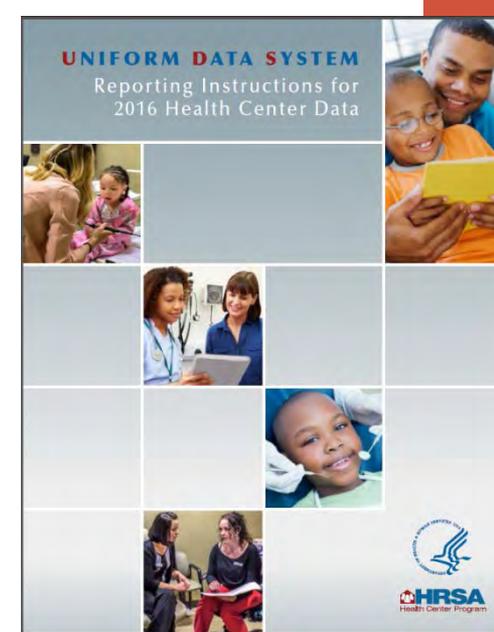


# UNIFORM DATA SYSTEM



## Introduction to 2016 UDS Clinical Measures

Bureau of Primary Health Care (BPHC)

December 14, 2016 1–2:30 p.m. (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, and quality primary health care services.*



**Increase  
access to  
primary  
health care  
services**



**Modernize  
primary care  
infrastructure  
and delivery  
system**



**Improve health  
outcomes and  
health equity**



**Promote  
performance-  
driven,  
innovative  
organizations**

**Increase Value of Health Center Program**

# Objectives of this Webinar

- Understand the structure of the clinical tables
- Understand the changes to the clinical measures
- Identify ways to check data accuracy and reliability
- Identify benchmarks for assessing clinical quality (where available)
  - BPHC's three-year health center trends and program averages
  - National benchmarks, including Healthy People 2020

# Agenda

- Introduction to Uniform Data System (UDS) Clinical Tables
- Changes to 2016 UDS Clinical Tables
- Clinical Measures Overview
- Meeting the Measurement Standard
- Data Reporting Methods
- Tips to Ensure Data Accuracy
- Reminders, Strategies, and References
- Questions

# **INTRODUCTION TO UDS CLINICAL TABLES AND CHANGES FOR 2016**

# 12 Tables Provide a Snapshot of Patients and Performance

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
<b>The care delivered and quality and equity of care provided</b>	<b>6A, 6B, 7</b>
Costs of providing services	8A
Revenue sources	9D, 9E
Additional Reporting Requirement	Form
Health information technology (HIT) capabilities, electronic health record (EHR) interoperability, Meaningful Use leveraging, telehealth, and medication-assisted treatment (MAT)	HIT 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
- Beginning this year, most UDS clinical measures will be revised annually to align with the Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (e-CQMs)

# Clinical Reporting Changes for 2016 UDS

- Codes have completely transitioned to International Classification of Diseases, Tenth Revision (ICD-10)
  - ICD-9 is no longer reported
- Virtually all of the UDS quality of care measures are now aligned with the CMS e-CQMs for eligible professionals
  - The 2016 e-CQMs must be used for the 2016 UDS reporting period

# Clinical Measures Aligned with e-CQMs

Table	Line	Description	e-CQM
6B	10	Childhood Immunization Status	<a href="#">CMS117v4</a>
6B	11	Cervical Cancer Screening	<a href="#">CMS124v4</a>
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	<a href="#">CMS155v4</a>
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	<a href="#">CMS69v4</a>
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	<a href="#">CMS138v4</a>
6B	16	Use of Appropriate Medications for Asthma	<a href="#">CMS126v4</a>
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	<a href="#">CMS164v4</a>
6B	19	Colorectal Cancer Screening	<a href="#">CMS130v4</a>
6B	21	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	<a href="#">CMS2v5</a>
6B	22	Dental Sealants for Children between 6–9 Years	<a href="#">CMS277v0</a>
7	Part B	Controlling High Blood Pressure	<a href="#">CMS165v4</a>
7	Part C	Diabetes: Hemoglobin A1c Poor Control	<a href="#">CMS122v4</a>

# **CLINICAL MEASURES OVERVIEW**

**Including Measurement Standards and Tips to  
Ensure Data Accuracy**

# **Table 6A: Selected Diagnoses and Services Rendered**

# Table 6A: Selected Diagnoses and Services Rendered

	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
<b>Selected Infectious and Parasitic Diseases</b>				
1-2.	Symptomatic/Asymptomatic HIV	B20, B97.35, O98.7-, Z21		
3.	Tuberculosis	A15- through A19-		
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-		
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51		
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52		
<b>Selected Diseases of the Respiratory System</b>				
5.	Asthma	J45-		
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-		
<b>Selected Other Medical Conditions</b>				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, R92-		
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820		

