

NWX-BPHC

Moderator: Whitney Welsh
April 12, 2016
1:00 pm CT

Coordinator: Thank you for standing by. At this time all participants are in a listen-only mode. This conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the conference over to (Alec). Thank you. You may begin.

Dr. (Alec Sripipatana): Great, thank you, operator, and before we get started, I did want to draw folks' attention to a couple of links from the Webinar. In the upper left hand column you'll find the link to the UDS uniform resources page. There we will be archiving this Webinar, the 508 compliance slide deck will be posted there. Right beneath that is a link to download today's slide deck, and that also is 508 compliant.

So good afternoon on the east coast, and good morning for those tuning in from all parts West of the Rockies. Welcome to our kickoff Webinar, to the series of Webinars for the 2016 uniform data system, or UDS. I'm Dr. (Alec Sripipatana), the director for the data and evaluation division here in the office of quality improvement at HRSA's bureau of primary healthcare.

Our division oversees the bureau's primary data collection strategies like the UDS as well as its research and evaluation activities that help assess how well the health center program is improving access and quality of healthcare while being cost conscious. Before we start as always, first and foremost I want to thank you all for the incredible valuable work that you do for over 24 million lives.

Your care and services are a critical component of America's healthcare safety net, providing a robust menu of healthcare services to some of America's most vulnerable population groups. All right, so now onto the uniform data system. The UDS is an incredibly important activity of the bureau of primary healthcare. It provides empirically based information for strategic planning.

It helps to draw attention to areas of healthcare services that could use more attention, and helps to direct resource allocation and deploy intervention activities. It attracts the quality of care to our 24 million patients, as well as highlights the terrific and innovative work of health centers. Using the UDS data, we've compared how health centers have met national benchmarks like healthy people 2020.

In fact nearly 35% of HRSA funded health centers have met or exceeded at least three healthy people 2020 objectives. This is not an easy achievement given the nature of complexity of our patients. The health commissions, the neighborhoods and environments in which they're nested in, and the very real competing life priorities our patients have with obtaining healthcare services.

Today's Webinar helps to set the stage for 2016 UDS. We at the bureau appreciate the effort that goes into these annual submissions and try to be very strategic and judicious when it comes to making changes.

We feel that the modifications that have been made for the 2016 UDS reporting year will help capture important sociodemographic information that will help tailor healthcare service delivery in a culturally competent way, identify organizational capacity like staffing that highlight the robust services provided at health centers, leverage technology like electronic health record systems to reduce reporting burdens and help position health centers in evolving healthcare delivery reimbursement landscape, and finally to support quality improvement.

Today's presentation will provide a review of the calendar year 2015 UDS reporting changes, an overview of new patient demographic reporting requirements, highlight staffing and cost changes, introduce the integration of ICD10 code usage, describe revisions to the UDS's clinical quality measures, and finally showcase new elements to the electronic health records' capabilities and quality recognition form.

We hope that this session will provide you with the information needed to ensure health centers have systems in place to capture these key elements. Please be mindful of and incorporate these required changes that are necessary for accurate reporting, due February 15th of 2017. The UDS is a robust data collection activity and can seem arduous at first glance. But don't fret, you're in good hands.

We have an incredibly talented UDS team, including those team members that are on this side of the Webinar. So without further ado let's begin our

conversation on the 2016 UDS. I will hand over the presentation to (Suze Frederick) to drive us through the next portion of today's Webinar. (Suze)?

(Suze Frederick): Thank you very much, (Alec). Welcome, everyone. Again, my name is (Suze Frederick) with JSI and during today's Webinar I'm going to be reviewing the changes approved for the 2016 UDS reporting. These changes apply to data reported for the period beginning January 2016 so going back a few months.

For official notification of the UDS changes, you can reference the PALS, available at the links listed on your screen. These changes will also be reviewed this coming fall and winter during the UDS face to face trainings. The next slides summarize the changes. If the table is not referenced in the coming slides, then no changes were made to that table.

