2012 Changes Webinar
April 18, 2012
3:00-5:00 PM ET

Operator: Ladies and gentlemen, thank you for standing by and welcome to the HRSA Webinar. During the presentation all participants will be in a listen-only mode. Afterwards we will conduct a question and answer session.

To ask a question you will need to be connected on your telephone at 800-741-3792.

To register a question please press the 1 followed by the 4 on your telephone. If you need to reach an operator at any time, please press star zero. As a reminder this conference is being recorded Wednesday, April 18, 2012.

I would now like to turn the conference over to Quyen Ngo-Metzger. Please go ahead.

Quyen Ngo-Metzger: Good afternoon. My name is Dr. Quyen Ngo-Metzger and I'm the Data Branch Chief in the Office of Quality and Data in the Bureau of Primary Health Care.

It's my pleasure today to introduce Jim Macrae who will speak to you for a few minutes.

Jim Macrae: Thank you Quyen and let's see, I think I can still say good afternoon and good morning to those folks way out West. Thank you so much for joining us for today's call.

It actually turned out to be a very timely call in terms of the Uniform Data System given the recent -- actually I think it was this morning -- publication of the USA Today and Kaiser Health News Network story on health center clinical quality.

I think it just goes to show the importance of the data that you all submit and provide to us, really in terms of providing a snapshot on where you are and

most importantly in working with us, where do you want to be in terms of your goals or outcomes.

We really do think that we are out in the forefront in terms of collecting this data and information. I think personally it's one of the real strengths and values of the program that we are willing and able and you all are able to present data that shows the clinical quality of care that you provide. And even more importantly, the health outcomes that you all are able to achieve.

I think one of the real reasons for the success of our program overall has been its ability to show that the investment does pay off. And I think in terms of the clinical quality data that we have for health centers, overall it is tremendous.

That didn't always come out as clearly in the story as we may have liked, but I think overall when we look at the data, we really do see a wonderful picture of what health centers are able to accomplish.

But does that mean that there is always room for improvement; absolutely. And we think one of the real benefits of collecting this data is to be able to see where you are in terms of your performance.

And that's why it's so critically important to have sessions like today where we have the opportunity to share with you updates on our UDS measures, answer any questions that you may have, and really help you in terms of thinking through how do I do this the best way possible.

And that really is the focus of what we're doing. We here at HRSA are trying to use data and information to identify those best practices, identify those who are really making tremendous efforts in certain area, and those health centers that are struggling in particular areas in terms of how do they perform better.

And I think that's really the spirit that we have. I think we're going to have the opportunity because of the articles that came out today, to be able to tell that story behind the curve a lot more to a lot of different folks.

I've already had the opportunity this morning and this afternoon to share the story of health centers quite a bit in terms of that quality journey. And I think you all are going to have that opportunity at a State level as well as down to a grantee and health center level to be able to share that information in your story.

And again I think the story overall is very good. But, you know, where there are opportunities to improve, we need to work on that and we need to work on that together in terms of that whole focus on improvement.

So, I'm very excited about having today's call and to share some of that updated data and information with you all. And so I will turn it back over to Quyen to walk us through and then we will have time at the end to answer any questions that you all may have. So thanks a lot everybody.

Quyen Ngo-Metzger: Thank you Jim.

I'm just going to give you an overview of today's presentation. We're going to talk about the new changes to the UDS for 2012 where we'll be talking about the table in Table 5A that will permit grantees to demonstrate as far as the tenure and continuity of the staff, because I know that that's one issue that we're always concerned about.

The other major change it has to do with changing the diagnosis in Table 6A, that basically is not just the primary diagnosis but all diagnoses that patients are seeing.

We're going to talk about three new clinical measures, and we're going to talk about revised data on the electronic health records and quality of recognition at the health centers.

But again I just wanted to echo what Jim said that, you know, this data collection effort is part of our efforts for quality improvement. And so I want to give you a big picture a little bit.

You know, what we want, the data is not just for data collection itself but the data is for you to use as well as for us to use for quality improvement. We

want to improve the quality of care for our patients. We want to be able to know and track how we're doing.

And I think that for, you know, Medicare, Medicaid, CMS for meaningful use of the electronic health records, we want to be able to use the data for tracking.