Purpose of the table:

- Reports visits and patients for *selected* diagnoses and services
- Can *estimate* prevalence for specific diagnoses and services
  - Called an *estimate* because there will be some patients at the health center with a condition (e.g., diabetes) who were not treated for it during the year and who will therefore not be counted
- Indicates continuity of care (e.g., average visits per patient by diagnosis)
- *Note: The applicable ICD-9 CM codes have been removed*

\*Excerpt of Table 6A

# Data Requirements for Visit Counts for Selected Diagnoses: Column A, Lines 1–20d

- Report the number of visits where the diagnosis was coded either as a primary diagnosis or an additional diagnosis
  - Each visit where the identified diagnosis is coded is counted
  - If patients have more than one reportable diagnoses during a visit, each is counted
- Diagnoses must be made by the appropriately licensed provider

# Data Requirements for Visit Counts for Selected Services: Column A, Lines 21–34

- Report the number of visits at which one or more of the selected services were provided
  - Each visit during which 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 → count one visit on each line
  - Multiple services in the same category at one visit are not counted
    - e.g., multiple immunizations given at the same visit → count only one visit

# Data Requirements for Patient Count (Services or Diagnoses): Column B

- Reports on the number of unduplicated patients who had a specified diagnosis or who received one or more of the selected services
  - e.g., patient seen five times for diabetes is counted only once as a patient in Column B

# Tips to Assess Accuracy of Table 6A Data

- Check patient counts in Column B for lines 1–20d (diagnoses) by estimating prevalence for chronic conditions and comparing that to what you report for your community in your needs assessment
  - Column B number is divided by medical patients in Table 5
- Check Columns A and B by calculating the average number of service visits per patient for all lines (e.g., visits per year for patients with diabetes, well child visits per child)
  - Compare with what your providers say is the frequency at which they see patients

## **TABLE 6B: QUALITY OF CARE MEASURES**

# Table 6B: Quality of Care Measures

**Purpose of the table:** Evaluate the extent to which medical (dental for sealants measure) patients are receiving timely and appropriate preventive and chronic care services

- Early Entry into Prenatal Care
- Childhood Immunization Status
- Cervical Cancer Screening
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Adult Body Mass Index (BMI) Screening and Follow-Up
- Tobacco Use: Screening and Cessation Intervention
- Use of Appropriate Medications for Asthma
- Coronary Artery Disease (CAD): Lipid Therapy
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Therapy
- Colorectal Cancer Screening
- HIV Linkage to Care
- Screening for Clinical Depression and Follow-Up
- Dental Sealants for Children between 6–9 Years

# Who Counts as a Prenatal Care Patient?

Health centers are to report on all pregnant medical patients who were provided some or all of their prenatal services in the health center or who were referred elsewhere for prenatal care. This includes women who:

- Were referred for prenatal care and had no prenatal care provided by the health center
- Had some prenatal care and then transferred because of risk status
- Had some prenatal care and then were referred out for late prenatal care and delivery
- Had some or all prenatal care and then were referred out for delivery only
- Received full prenatal services, including delivery, by the health center

# Age Categories for Prenatal Care Patients

- Report the total number of patients who received or were referred for prenatal care services at any time during the reporting period by age group.
- Include all women receiving any prenatal care during the reporting year, including the delivery of her child, regardless of when that care was initiated, including women who:
  - Began or were referred for prenatal care during the previous reporting period and continued into this reporting period,
  - Began or were referred for care and delivered during the reporting year, or
  - Began or were referred for their care in this reporting period, but will not/did not deliver until the next year.
- Age is reported as of June 30 of the reporting year

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15–19	
3	Ages 20–24	
4	Ages 25–44	
5	Ages 45 and over	
6	Total Patients (sum lines 1–5)	

# Early Entry into Prenatal Care

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

Line	Early 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 Early Entry into Prenatal Care Data

- **Universe:** Total number of patients who received or were referred for prenatal care services at *any time during the reporting period* by age group.
- **Measurement Standard:** Early (first trimester) entry into prenatal care

# Tips to Assess Early Entry into Prenatal Care Data

- **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 an error
  - Prenatal care provided by referral only but all patients are reported as having first visit with another provider indicates an error
- **National Comparisons:**
  - 2015 Health Center Program average: 73% of women entered prenatal care in the first trimester
  - Healthy People 2020 goal: to have 77.9% of females receiving prenatal care in first trimester

