sampled and all people in that universe must have an equal chance to be included.

To do a sample - as I said - first you have to find the patient population. That'll be hopefully mostly possible with your computers though it is possible that at a given site or for a given situation you'll also have to add in some that you are reporting from charts.

And then you'll need to list - to create a list of all those patients and number the patients in that list. After you've done that you'll randomly select 70 of those. There are some EHR's that are actually capable of sampling a list and if you have an EHR that can do that, even if you don't have the information about persistent asthma in your EHR you can still use the EHR to - for example - identify all asthmatics or even if you don't have all of the vaccination data you can still use the EHR to produce a sample of 70 three year olds. But that's only if your EHR can do that.

Otherwise we'll talk about two other methods to get random samples and we're going to suggest that while you need 70 in that sample you'll probably want to sample more that you have five or ten extras just in case after you ask

for all of your three year olds, one of them pops up and turns out to be just a dental user and not a medical user or something else like that.

Once you've identified the 70 you need to review those records to determine whether or not the measurement standard has been used. Sometimes even though you can't use the EHR to look at the universe, you can look at the EHR to answer your questions. For example if you have routinely scanned in the results of PAP tests while you can't query that scanned record, you can open up the record and look at the scanned in documents and find it.

And then step four - if while you're looking at all those records you find one or two that simply doesn't qualify then you'll use one of the replacement records to review so that you still have 70.

We're going to talk about two options to create a random sample if your EHR doesn't do that automatically. The first and probably the preferred method is to use a random number list and then select 70 records using that. To do that you're going to prepare your numbered list of all the patients in the universe. You're then going to generate random numbers. So if you have 5000 in the universe you're going to create the list and number them 1 to 5000. Ideally you won't have to print out this list. It'll be in a readable file that can be downloaded.

Then you'll generate a set of random numbers. We suggest that you use the URL here to go to the randomizer to create that list. That list is going to create a - that program is going to create a list and it'll say like the first random number is 3212 and then you will go to chart, random number 3212 and look at the chart that is referenced there and that may be the chart for John Smith and then you'll order the next number and so on.

If you have your replacement set right there - if John Smith turns out to in fact be a dental patient instead of a medical patient and you need to replace him then you'll continue and look at the 71st record as well as the first 70. You can do this by either pulling your random sample of like 80 and then in which this case you will not sort the numbers. You'll just do 80 and you'll look at the first 70 that qualify. Or you can do one list of 70 and then a second list of five or ten more also random and literally replace from one list into the other.

When you go to the randomizer website it looks like this and you'll fill it in by saying for the first question how many sets of numbers, one. For the second question how many numbers in that set, 70 or if you're doing an older sample, 80.

For the third one, the range. So if for example you had 230 patients with coronary artery disease, you'd say from 1 to 230. Where it asks if you want a unique set of numbers, you'll see yes. For those in statistics you'll know that this means we're doing a random list without replacement into the set so that the same number cannot in fact be sampled twice. And then if it makes it easier you can look at 70 and sort them from bottom to top but if you're going to be looking into your EHR for most of this you might just as well sample 80 and then say no, do not sort them.

There's another way of doing this. Again it starts out with preparing a numbered list of all the patients and then calculating a sample interval. So for example if we were going to do those 230 CAD patients we would divide 230 by 70 and that would tell us that our starting interval is roughly three. We'll then start at a random point in the list and from there on pick every third patient.

So if we randomly start on record number 160 we'll look at record number 160 then record 163 then record 166 and when we get to the end of the list we'll just cycle around to the top and continue until we get our full 70. Using this system if one of the records needs to be replaced, simply go to the next record. So if record 166 turned out to be a patient who shouldn't have been in the universe, you'll go to record number 167 but then go back and look at record 169.

And this is more or less a graphic concept of what we're doing. We've got the records listed out. We're going to in this case the second record - starting there looking at chart 234951, skipping three or skipping two then going to the third one 736812 and so on.

To extract the data from the records before the charts or records are actually looked at, make sure that there isn't a simple way to ask the question. In some instances the EHR or the practice management system or the eye to eye track system or whatever you're using will give you some of the information or all of the information for some of the patients.

If you can do that - if you can look at your children and find out from your automated system that 45 of these are fully immunized, you're good on the first 45. And that means for the other 25 you'll need to go and actually look at their charts, look at the notes, look at the immunization data and see if perhaps they were immunized somewhere else. And again use whatever data you have that you can use to find out if these patients have met the standard.