We want to be able to use the data and see where we are as far as having achieved or moving towards patients that are medical home recognition. And all of that is really just to improve patient clinical outcomes, because we are health centers and we want to improve the health of our patient population.

So I think that, you know, as Jim has mentioned, we're on a path to continuance, quality improvement, and that's what the UDS is all about.

So I'm going to turn it over right now to Art who will go over the details of the changes to the 2012 UDS.

Art Stickgold: Okay Quyen. Well thanks very much. And we're going to be talking about these changes in a context.

These changes go through the same process every year that they occur. They're first vetted with individual grantees before being published in the PAL. This one originally came out in October of last year.

The PAL has just been updated, so those of you who haven't seen the new PAL, PAL 2012-03 contains the final information on the changes. And there is in fact a small difference between them. We'll talk about it today.

After the PAL comes out it goes through the Federal Register. Comments are received from PCAs and PCOs and the general public. And the Office of Management and Budget ends up reviewing it and approving it.

These were finally approved in February and we now have the opportunity to share them with you and to share the details of where it is we're going.

Today's presentation is to give you an idea of where these measures have come from. They aren't just born whole cloth, they are the result of a myriad of discussions and questions and answers.

We're going to talk about what each of these changes are -- new measures, new tables. We're going to talk about how to complete those tables and how to submit the revised data in the coming year.

Now the first change is to Table 5A. Interestingly one of the -- or excuse me, is to the creation of Table 5A, the extension of Table 5.

One of the things in the article in the USA Today talked about the question of staff turnover. And when staff turnover is discussed, we don't have good data that tell us about that.

So beginning with 2012, grantees are going to be asked to collect information about the tenure of key staff working at the center. It will look at the center's clinical and non-clinical professionals, those that are specifically identified on the UDS, so it will be the same categories as on Table 5.

And then look at the full workforce rather than just FTEs. We actually have no idea how many physicians work for community health centers. We know there are about 10,000 FTEs, but is that 10,001 physicians or 20,000 physicians. Next year we'll know.

And finally as I said, we'll be able to discuss the question of staff turnover. Is it a factor at community health centers, and to what extent might it be affecting them.

So Table 5A, Tenure for Staff -- the data presented are generally available in health center personnel or human resource employment records. These should all be there.

We're asking that you have data such as when did this person start working with you. And unfortunately of course, some of our most successful health centers have gone from two file cabinets full of paper records to very sophisticated computerized records and may have to do a little bit of work

going backwards into what we now call the legacy system in order to track this.

But what we will want to know is the tenure in a form that reflects seniority information which means that we want to know how long those people -- those key people have been working for you in months. And we're looking about continuous employment.

All of this can be done today, not for your submission but you can test out your systems right now so that you'll know whether or not there is going to be a problem. And if there is, how you're going to address it and how you're going to cure it.

Workforce and tenure data are going to be collected for all clinical providers, so physicians, mid-level, dental providers, mental health providers, vision providers -- all licensed clinical providers.

And then key non-clinical staff - your executive director, your fiscal officer, your chief information officer, your medical director.

The lines on the new Table 5A will in fact be the exact same lines as on Table 5. So you see it will go 1, 2, 3, 4, 5, 7; skipping Line 6 which isn't there. It will skip Line 8 -- that's a total -- and so on.

So these lines will tie exactly, which means that we'll be able to look at Table 5, compare it to Table 5A and actually know how many warm bodies were present at the end of the year that accounted for the FTEs that were reported on during the course of the year.

Now some definitions -- what do we mean by full and part-time staff? First of all we're going to take a census state. We want to know what was happening on December 31.

Now this is very different from Table 5. Table 5 says tell us about what happened all year long, but on Table 5A we want to know what was happening on December 31.

And if you had a physician who was there all year long, you'll tell us you had one physician.

And if you had a physician who started July 10 and is still there, you'll tell us one physician.

And if you had a part-time physician that was there all year long, you would tell us one physician.

And if you had a contract physician who was working onsite, you would tell us one physician.

Now on Table 5A when we ask about FTEs, it's entirely different. But here it's a point of site, what was going on on December 31.

The doctor that worked for you until December25 then left, that's zero physician. And the offsite referral physician who was paid by visit isn't counted.