# Childhood Immunization Status (CMS117v4)

- **Goal:** Fully immunized children
- **Universe:** Include all children who:
  - Turned 2 during the measurement year (children born between January 1, 2014, and December 31, 2014)
  - Includes those with at least one medical visit in measurement year; includes any medical visit, not just well-child visits

Line	Childhood Immunization Status	Total Patients with 2 <sup>nd</sup> Birthday (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2 <sup>nd</sup> birthday			

# Child Immunization Status

- **Measurement Standard:** Number of children age 2 years who were fully immunized\* by their 2nd birthday
  - If immunizations were provided outside the clinic, make sure that the records indicate the name of the provider and the date for each vaccine
  - Parental refusal or failure to bring in the patient is defined as non-compliance
  - Current Advisory Committee on Immunization Practices (ACIP) guidelines recommends these vaccines be completed by 18 months of age
  - Requires 2 years of immunization history
- **\*Required vaccines:**
  - 4 diphtheria, tetanus, and acellular pertussis (DTP/DTaP)
  - 3 polio (IPV)
  - 1 measles, mumps, rubella (MMR)
  - 3 H influenza type b (Hib)
  - 3 Hepatitis B (Hep B)
  - 1 chicken pox VZV (Varicella)
  - 4 pneumococcal conjugate (PCV)
  - 1 Hepatitis A (Hep A)
  - 2 or 3 rotavirus (RV)
  - 2 influenza (flu) vaccines

# Tips to Assess Accuracy of Childhood Immunization Status Data

- **Universe:**
  - May be different than the number of two-year-olds reported on Table 3A
  - Will not equal the count of selected immunizations on Table 6A
- **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:**
  - Healthy People 2020 goal: 80% for complete series

# Cervical Cancer Screening

(CMS124v4)

- **Goal:** Women age 21–64 receive cervical cancer screening
- **Universe:** Include women age 23–64 years with at least one medical visit in measurement year
  - **Exclude:** Women who have had a hysterectomy and who have no residual cervix

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer			

# 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 calendar years
  - Documentation in the medical record of a test performed outside of the health center must include the date the test was performed, who performed it, and the findings
    - By including a note indicating that a “patient was referred”
    - By including a note that “patient reported receiving Pap test”
    - By noting that the patient refuses or failed to return for the test
  - May need three years of data

# Tips to Assess Accuracy of Cervical Cancer Screening Data

- **Universe:**
  - Unlikely to exceed total women age 23–64 reported on Table 3A
  - Will be less than Table 3A count if there are non-medical patients at the clinic (e.g., those who receive only dental, mental health)
- **Measurement Standard:**
  - Will not be equal to “Pap test” reported on Table 6A (Line 23) because patients may receive Pap tests elsewhere and Table 6A includes women over age 65
- **National Comparisons:**
  - 2015 Health Center Program average: 56%, but with a different standard being used
  - Healthy People 2020 goal: 93%

# Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v4)

- **Goal:** Children and adolescents have their weight assessed and receive related counseling
- **Universe:** Include children ages 3–17 who had at least one medical visit in a clinical setting during the measurement year
  - **Exclude:** patients with a diagnosis of pregnancy during the reporting year

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–17 years of age with a BMI percentile <i>and</i> counseling on nutrition and physical activity documented			

# Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Data

- **Measurement Standard:** Patients who had a recorded BMI percentile and documented counseling on both nutrition and physical activity during the measurement year
  - All three criteria must be documented: BMI percentile, counseling on nutrition, and counseling on physical activity
  - Just recording a well child visit does not meet the requirement

# Tips to Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Data

- **Universe:**
  - Number will be less than Table 3A if some children are seen just for dental or other non-medical services
  - Includes all medical visits, not just well child visits
- **Measurement Standard**
  - Review medical records for the entire measurement year—services may be provided at multiple visits
- **National Comparison:**
  - 2015 Health Center Program average: 57.9%

# Adult BMI Screening and Follow-Up (CMS69v4)

- **Goal:** Adults 18 and older have their weight assessed and follow-up provided, if needed
- **Universe:** Patients age 18 or older with a medical visit during the reporting year
  - **Exclude:**
    - Pregnant patients
    - Visits where the patient:
      - received palliative care
      - refused measurement of height and/or weight
      - was in an urgent/emergent medical situation
    - Any other reason documented by the provider explaining why BMI measurement was inappropriate

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients aged 18 and older with (1) BMI documented <i>and</i> (2) follow-up plan documented if BMI is outside normal parameters			

# Measuring Adult BMI

## Screening and Follow-Up Data

- **Measurement Standard:** Adults assessed at their most recent medical visit or in the six months prior to that visit:
  - Whose BMI was within normal parameters *and*
  - Those whose BMI is outside range with a follow-up plan documented during the visit or the previous six months of the visit
    - Normal parameters:
      - Age 18–64:  $18.25 \leq \text{BMI} < 25$
      - Age 65 and older:  $23 \leq \text{BMI} < 30$