The first changes appear on the patient tables 3A and 3B. The changes to the patient demographic table standardized reporting of sexual orientation and gender identity with the addition of the new tables to capture SOGI, table 3A which is patients by age and gender, will now report the patient's sex at birth. This is a change from prior reporting which captured the patient's self-identified gender.

Two new tables have – or two new sections of table 3B have been added to capture SOGI, sexual orientation and gender identity can play a significant role in determining health outcomes and gaining a better understanding of populations served by health centers, including their sexual orientation and gender identity helps to promote culturally competent care delivery and contributes to reduced health disparities.

To more accurately reflect sexual orientation and gender identity, new sections to table 3B. Patient registration information should be modified to

collect this information if you have not already done so. Adopting sexual orientation and gender identity data collection in the UDS aligns with the 2015 edition health information technology certification criteria, the 2015 edition base electronic health record definition, and the office of the national coordinator for health information technology, health IT certification program.

By aligning the UDS SOGI data elements with ONC certification criteria, overall health center reporting burden is reduced. If you've not been collecting SOGI information starting back in January, you may report patients for whom this information is not known as choose not to disclose for this reporting year. However please note that this is a temporary option which should not be used in future years.

So again you need to revise your patient registration information to allow patient to disclose their sexual orientation and gender identity. The next set of changes appear on tables 5 and 8A with the addition of some new categories of staff. Three new categories of staff are added now to table 5 and corresponding lines have been added to table 8A to capture the costs for these staff categories.

The first new line is added to the dental service category for dental therapists. Line 17A reports dental therapists and costs are reported on table 8A line 5. You should only report on this line if your state has licensed dental therapists as a provider type. A new enabling staff category has been added to line 27A, the cost for this line on table 8A are reported on line 11H. This line is for reporting community health workers.

And then finally given the growing importance and of and need for staff engaged in quality improvement activities, a new line 29A has been added for QI staff. These staff were previously reported as medical. You may have

reported them as nurses or medical assistants, under the medical lines these staff will no longer be included with medical costs on table 8A, but they're going to be reported on their own cost line 12A.

This slide provides definitions for these three new categories of staff. As mentioned, dental therapists are licensed as dental providers in some states. Community health workers are a class of staff who work in the community. They usually perform a range of functions such as outreach and health education. You may not use this term for that staff category, but if they meet those criteria we encourage you to report them on this line.

QI staff are engaged in quality improvement activities and include designing QI metrics and recording and measuring clinical quality. At this point I think we're going to do a quick quiz to see if you've been paying attention, so with that I'm going to hand it over to our quiz people. If you can please answer the question on your screen true or false, health centers are to report sexual orientation and gender identity information related to the populations served.

And the second question has to do with the staffing and utilization changes to the table 5A and – 5 and 8A, and this question is in the staffing and utilization table and financial cost table, how many new staff categories have been added, and then finally another true or false question, quality improvement staff are involved in the design of QI metrics and in the recording and measuring of clinical quality.

So please go ahead and enter your answers, and as soon as we have a quorum we can move on. And if the quiz person can just let me know when I can proceed, I will do that. All right. I'm going to continue, a number of changes have been made to the clinical tables, 6A, 6B, and 7. On table 6A the

transition to ICD10 in 2015, will require that the ICD9 codes be removed from table 6A.

So starting in 2015 – excuse me, 2016 you’ll be reporting using only ICD10 codes. A number of changes have been made to table 6B and 7. To support department wide standardization of data collection and to reduce health center reporting burden, the specifications for the clinical measures on table 6B and 7 have been revised to align with the centers for Medicare and Medicaid services electronic specified clinical quality measures or ECQMs.

So this table shows the alignment of the UDS measures with the corresponding CMS ECQMs. This alignment resulted in changes to most of the clinical measures. I’m going to go through each of the measures and share with you which measures have any kind of changes. If there are no changes, I will also let you know that.