But a National Health Service Corps assignee who started September 1, that's one physician. And the chief medical officer who is also an OB/GYN is one chief medical officer and one OB/GYN. They're counted on each line where that's relevant, though we don't expect that to happen too often.

And what we want to know is first we'll ask you how many were there and then how many months have they worked in that position.

So, count from the first day of the month of the most recent hiring. If your CEO was hired on September 25, 2010, that will be 27 months between September of '10 and December of 2012 and you'll report 27 months of tenure for that CEO.

If Doctor X was a loan repayer from January 1, 2002 to December 31, 2005, left for a position out of state but came back to the center on July 1st of 2009, all we're interested in is since their most recent hire.

So it's 42 months from July of '09 to December of 2012, though all told that doctor may have been employed at the health center more often.

And we count only in the current position. So an employee who started work in ’93 as - and then 1998 is promoted from medical assistant to LVN as he finally gets his license, is counted as one hundred and -- oops -- we’re going to count - oh yes, and promoted -- reading my own and confusing myself -- is promoted in ’98 and we’re going to count 171 months from June of ’98 to December of 2012; not from 1993 when they started work but from 1998 when they started in this most recent position.

An employee works in two positions simultaneously, we report the time in each using the start date in each. So the pediatrician who is hired in August of 2002 and promoted to CMO in September of 2010 is going to have 125 months of tenure as a pediatrician and only 28 months of tenure as a chief medical officer.

A chief operations officer hired in ’88 and then promoted to deputy director and then promoted to CEO in 2012 is only going to be shown as seven months as CEO.

And yes, we recognize that this is somebody who is really been working there for 14 years, but so far as the conventional concept of turnover, as CEO this person has been there since in fact they were promoted in June of 2012.

Or after downsizing a CEO is hired to fill the role of both the chief information officer and the CFO as well as CEO, and they’ll be reported as 32 months as the CEO, 32 months as the CFO, and 32 months as the CIO. So we’re talking about people and how much time they’ve been in the current positions.

Some health centers make use, either limited or extensive, of locums or on-calls or volunteer providers. And to the extent that they’re an important part of the staff, we want to know about them too.

Some are in place for an extended period of time, serving that Saturday clinic every week for years. Others may be present only for a day or two. We want to know about them and they’re reported in Columns C and D.

And again, just brief discussion, locum tenens, those who were hired through an agency and may not even be employees, on-call providers who are hired by the center on an as-needed basis.

Volunteers -- clinical or non-clinical -- residents, interns; all of these are counted as in Columns C and D.

Not also that there can be administrative consultants in these roles, especially in smaller agencies that can't afford fulltime CFOs or CIOs. In all instances these individuals are reported on Table 5 if they were working on December 31, or if they had a continuing schedule of work which included dates prior to and after December 31.

So that doctor that works every single Saturday as a locum, even if December 31 isn't a Saturday, would be counted. But the one who is working to fill somebody's time who was on vacation for the month of November and is not working in December would not be counted.

They might be there for a day or longer; they might be there to replace a regular staff who are absent. They might be there in lieu of regular staff when a position is not filled.

They might be there to provide a service which otherwise could not be afforded. I think especially of vision consultants who come in for one day a month regularly, or there might be they are participants in a training program.

The table itself looks like this. It's printed in the PAL and you can download the PAL and see the entire table. But you'll see Column A and Column B for the full and part-time staff and Column C and Column D for the others.

Table 6A has been with us since we began the UDS. It deals with selected diagnoses and services rendered. The difference is that we are now changing Table 6A.

Grantees have commented over and over that Table 6A, because it looks only at the primary diagnosis, sometimes fails to adequately or accurately indicate the intensity of the multi-problem population that we serve.

And especially in situations of mental health, behavioral health, or substance abuse where the diagnosis is rarely the primary diagnosis, or even in areas of co-morbidity where out of habit the hypertensive diabetic is always coded as hypertensive primary, diabetic secondary and result in a real understatement of diabetics.

So beginning with the data for 2012 which you will submit February 15 of 2013, Table 6A will have the exact same lines, but the columns will be titled differently.

So we're only talking about the diagnostic lines; lines through 20V where the title of the columns will be changed.