# Tips to Assess Accuracy of Adult BMI Screening and Follow-Up Data

- **Measurement Standard:**
  - BMI must be recorded; 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 at last visit or in the 6 months prior to last visit
- **National Comparison:**
  - 2015 Health Center Program average: 59.4%

# Tobacco Use: Screening and Cessation Intervention (CMS138v4)

- **Goal:** Adults are assessed for tobacco use and, if identified as a tobacco user, receive cessation intervention
- **Universe:** Patients aged 18 years and older seen for at least two medical visits in the measurement year or at least one preventive medical visit during the measurement period
  - **Exclude:** Patients whose records document a medical reason for not screening for tobacco use

Line	Preventive Care and Screening: 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: Percentage of patients aged 18 years and older who (1) were screened for tobacco use one or more times within 24 months and if identified to be a tobacco user (2) received cessation counseling intervention			

# Tobacco Use: Screening and Cessation Intervention Data

- **Measurement Standard:** Patients who were screened for *tobacco* use at least once within 24 months of their most recent visit **and** 1) were not a tobacco user **or** 2) 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*
  - Were found to be on/using a smoking cessation agent

# Tips to Assess Accuracy of Tobacco Use: Screening and Cessation Intervention Data

- **Universe:**
  - Number is compared to adults age 18 and older on Table 3A adjusted for non-medical patients
  - Would be less than the universe reported for the adult BMI Screening and Follow-Up measure
- **Measurement Standard:**
  - Must include assessed adults who are not tobacco users AND tobacco users with cessation services
  - Three years of data are required
- **National comparison:**
  - 2015 Health Center Program average: 82.8%

# Use of Appropriate Medications for Asthma (CMS126v4)

- **Goal:** Asthma patients are on appropriate medications
- **Universe:** Patients age 5 through 64 years with a diagnosis of persistent asthma and who had at least one medical visit during the measurement period
  - **Exclude:** Patients with emphysema, chronic obstructive pulmonary disease, cystic fibrosis, or acute respiratory failure during or prior to the measurement period

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number of Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Percentage of patients aged 5 through 64 years of age identified as having persistent asthma and were appropriately prescribed medication during the measurement period			

# Measuring Use of Appropriate Medications for Asthma Data

- **Measurement Standard:** Patients who had at least one prescription for preferred therapy during the measurement period
  - Received a prescription for or were using an inhaled corticosteroid *or*
  - Received a prescription for or were using an acceptable pharmacological agent

# Tips to Assess Accurate Use of Appropriate Medications for Asthma Data

- **Universe:**
  - Estimated prevalence: 2015 BPHC average indicates 3%
  - 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

# Coronary Artery Disease (CAD): Lipid Therapy

- **Goal:** CAD patients with high LDL (low-density lipoprotein) are on lipid-lowering therapy
- **Universe:** Patients 18 years of age and older who had an active diagnosis of CAD or who have had a myocardial infarction (MI) or cardiac surgery in the past, with at least one medical visit during the measurement period and had at least two medical visits ever
  - **Exclude:** 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

- **Measurement Standard:** CAD patients in the universe who received a prescription for, were provided with, or were taking lipid-lowering medications

# Tips to Assess Accuracy of CAD Lipid Therapy Data

- **Universe:**
  - Look back into 2 years of patient records to identify all CAD patients
  - Do not need to have been seen with a CAD diagnosis in the current measurement year
  - Estimated prevalence: 2015 BPHC average indicates 2% of estimated adult medical patients had a diagnosis of CAD
- **National Comparison:**
  - 2015 Health Center Program average: 77.9%

# Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (CMS164v4)

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- **Goal:** IVD patients on aspirin or other antithrombotic therapy
- **Universe:** Patients 18 years of age and older with a medical visit during the measurement period and who had an active diagnosis of IVD or who were discharged alive after acute myocardial infarction (AMI), a coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antithrombotic Therapy (c)
18	MEASURE: Percentage of patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antithrombotic therapy			

# Measuring IVD: Use of Aspirin or Another Antithrombotic

- **Measurement Standard:** Documentation of use of aspirin or another antithrombotic medication during the measurement period

# Tips to Assess Accuracy of IVD: Use of Aspirin or Another Antithrombotic Data

- **Universe:**
  - Estimated prevalence: 2015 BPHC average indicates 3% of estimated adult medical patients had a diagnosis of IVD
  - Compare to your own prior year's universe
  - Look back into 2 years of patient records to find universe of IVD patients
- **National Comparison:**
  - 2015 Health Center Program average: 78%