So the first clinical measure is childhood immunization. The childhood immunization measure is aligned with CMS 117. This measure is the percentage of children 2 years of age who were fully immunized by their second birthday. Major changes to this measure include a change in the universe, it is now 2 year olds and not 3 year olds. It also – it has involved a list of additional immunizations added to the standard, including hep A, roto virus, and flu vaccines.

So CMS 117 will hopefully for many of you seem very similar to the UDS clinical measure for childhood immunization that was used for a couple of years ago for a number of years. As with the current childhood immunization measure, there are no exclusions for refusing to be vaccinated or a missed appointment, so again this measure was similar to one that was used a couple

of years ago, has a universe of 2 year olds rather than 3 year olds, and has added some additional vaccines to the standard.

The next measure, cervical cancer screening, has been revised to align with CMS 124. This measures the percentage of women 21 to 64 years of age who received one or more pap tests to screen for cervical cancer. Major changes to this measure include a change in the age range, from 23 to 64. That involves that look back, which is one year earlier than the current UDS measure.

Also the alternative option which is currently in the existing measure for meeting the standard with an HPV and pap test for patients 30 years of age and older has been removed. Thus meeting the standard for this measure requires documentation of one or more pap tests within the three year period, from the current year only.

The weight assessment and counseling for children and adolescents is aligned with CMS 155. This measure currently has no change in the definition for reporting. Adult weight screening and follow-up has been revised to align with CMS 69. This measure is the percentage of patients aged 18 years of age and older, with a visit during the reporting period with a documented BMI during the visit or during the previous six months.

And when the BMI is outside normal parameters, a follow-up plan is documented. Major changes to this measure include new exclusions, the denominator or the universe of patients included in this measure now excludes patients whose only visits are for palliative care, or the only visits were for urgent or emergent care, and/or the patient refused to have their height and weight measures.

Now previously a patient who did not have a recorded height and weight would be considered out of compliance. Tobacco use screening and cessation intervention has been revised to align with CMS 138. This measure is the percentage of patients age 18 years of age and older who were screened for tobacco use one or more times within the 24 months and who received cessation counseling intervention if defined as a tobacco user.

Major changes to this measure include a new exclusion, the denominator or universe will exclude patients if there is documentation of a medical reason not to screen for tobacco use. Also it should be noted that the previous measure required two medical visits ever for patients to be included in the universe. The revised measure requires either two visits of any type, that could be mental health, substance abuse, other professional or medical, or at least one preventive visit during the reporting year.

So two visits of any type or one preventive measure would include that individual in the universe. Asthma pharmacological therapy has been revised to align with CMS126. This measures the percentage of patients 5 to 64 years of age who are identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Major changes to this measure include a change in the age range from five to 64 rather than the old 5 through 40. It eliminates the requirement for two visits ever, and it has different exclusions, so the new exclusions include patients with emphysema, chronic obstructive pulmonary disease, cystic fibrosis, or acute respiratory failure during or prior to the measurement period.

It removes the current exclusion in the UDS measure for patients with an allergic reaction to asthma medication, so those patients would not be excluded in the new measure. Isthchemic vascular disease, use of aspirin or

another antithrombotic has been revised to align with CMS 164 and currently there are no changes to the definition with that alignment.

Colorectal cancer screening has been revised to align with CMS 130, this measure the percentage of adults 50 through 75 years of age who had appropriate screening for colorectal cancer. The change in this measure is a change in the age range from 50 through 75 rather than the 51 through 74 in the previous measure.

Depression screening and follow up has been revised to align with CMS #2, this measure is the percentage of patients age 12 years and older screened for clinical depression on the date of the visit using an age appropriate standardized screening tool, and if positive a follow up plan is documented on the date of the positive screen, so changes to this measure include additional exclusions.

The new measure excludes patients who refuse to participate, patients who are seen for urgent or emergent situations, and patients whose functional capacity or motivation to improve impacts the accuracy of results from the universe. Unlike the previous measure there is no exclusion for prior diagnosis of depression or bipolar disorder or a patient already participating in ongoing treatment.