Eventually you will probably have to look at the details in one or more of the records - actually look at chart notes in text form that the provider answered and that's fine too. A data tool is available from the support center. It's an Excel spreadsheet and you can use it to record this information if you want.

It's not required but it is there at this URL and you can download it to use that for your work.

Note that we talked about exclusions and criteria. They're actually two sides of the same coin. So you can either for example look at all the children and adolescents and then if one of them happens to be pregnant, drop that one and replace it with another one. That's using an exclusion. You can also make a criteria and look at all the patients who meet the age criteria who were not pregnant in which case your list would come out with the exclusions already programmed in. So exclusions can be either used to develop the universe or to exclude patients from the universe.

And here we talk about it with cervical cancer. You can do it here either by saying show me all the women age 24 to 64 who meet the criteria or show me all the women who have had - not had a hysterectomy who are in that age range in which case you won't have to deal with an exclusion. If you are excluding a patient, do not attempt to go back and change the universe. The error will be minor and we're not going to try to fix the universe from the sample here.

We do want to talk about one specific situation and that's especially with the persistent asthma patients since it has been - since it's the problem. Sometimes you may need to actually calculate what your universe is. So while it would be great if you could get all the criteria into your EHR, we're going to take an example and show how to do this with persistent asthma.

So if persistent asthma is not identifiable in your EHR but asthma is, first you identify all the patients with asthma. Because only some of them have persistent asthma you'll need to change that to a sample - to a much larger

sample so that you can find the persistent asthma. For example randomly select some 300 charts.

I'm looking at my notes and they're totally cryptic. It says one MD in MD. Actually what I mean is one doctor in Maryland told us that he had to actually go through 150 charts before he could find 70 that had persistent asthma but that's what you're going to do. You're going to look at the medical records for as many as you need to find the first 70. Once you have found the 70 you'll know how many you went through to find the 70. In the case of that particular Maryland clinic - they needed 150.

That means that 70/150 of the patients have persistent asthma or 46.7%. And if we knew that there were 950 patients with asthma then we would take 46.7% of 950 and that number - 443 - is the one that we would report in column A. By the way, this entire discussion is covered in appendix C of the manual and again the manual will be online by next week some time.

Okay before we go to questions, just a few reminders. Your electronic handbook will have the UDS two weeks from today. So on January 1st you'll be able to go in and actually look at the UDS in your electronic handbook. The UDS is due on February 15th, not the 17th or the 18th but the 15th. So roughly 60 days from now your UDS needs to be filed.

And over the next 45 days you'll work with your reviewer to address any questions that come up and finally submit your UDS by the end of March. By mid-summer or late summer you'll be able to look at your data, your trend reports, and your comparison reports to see the final data of the QI initiatives.

Some strategies - work as a team. We know that the IT people and the QI people are the ones that are going to be responsible for this but make sure that

the clinical director and the clinical staff have seen what you're submitting before you submit it. Make sure you've looked at the manual and the fact sheets to clearly identify the populations that you're reviewing and what constitutes meeting the standard.

Look at your data for the last year. If last year you were at 90% and this year you're at 10% check to make sure that you're not making a mistake. And if last year your letter from your reviewer said this is a mistake and you have to fix it, well make sure you're not making the exact same mistake this way. If the data do look strange, tell us why. Don't just say the data are accurate. Tell us why you have an unusually high or an unusually low compliance or why your compliance rate has changed dramatically from last year. And work with your reviewer to make the corrections that are necessary.

Resources are available. I won't read URL's to you but the manual, the tool, the random sampling website - all of those are listed. And then the health line - 866-UDS-HELP - or you may email data and questions to the helpline for further information. Whoops, let's see what I did. Okay so we're at the point for the questions and at this point we'd like the operator to throw this back open and (Jonathon) can step in now and explain to people how to ask questions. We'll go ahead and see what questions we have.

Coordinator: Thank you. We will now begin the question and answer session of today's conference. In order to ask a question, please press star 1 on your touchtone phone. One moment please for the questions to come through.

Art Stickgold: And let me reiterate that this is not your only chance to ask questions but of course you can go to the helpline and continue once you begin working on your data and develop questions.

Coordinator: Our first question comes from (Rene Higgins). Go ahead. Your line is open.