# Colorectal Cancer Screening

(CMS130v4)

- **Goal:** Patients screened for colorectal cancer
- **Universe:** Patients who were age 50 through 75 with a medical visit during the measurement period
  - **Exclude:** Patients with a diagnosis or past history of colorectal cancer or colectomy

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer			

# Measuring Colorectal Cancer Screening

- **Measurement Standard:** Patients with a record of a timely screening for colorectal cancer
  - Timely screenings include:
    - A colonoscopy during the measurement period or the nine years prior to the measurement period (January 1, 2007, or later), *or*
    - A flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period (January 1, 2012, or later), *or*
    - A fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test *during* the measurement period.
  - Note that deoxyribonucleic acid (DNA)-based tests such as Cologuard are not acceptable

# Tips to Assess Accuracy of Colorectal Cancer Screening Data

- **Universe:**
  - Includes adults on Table 3A adjusted for non-medical patients
  - Age 50 through 75 is being assessed
- **Measurement Standard:**
  - Look back into 10 years of patient records for screening
- **National Comparisons:**
  - 2015 Health Center Program average: 38.4%
  - Healthy People 2020 goal: 70.5% screened for colorectal cancer

# HIV Linkage to Care

- **Goal:** Initiate HIV treatment for patients newly diagnosed with HIV within 90 days of diagnosis
- **Universe:** Patients first diagnosed with HIV by the health center between October 1, 2015, and September 30, 2016, and who had at least one medical visit during 2015 or 2016

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 Diagnosis of HIV (c)
20	MEASURE: Percentage of 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

- **Measurement Standard:** Newly diagnosed HIV patients that received treatment within 90 days of diagnosis. Include patients who were newly diagnosed by your health center providers, **and**
  - Had a medical visit with your health center provider who initiates treatment for HIV, **or**
  - Had a visit with a referral resource who initiates treatment for HIV
    - Visit must be conducted and referral loop closed

# Tips to Assess Accuracy of HIV Linkage to Care Data

- **Universe:**
  - Includes patients referred to the health center after a reactive, initial test done elsewhere where you run the supplemental test
  - Does not include 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
- **Measurement Standard:**
  - Actual treatment must be initiated
  - For referrals to care to meet the measurement standard, the referral loop must be closed
- **National Comparison:**
  - 2015 Health Center Program average: 74.7%

# Screening for Clinical Depression and Follow-Up

## Plan (CMS2v5.0)

- **Goal:** Patients are screened yearly for depression using a standardized tool and, if positive, have a follow-up plan documented
- **Universe:** Patients age 12 years and older with at least one medical visit during the measurement period
  - **Exclude:**
    - Patients who refuse to participate
    - Patients who are in urgent or emergent situations
    - Patients whose functional capacity or motivation to improve affects the accuracy of results
    - Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Line	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	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: Percentage of patients age 12 and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented			

# Measuring Screening for Clinical Depression and Follow-Up Plan

- **Measurement Standard:** Patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool *and*
  - Had a negative result *or*
  - If screening was positive for depression, a follow-up plan was documented on the date of the positive screen

# Tips to Assess Accuracy of Screening for Clinical Depression and Follow-Up Plan Data

- **Universe:**
  - Will be less than total patients 12 and older reported on Table 3A if some patients do not receive medical services and because some patients may be excluded
- **Measurement Standard:**
  - Include both patients that screen negative *and* those who screen positive and have a follow-up plan documented
- **National Comparison:**
  - 2015 Health Center Program average: 50.6%

# Dental Sealants for Children between 6–9 Years (CMS277v0)

- **Goal:** Children at moderate to high risk for caries receive a sealant on a first permanent molar
- **Universe:** Children 6 through 9 years of age who had a dental visit in the measurement period who had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the measurement period
  - **Exclude:** Children whose first permanent molars are non-sealable

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

# Measuring Dental Sealants for Children between 6–9 Years

- **Measurement Standard:** Children who received a sealant on a permanent first molar tooth during the measurement period

# Tips to Assess Accuracy of Dental Sealants for Children Between 6–9 Years Data

- **Universe:**
  - Includes dental patients age 6 through 9, not 5 through 9
  - Must be 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
- **Measurement Standard:**
  - If there is not adequate documentation as to which tooth is sealed, health center staff are to review a sample of charts for this information
- **National Comparison:**
  - 2015 Health Center Program average: 42.5%
  - Healthy People 2020 goal: 28%