What we will now be asking is that when patients are seen, the provider -- and that's really only the provider -- identifies all the diagnoses that are being addressed at that meeting -- it could be hypertension and diabetes and obesity and substance abuse and tobacco use -- and effective January 1, we will report on all of those, not just the primary diagnosis.

Note that we are talking about diagnoses. The fact that there's a problem list that may include some problems that you've addressed over time is not being looked at. We're talking only about those that are addressed as diagnoses.

So, a patient who is seen for hypertension and diabetes is going to be counted in both the hypertension column and -- or row, and the diabetes row in column A.

A hypertensive diabetic patient who is also overweight and smokes but neither of those were addressed during the visit, we will only hear about -- we will only see the hypertension and diabetes visits being counted in that visit.

A hypertensive patient that comes in because of an asthma attack and asthma and smoking are addressed but hypertension is not, we won't count that on the hypertension line but we will on both asthma and smoking.

So in column B, each patient is counted once and only once on every line where they had a diagnosis during the course of the year.

All diagnoses will be reported on Table 6A. It is whether they were diagnosed primary diagnosis, secondary diagnosis, tertiary, I believe that some forms actually allow for nine diagnoses.

I don't know very many clinics where the doctors have enough time to address nine diagnoses but if they were addressed, all nine would be shown.

And then examples again if the patient is seen for hypertension and diabetes, count them on both lines. Hypertension and diabetes with overweight and smoking not addressed, we will not count those.

Hypertension where it is not addressed at all even though they are hypertensive we will not count it.

And again, what you can see is that the title on the top of the columns has been changed. It now says visits with diagnosis regardless of primacy, where it used to say primary diagnosis, and total patients with this diagnosis regardless of primacy where it once said patients with this primary diagnosis.

We're all looking forward very eagerly to in fact see the demonstration in our data of what this makes -- difference this makes and whether co-morbidity in fact has led to an underreporting of the difficulties of the health center patients. And we're quite confident that we'll see a different patient -- a different picture.

Table 6B continues with the Bureau's efforts to expand and address the various forms of clinical services that are provided by community health centers and to go further now into adult conditions, both chronic and screening and prevention.

And in that vein, three new measure have been added -- coronary artery disease with regard to lipid lowering therapy, the schematic vascular disease with regard to aspirin or other anti-thrombotic therapy, and colorectal cancer screening.

Today, data to document performance on these three measures are being collected at your health centers.

We are only asking you to continue reporting on the data that you are already collecting. In other words if you are seeing these patients, they are already in your system and the codes should already be there. So there should be no new data over and above that which might be needed to ensure that rigorous charting is conducted.

EHRs may be used. Chart review may still be used as appropriate, and the use of CPT Category 2 codes again may simplify the reporting process. Very few health centers have adopted that, though during the last year a significant number have in fact looked at those additional codes that at the end of the CPT Manual and which have been designed specifically to permit reporting on these variables.

There should be no new clinical activities required to report on these clinical measures. Clinicians should not be required to spend any additional time in producing the data necessary to report these measures.

And they will be submitted for the first time in the 2012 UDS Report due February 15, 2013.

These continue the Bureau's focus on quality; slides that were developed long before today's newspaper headlines came out because in fact the Bureau has had a focus on quality of patient care, prevention and treatment, and a commitment to this.

And these new measures focus on preventive healthcare and chronic healthcare now for adults and seniors, the populations which are the last to be added to that list.

This year, all do have ICD-9 diagnostic codes, though it may be necessary for our people to look even further through charts when reviewing them. And all will qualify under meaningful use rules using the definitions as they have been established in that system.

That leads us to of course the second Bureau focus; the focus of comparability.

The new clinical measures are being adopted by a wide range of non-330 organizations. It is our hope that in future years, data that you are collecting will actually be able to be compared to comparable data from other organizations.

Today's USA Today article sort of grabbed data as best they could from the rest of the world because the rest of the world is reporting these as well as we are.

But because the definitions are going to be the same as those required for meaningful use, we will have comparable data that will allow us to make valid comparisons in the future.

The BPHC of course, will continue to provide reports that provide health centers the opportunity to compare themselves with their peers and to identify targets for quality improvement.