Dental sealants for children have been revised to align with CMS 277. At this time there is no change to the definition with the alignment. Hypertension has been revised to align with CMS 165. This measure is the percentage of patients 18 through 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

There are a number of changes to this measure, including a change in the age range. It's now 18 through 85 rather than 18 through 84. There is now no requirement for at least two medical visits during the reporting year, and there are additional exclusions beyond the current pregnant patients and patients with end stage renal disease. The additional exclusions include patients with renal dialysis or renal transplant, chronic kidney disease and stage five renal disease.

And the diabetes measure has been revised to align with CMS 122. This measure is the percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1C greater than 9% during the measurement year. Major changes include a revision to the age range from 18 through 75 rather than 18 through 74. There are now no exclusion whereas previously patients with gestational diabetes or steroid induced diabetes were excluded.

And there's no longer a requirement for at least two medical visits during the reporting year. That was quite a mouthful and in order to see whether any of it stuck we're going to do a quick quiz with a few quick questions, if I can have the quiz person pull those up. So if you can answer the question, the first one is a true or false question for 2016 UDS reporting health centers are asked to report using ICD codes only.

The second question is which of the following clinical measures did not align with a CMS clinical measure? And then finally which of the following clinical measures has experienced no significant change from the prior year? So if everybody could go ahead and answer promptly, we can then move on. Oh, there's one more. Which of the following clinical measures – well, it's now on your screen, has experienced no significant change from the prior year?

And when we're finished if the quiz can go away, then I'll continue with the presentation. Thank you. All right, and the last section of this presentation is on the electronic health record form, the EHR survey form has also been updated. There are two new lines which have been added for medication assisted treatment and telehealth. To understand the use of medication assisted treatment in health centers, two questions ask for the number of employed or contracted physicians who have obtained a data waiver to treat opioid use, and the number of patients receiving MAP for opioid use disorder.

Addressing America's opioid misuse crisis is a national priority. Medication assisted treatment is a comprehensive treatment for helping patients overcome addiction through the use of medication, counseling, and other behavioral health services, increasing the use of MAP in primary care including HRSA funded health centers is a federal priority, so this question captures your participation in this program.

The second new line on the EHR survey asks if you are using telehealth, similarly telehealth is increasingly used as a method for healthcare delivery for health center patient populations, especially those hard to reach patients living in geographically isolated communities. Collecting information on telehealth capacity and use of telehealth is essential for both the delivery of technical assistance for health centers and positioning health centers to better meet their mission of improving the health of the nation's underserved and vulnerable populations.

Finally I just want to remind you that there are a number of resources available to help you going forward as you begin to use the new reporting requirements. Resources are available to help you with accurate reporting including UDS trainings, the PALS, the help line, which is available year

round, and EHB support, so again if you have any questions please feel free to reference these resources.

Here are some links that provide some additional detail on the clinical measures which if you're interested in more information about the ECQMs and other related topics, please reference these links. And finally a few additional links that may help you. With that I'm going to pass the presentation back to (Alec) and (Laura) to answer your questions. Thank you.

Dr. (Alec Sripipatana): Great. Thanks a lot, (Suze), and we've been getting a lot of really interesting inquiries through our chat pod, and we're trying to triage and answer many of those through the chat pod. We're currently trying to identify some questions that might be more relevant across more health centers than not to take on during this Q&A period. Okay, terrific. I think we've got a question identified.

(Laura McGraff): Yes, hi, everyone, this is (Laura McGraff), I'm the senior clinical advisor in our office of home improvement here. I think I've met many of you and others I haven't, but nice to be with you. So I am going to sort of just try to look at some of the questions that apply to the broad audience and we'll answer them here. If other questions that you have are more specific to your setting, please feel free to contact the UDS help line to ask those more specific questions if we don't address them in this question and answer session.

All right, so let's start with, there were several questions around the SOGI data question, so let's start with that. I think there were questions about at what age do we – do you want – do we want health centers to start asking questions about sexual orientation and gender identity and capturing that data, and also just some questions around best practices and how to actually start to do – make your workflows work for that kind of data collection.