Rene Higgins: Hi Art. I'm from Ventura County Healthcare Agency. We've spoken before. You mentioned when you were talking about the colorectal cancer sampling the patients were 50 to 74. Did you mean 51 to 74?

Art Stickgold: Yes. I meant 51 to 74. So much for not having my notes in front of me. What it is, is 50 year olds who have had it within one year of turning 50. So actually it's 51 year olds. Thank you for clearing that up.

Rene Higgins: Okay. And then also we are adding that we are having for table 6B the CAD process measure, correct? We are not deleting it, correct?

Art Stickgold: There was some discussion of deleting the CAD measure next year.

Rene Higgins: Next year, okay.

Art Stickgold: In fact watch for a PAL that should be coming out in the very near future discussing the bureau's position on that. As you may know, the American Heart Association and others have been in a mild dust up about what the proper way is to deal with this condition and so the bureau will be responding to that in a PAL coming rather soon.

Rene Higgins: But as of right now it's included.

Art Stickgold: It was always intended to be included in 2013.

Rene Higgins: Okay.

Art Stickgold: There never was a change. The question is 2014 and it looks like we won't change 2014.

Rene Higgins: Okay. Thank you.

Coordinator: Our next question comes from (Rita Bouche). Go ahead. Your line is open.

Rita Bouche: Hi Art. I was trying to find the 2013 UDS manual online. I can't find it. Do you know where I could get ahold of that?

Art Stickgold: Yes. Hi Rita. How is (unintelligible)? Cold I suppose.

There is - the manual should be posted in the next few days. It is still in draft status. If you want to give a call to me to the helpline, perhaps I can help you and get a copy of draft but the final version should be posted by next week.

Rita Bouche: Okay, great. Thank you. And we've been pretty warm and we're probably getting snow though.

Coordinator: Our next question comes from (Arial Fermiento). Go ahead. Your line is open.

Arial Fermiento: Hi. This is more of a comment and I think this is also mentioned but I just attended the UDS training sponsored by Chicanes New York State Community Health Center Organization yesterday and it appears that the CAD revision has not been approved for 2014. So I think you mentioned this as well but just to confirm, that's what we were told that I think the CAD measure is going to stay as it is.

Art Stickgold: Yes. So without getting into the complications of OMB clearance and clearance up and down within the bureau, I think it's safe to say that that is

what is going to happen but official word has not yet been finalized. And so since it is a 2014 issue we don't have to worry about it. We've got a lot of time to take it into consideration.

Coordinator: Again as a reminder to ask a question, please press star 1 on your phone. One moment please for more questions to come through.

Art Stickgold: Well if there are no further questions, I would like to thank all of you - probably a couple hundred of you here today - for participating and give you - we wish you the best of the holiday seasons and I know that you'll all be there on New Year's day to open up your electronic handbook and begin entering data in the UDS and we look forward to seeing your completed UDS by February 15th.

Again if you have questions 866-UDS-HELP is available to you basically nine to five east coast time and thank you very much for your participation in this webinar.

Coordinator: We do have one more question on the phone. It comes from (Brigetta Ober). Go ahead. Your line is open.

Brigetta Ober: Hi. I was just wondering - I'm really confused and I know that this may be a nonissue next year but for the CAD measure we had a lot of internal debate as to when - I mean is it an infinite look back for the LDL or is there a time period that we should be looking for an LDL to have been done?

Art Stickgold: We're looking - the exclusion that relates to the LDL is the most recent LDL.

Brigetta Ober: Okay. So it would be - if the most recent was ten years ago and it was normal, it doesn't matter. It's still or if it was last year and it was normal so they are

controlled. I guess we were trying to figure out the intent behind excluding a normal LDL that might have been done kind of recently which means that the person is in a controlled state.

Art Stickgold: Without trying to get in the middle of the debate over this one - and there is a debate - the intent is that with a coronary artery disease patient who you are treating - if you are successfully treating that patient and their LDL has been gotten below 130 that we are no longer asking the question of are you insuring that they're taking their medications. So the universe is those who - is made up of those individuals whose lipids are essentially not well controlled.

Brigetta Ober: Okay. Thank you.

Coordinator: There are no further questions at this time.

Art Stickgold: Well again thank you and enjoy your holidays.

Coordinator: That concludes today's conference call. Thank you for participating. You may disconnect your line at this time.

END