## **TABLE 7: HEALTH OUTCOMES AND DISPARITIES**

# Purpose of Table 7

- Evaluate the extent to which medical patients are receiving clinical intervention which will lead to 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
  - Controlling High Blood Pressure
  - Diabetes: Hemoglobin A1c Poor Control

# Low Birth Weight

- **Goal:** Fewer newborns with low birth weight
- **Universe:** Babies born during the measurement period to prenatal care patients or women referred out for prenatal care
  - **Exclude:** stillbirths and miscarriages
- *Note:* Negative measure
- Report women who had a delivery in Column 1a

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)
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# Measuring Low Birth Weight

- **Measurement Standard:** Number of babies born with a birth weight of 2,499 grams or less
  - Report birth outcomes for all prenatal patients or referrals 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 2016 was their delivery
  - Births are reported by infant's race and ethnicity

# Tips to Assess Accuracy of Low Birth Weight Data

- **Universe and Measurement Standard:**
  - Compare race and ethnicity data reported in this section to race and ethnicity data reported on Table 3B
  - Compare number of prenatal patients (Table 6B) to women delivering (Table 7)
    - Not all women deliver in same reporting year or carry to term
    - Prenatal women  $\neq$  deliveries  $\neq$  birth outcomes
  - Compare the number of births to women delivering (both Table 7)
    - Multiple births = one delivery, multiple children
    - Stillbirth = one delivery, no children
- **National Comparisons:**
  - 2015 Health Center Program average: 1.3% VLBW, 6.2% LBW, 7.6% combined
  - Healthy People 2020 goal: 1.4% VLBW, 6.4% LBW, 7.8% combined

# Controlling High Blood Pressure

(CMS165v4)

- **Goal:** Control blood pressure of patients with hypertension
- **Universe:** Patients 18–85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period and had a medical visit during the measurement period
  - **Exclude:** Patients with evidence of end-stage renal disease, dialysis, or renal transplant before or during the measurement period; also exclude patients with a diagnosis of pregnancy during the measurement period

<b>Total Patients 18 through 85 Years of Age with Hypertension</b> (2a)	<b>Charts Sampled or EHR Total</b> (2b)	<b>Patients with HTN Controlled</b> (2c)
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# Measuring Controlling High Blood Pressure

- **Measurement Standard:** Patients whose blood pressure at the most recent visit is adequately controlled during the measurement period (<140/90 mm Hg)
  - Patients with no blood pressure test do not meet the measurement standard and are reported in the same category as those with blood pressure 140/90 mm Hg or greater

# Tips to Assess Accuracy of Controlling High Blood Pressure Data

- **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 being treated for hypertension reported on Table 6A (line 11)
  - Estimated prevalence:
    - 2015 BPHC estimate: 23% of adult (age 18–84) medical patients have hypertension
    - Other national prevalence: 33.5% of adults age 20 and older have hypertension
- **Measurement Standard:** Look back into 3 years of patient records to identify patients with hypertension
- **National Comparisons:**
  - 2015 Health Center Program average: 63.8%
  - Healthy People 2020 goal: 61.2% of patients with hypertension to have blood pressure control

# Diabetes: Hemoglobin A1c

## Poor Control (CMS122v4)

- **Goal:** Fewer patients with uncontrolled diabetes
- **Evaluate:** Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

*Note:* Negative measure

Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <8% (3d1)	Patients with Hba1c >9% or No Test During Year (3f)
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# Measuring Diabetes: Hemoglobin A1c Poor Control

- **Universe:** Patients 18–75 years of age that have a diagnosis of Type 1 or Type 2 diabetes and had a medical visit during the measurement period
  - Report on patients with diabetes regardless of when they were first diagnosed
  - **Exclude:** Patients with gestational diabetes or steroid-induced diabetes; patients with a diagnosis of secondary diabetes due to another condition should not be included
- **Measurement Standard:** Patients whose most recent hemoglobin A1c level during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period
  - Report hemoglobin A1c levels:
    - HbA1c < 8%
    - HbA1c > 9% (or no test)

# Tips to Assess Accuracy of Hemoglobin A1c Poor Control Data

- **Universe:**
  - Compare to adults (adjusted for non-medical patients) on Table 3A (age) and race and ethnicity on Table 3B
  - Compare prevalence to patients reported as having been treated for Diabetes Mellitus on Table 6A Line 9
  - Estimated prevalence:
    - 2015 BPHC estimate = 13% of adult (age 18–74) medical patients have diabetes
    - Other national prevalence: 9.3% of adults age 20 and older have diabetes
- **Measurement Standard:**
  - Usually Columns 3d1 + 3f ≠ 3b
- **National Comparisons:**
  - 2015 Health Center Program average: 29.8% with HbA1c >9%
  - Healthy People 2020 goal: Fewer than 16.1% with HbA1c >9%