Dr. (Alec Sripipatana): Sure, so we actually hosted a very informative Webinar last week with the LGBT health education center at Fenway, and we're currently working with the education center on assessing the best practices, and we'll be sharing that with the health centers at large. That information will also be posted on their resources Web pages in the near future.

We'll be sure to provide links maybe and send out a correspondence through the BPHC digest in the near future. No, that's a great question and certainly something that we want to respond to and we'll also detail in the UDS manual when that comes out.

(Laura McGraff): Great, thanks, (Alec). And then the other, there's several questions related to the cervical cancer screening measure, so I'll tackle that one and talk about kind of how the EQCM doesn't – is different than the past definition of the UDS cervical cancer screening measure and what that means for the guidelines and things like that.

So you were all correct that the CMS EQCM for cervical cancer screening does not include the option for every five year accessing with co-testing with HPV, and that is different than the current guidelines both by (unintelligible) and the US preventive services task force, so we're aware of that. I think the important thing to note is two things, one, well actually three things. First the efforts of making the changes to the measures to match the CMS HCPOs is really an effort to reduce reporting burden and improve measure alignments.

So there – it's you know, I think change can be hard and these measures are complex and challenging for many different reasons. And they're one marker of quality of care. We have to remember that, that the point is quality improvement and that we want to just continue to encourage all of you to

work on your quality improvement systems, to have good data collection systems, to use your HIT capacity and improve that where needed, and then to know the story behind your data.

So that's sort of the background on why we're making these changes at all. The cervical cancer measure is interesting and we've heard from you know, many other different stakeholders over the past few months about this challenge, so a couple things to say on that, one is that CMS is in the process of updating the ECQMs. We don't know the exact timing on that, but we know it's in process.

If it gets updated this year then we'll be able to incorporate that right into the UDS. If it's not updated then we will address this question in the UDS manual or through some FAQs in the meantime. The important thing is this, is that a measure is a measure, and a measure is not global guidelines, and so you all choose how you want to do that in your health centers and you just will know the story behind your data.

I think someone typed in the chat pod that they have chosen to just follow the global guidelines and know that their measure will go down a little bit and they can tell the story behind that, and we understand that. We know that this year as we're making all of these changes to the measures, is a new base line. So there's no – we're not going to go back and try to compare to previous years because the measure definitions have changed so that wouldn't make any sense.

So that hopefully will help answer some of those questions about that, challenge with the measure definition versus social guidelines, so it's really just a reflection of the timing of how measures were developed and how clinical guidelines are updated and changed, and so they're not necessarily

unique to sort of a cancer screening but it is really a challenge I think across the board for many different measures.

So bear with us, we're working with our federal partners and others who do measure development to make that process better. Is there anything you want to add on that, (Alec)? No? Okay, no, okay, great, so let's move on to a couple other questions, there was a good question about how – who would classify as a community health worker in table 5 and 8A, and there's a certain criteria to be met to differentiate them from other outreach staff.

So I'll answer that one also, in that is that we are currently working on making a definition of who fits into the community health worker line in those tables, and so that'll be clear in the UDS manual, who fits as a community health worker, and then who fits into other outreach staff, so stay tuned for that. We're working with – there's a federal work group around community health workers and lots of work going on in the field about sort of defining the role and responsibilities of a community health worker.

So we want to be able to capture that in the right way, so that'll be clear in the manual. Let's see here, there's another question about – the question says this, I'll just read it. It says must health centers adhere strictly to EC code definitions? Are revisions (unintelligible) systems allowed beyond what an ECQM allows for a particular value set? EG, can a pre-test entry be used to count for depression follow up beyond what the ECQM expects as (unintelligible) codes, etcetera?

So that's a very good question, and the – what I can tell you about that is that yes, for now, we still allow for a chart sample, so we want to continue to encourage health workers to use their electronic health records, to do full universe reporting and be able to have that capacity so we're continuing to

work on that, but for now we're still allowing a chart sample. The hope and the goal as part of making the change to the ECQMs is that you'll be able to do full universe sampling easier with the ECQMs.

If there's other things that need to happen and you adjust how your EHR collects information, then I would say yes, that's allowed, just have your report make sense and capture the right information that the definition is asking for. Okay, there's also some questions of course I expected about how will these changes in the measures affect the annual quality scores used for the QI awards to show improvement year to year?

So this again is a base line year. We won't compare the past years. The QI awards, it'll be based on UDS 2016, you know they will be available pending you know, budgets and other plans and priorities, so if the QI awards are available in the following years the criteria for the awards will adjust and reflect the changes in the measures.

Okay, there were several other questions about specific criteria and specifications on different measures, like depression screening and other ones on the exclusion criteria. That I would encourage everyone if you have questions about those things, you can write the UDS help line to get your detailed questions answered, that'll probably be more helpful, or in the meantime you can also you know, search online.

CMS has a very large ECQM library you can look at all the measure specifications for those measures, that's why we gave you the numbers of what ECQM we're trying to align with. And then I'll ask one more question here about manuals, what's the expected delivery date of those 2016 UDS manuals.

Dr. (Alec Sripipatana): That's a great question. We're actually upon lots of feedback from folks regarding the language used in the UDS manual, we're actually working with other partners within the bureau to help streamline the content and language of the UDS manual. We are shooting for early, early, early fall. I think we're going to try and map it better than last year's debut of the manual. I think last year's came out in September.

So we're shooting for earlier but we've added an extra layer of oversight to help reduce the amount of language perhaps, remove some of the unnecessary language of the UDS manual.

(Laura McGraff): Yes, that's great, so we're – you know, I think we're aiming to get those as soon as we can. We want it to be complete and accurate, so as soon as possible, and then we hear you. We know you're anxious for the manual and that the timing could be a lot better, so we're continuing to work on that. We appreciate your patience.

There's one other question I'll just answer here, is that about the dental measures, about dental sealant measure, these specifications are a draft form from a meaningful use standpoint. We're still planning to align with those.

I don't have a good answer as to when those draft specifications are going to be finalized, that's a question for the measure developer, so if you wanted to reach out to the measure developer who is dental quality alliance for that measure, they may know more about that. So is there – oh there is a question about training, any way we can talk about training for 2016?

Dr. (Alec Sripipatana): Sure. I – so what will happen, a few more UDS related Webinars that will roll out beginning in the fall as well as in person training, and those

are coordinated with state PCAs, so it will – there will be a fairly open list of in person trainings, and we will post those on the public safety and BPHC Web pages. We'll probably send an announcement out through the BPHC digest to draw people's attention when those resources become available.

(Laura McGraff): Great, great, that's helpful. So in closing, I will just ask if you can go back to the slide that shows the table with the measures and the CMS ECQM number, so you can see that, so those measure changes are in the slide. We'll just show you what slide that is. I think it's at the beginning, it's probably slide #12, so close your eyes for a second so you don't get dizzy looking at the screen. Oh wait, 17, slide 17. There we go.

So there it is, you can download the slides on the left hand side of your screen under that file box, click on the file name then click on download file and you can have the slides. They'll also be archived on the Web link on the upper left hand side of the screen also.

So we really thank you for joining us today. I'll turn it over to (Alec) for any closing comments and again if you have remaining questions, I know there are many in the chat pod. We tried to get to as many as we could. If you have remaining questions please feel free to reach out to UDS helpline.

Dr. (Alec Strivavitana): Well that's great, and you know, I really – we all really appreciate the hard work that our health workers are doing and we do understand that even the most modest revision can have a fairly large impact on workflow and treating information. You know, our long term objective is to facilitate modernizing health care infrastructure and environment where organizations can retrieve more real time information on the patients that they serve to better tailor and be more responsive to the needs of the patients that we care for.

So we really appreciate everyone's help in this process. I think many of the questions that have come about in the chat box will be addressed in the UDS manual and subsequent resources following this Webinar. So with that we'll close out the Webinar. Thank you so much for your time.

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