# **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 are reported as shown in this example:

Line	Childhood Immunization Status	Total Patients with 2 <sup>nd</sup> Birthday (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2 <sup>nd</sup> birthday	<p><b><u>Column A (Universe or Denominator):</u></b> The number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated</p>	<p><b><u>Column B: Sample or Universe</u></b> Patients from the universe for whom data have been reviewed. Three options are available:</p> <ul style="list-style-type: none"> <li>• All patients who fit the criteria (same as universe in Column A), or</li> <li>• A number equal to or greater than 80 percent* of all patients who fit the criteria (≥80 percent of the universe reported in Column A), or</li> <li>• A scientifically drawn sample of 70 patients selected from the universe</li> </ul> <p>*must not be restricted by any variable related to the test measure</p>	<p><b><u>Column C: Records meeting the measurement standard</u></b> Number of charts (from Column B) whose clinical record indicates that the measure rules and criteria have been met</p>

# Reporting Table 7

- **Columns 1a, 2a, and 3a:** All patients who meet the reporting criteria
  - 1a: women who delivered
  - 2a: patients with hypertension
  - 3a: patients with diabetes

<b>Prenatal Care Patients Who Delivered During the Year (1a)</b>	<b>Live Births: &lt;1500 grams (1b)</b>	<b>Live Births: 1500–2499 grams (1c)</b>	<b>Live Births: ≥ 2500 grams (1d)</b>
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<b>Total Patients 18 through 85 Years of Age with Hypertension (2a)</b>	<b>Charts Sampled or EHR Total (2b)</b>	<b>Patients with HTN Controlled (2c)</b>
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<b>Total Patients 18 through 75 Years of Age with Diabetes (3a)</b>	<b>Charts Sampled or EHR Total (3b)</b>	<b>Patients with Hba1c &lt;8% (3d1)</b>	<b>Patients with Hba1c &gt;9% or No Test During Year (3f)</b>
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# Table 7 Columns

- **Columns 1b–1d:** All delivery and birth data of women who delivered (1a)

<p><b>Prenatal Care Patients Who Delivered During the Year (1a)</b></p>	<p><b>Live Births: &lt;1500 grams (1b)</b></p>	<p><b>Live Births: 1500– 2499 grams (1c)</b></p>	<p><b>Live Births: ≥ 2500 grams (1d)</b></p>
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# Table 7 Columns, continued

- **Columns 2b:** number of charts reviewed of the total patients reported in Column 2a
- **Column 3b:** number of charts reviewed of the total patients reported in Column 3a

<p><b>Total Patients 18 through 85 Years of Age with Hypertension</b> (2a)</p>	<p><b>Charts Sampled or EHR Total</b> (2b)</p>	<p><b>Patients with HTN Controlled</b> (2c)</p>
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<p><b>Total Patients 18 through 75 Years of Age with Diabetes</b> (3a)</p>	<p><b>Charts Sampled or EHR Total</b> (3b)</p>	<p><b>Patients with Hba1c &lt;8%</b> (3d1)</p>	<p><b>Patients with Hba1c &gt;9% or No Test During Year</b> (3f)</p>
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# Table 7 Columns, continued

- **Column 2c:** Number of charts (from Column 2b) whose clinical record indicates that the measure rules and criteria have been met
- **Column 3d1 and 3f:** Number of charts (from Column 3b) whose clinical record is within the specified range

<p><b>Total Patients 18 through 85 Years of Age with Hypertension</b> (2a)</p>	<p><b>Charts Sampled or EHR Total</b> (2b)</p>	<p><b>Patients with HTN Controlled</b> (2c)</p>
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<p><b>Total Patients 18 through 75 Years of Age with Diabetes</b> (3a)</p>	<p><b>Charts Sampled or EHR Total</b> (3b)</p>	<p><b>Patients with Hba1c &lt;8%</b> (3d1)</p>	<p><b>Patients with Hba1c &gt;9% or No Test During Year</b> (3f)</p>
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# Reporting Racial and Ethnic Disparities on Table 7

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	<b>Total</b>

- Data must be reported by race and ethnicity for all Table 7 sections: Deliveries and Births, Hypertension, Diabetes
  - Ensure that race and ethnicity data across Tables 3B and 7 align

# Reasons to Report Using EHR

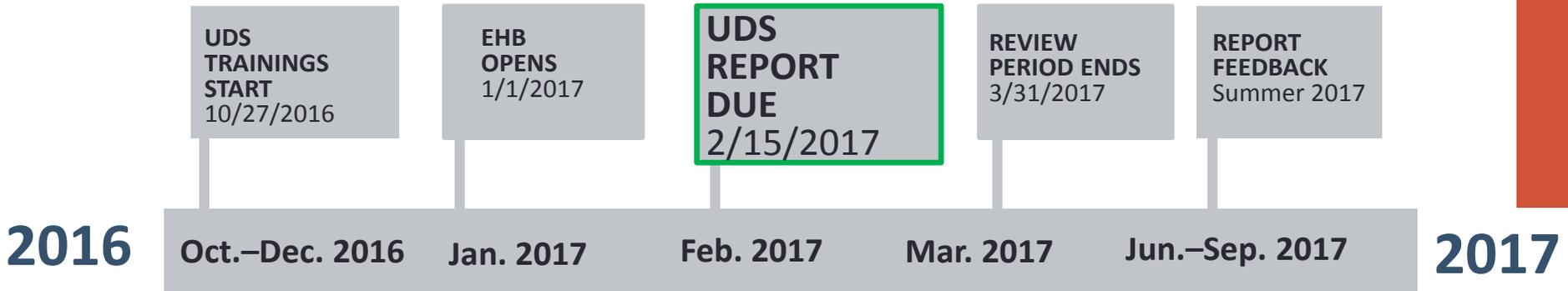
- BPHC encourages use of an EHR for reporting on clinical measures
- Performance measurement standard can be obtained from EHR when at least 80% of all health center patient records for the given measure is available
  - Must not be restricted by any variable related to the test measure
  - May be useful for health centers who have added capacity whose EHR has not yet followed the expansion
- Data can be extracted from EHR for all patients in the universe
  - Provides a better understanding of the clinical care provided to subgroups of patients

# 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

# **REMINDERS, STRATEGIES, AND REFERENCES**

# Critical Dates in UDS Process



**OCT. 2016–  
JAN. 2017**  
CONTENT  
TRAININGS:  
*In-person trainings,  
modules, and  
webinars are  
available prior to  
submission*

**JAN. 1, 2017–  
FEB. 15, 2017**  
DATA ENTRY:  
*Report through  
EHB (“Electronic  
Handbooks”)  
beginning  
1/1/2017*

**FEB. 15, 2017–  
MAR. 31, 2017**  
REPORT AND  
REVIEW  
PROCESS:  
*Work with UDS  
reviewer to address  
data issues and  
finalize data  
submission*

**JUN. 2017–  
SEP. 2017**  
REPORT  
FEEDBACK:  
*Rollups, trend,  
and comparison  
reports available*

# Strategies for Successful Reporting

- Work as a team: Tables are interrelated
- 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, refer to last year's reviewer's letter, and compare data to benchmarks
  - Address edits in electronic handbook (EHB) by correcting or providing explanations that demonstrate your understanding
    - "The number is correct" is not sufficient
  - Report on time but do not submit incomplete reports
- Work with your reviewer

# Available Assistance

- Local trainings: <http://www.bphcdata.net/html/bphctraining.html>
- Online training modules, manual, fact sheets, webinars, and other technical assistance materials, including PALs available:
  - [BPHC HRSA Website](#)
  - [UDS Training Website](#)
- Technical support from a UDS reviewer during the review period
- [Primary Care Associations](#) or [National Cooperative Agreements](#)
- Telephone and [email support](#) line for UDS reporting questions and use of UDS data: 866-837-4357 or EHB Support
  - [HRSA Call Center](#) for EHB account access and roles: 877-464-4772
  - [Health Center Program Support](#) for EHB System issues: 877-464-4772

# Performance Measures References

- [eCQI Resource Center](#)
- [Clinical Quality Measures](#)
- [National Quality Forum](#)
- [Million Hearts Hypertension Control Change Package](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\)-HRSA Center for Integrated Health Solutions](#) for resources related to depression screening and follow-up
- [United States Health Information Knowledgebase \(USHIK\)](#)
- [Healthy People 2020](#)
- U.S. Preventive Services Task Force
  - [Obesity in Adults Screening](#)
  - [HIV Screening](#)
- [State Tobacco Statistics](#)
- [State Diabetes Statistics](#)
- [CDC National Center for Health Statistics State Facts](#)

# Webinars

## Upcoming Webinars

- Using UDS Data and Reports for Program Evaluation and Quality (1/11/2017)

## Past Webinars

- Preparing for and Understanding Your UDS Submission (11/17/2016)
- UDS for Bureau of Health Workforce Grantees (11/3/2016)

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

# Questions?

**UNIFORM  
DATA  
SYSTEM**



# Thank you!

UNIFORM  
DATA  
SYSTEM

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](mailto:UDSHelp330@BPHCDATA.NET)  
866-UDS-HELP