The quality improvement leads us to our focus on integration. Because these new clinical measures will be integrated into the service area competition and budget period renewal grant applications.

And grantees are encouraged to include these measures using the best data available, in the next round of BPR and SAC applications.

And by the way, it should be noted that any time a new measure like this comes up and a grantee includes it in their application before they have done intensive reviews, if their UDS data points to different numbers for the baselines in the subsequent year of the SAC or BPR application, they are permitted to change that baseline number to agree with what the UDS number actually is.

And of course this ties to our focus on meaningful use. The 2012 Clinical Measures complement CMS' meaningful use criteria. They are all drawn from the National Quality Forum Measures and support the implementation of EHR data collection and reporting procedures in health centers.

So let's talk about these measures and exactly what it is we're looking at. The new measures will be on Table 6B. They are quality of care measures that are consistent with the manner in which these have been collected in the past and consistent with Table 6B measures. They are in fact all process measures.

And by this we mean measures that re in the form of if the patient receives timely, routine, and preventive care then we can expect improved health status at least on a population basis.

So, for coronary artery disease, if clinicians assure that patients with established coronary artery disease receive lipid lowering therapy then the likelihood of coronary artery disease related clinical events will be reduced in this population in the future.

With ischemic vascular disease, if clinicians ensure that patients with established IVD use aspirin or another thrombotic drug then the likelihood of myocardial infarctions and other vascular events can be reduced. Take an aspirin - prevent a heart attack; fairly simple concept.

And with colorectal cancer screening, if patients 50 to 75, the population most likely to experience this problem, receive appropriate screening then early intervention will be possible and premature death averted.

So let's look at them one at a time. Coronary artery disease and lipid lowering therapy -- and you'll notice in the slide, NQF-0074, for those of you who actually are working with the meaningful use criteria and building those into your electronic health records or having them built in or using electronic records that have them built in, this is the citation that you would look to for an admittedly confusing set of statements and data for further information.

So the measure -- the measure is the percent of patients in the universe with lipid lowering therapy. This means it requires the documentation of the prescription of the medication or evidence of the use of the medication.

And medications are those consisted with the lipid lowering therapy consistent on current guidelines from the American College of Cardiology Foundation and the American Heart Association.

So those organizations have set the standards. They are adopted by CMS. They becoming meaningful use and they are what we are following.

The universe is all adults age 18 or over -- that's the population we've been looking at quite a bit lately -- who have an active diagnosis of CAD which includes myocardial infarction -- MIs -- or who have had cardiac surgery. So first criteria -- they have a significant CAD diagnosis or are post-surgery.

Second, they have had at least one medical visit during the measurement year, that is during 2012.

And third, that they have been seen at least twice in the medical clinic. Not necessarily both visits in 2012; it could be one in 2011 and one in 2012. Theoretically it could be one in 2008 and one in 2012, but they are an established patient with two or more visits and they were seen in 2012.

There are exclusions listed for allergies to these drugs or adverse reactions to these drugs. So if an individual is shown to have either of these two conditions then they are excluded from the universe.

And then -- and so that's the universe, that's the denominator. The numerator is those charts or associated files in a pharmacy or EHR records that demonstrate a prescription for lipid lowering medication or demonstrate that the patient is using lipid lowering medication. Either one of those signify compliance.

And true to the form for Table 6B in Column A you'll tell us how many of your patients have this condition that is, meet the full criteria. So, CAD plus a visit in 2012 plus two visits ever.

And in Column B, if you're using your EHR to do this the number is going to be the same as Column A. Of if you're going to look at a sample of 70 charts you'll say 70 in Column B. And in Column C, how many of those in Column B have evidence of lipid lowering medications.

Okay, or second new one, ischemic vascular disease -- IVD using aspirin or other anti-thrombotic therapy, NQF number 0068.

And the measure, again we're looking at a percent -- a percent of patients in the universe who are in fact using aspirin or other thrombotic therapy and specifically who have documentation of the prescription of this medication or the dispensing of the medication or evidence of the use of the medication.

So we talking about between the pharmacy and the charts, can you demonstrate that either the drug was prescribed to the patient, dispensed to the patient, or reported by the patient as being actively in use.

Universe, again the denominator -- all individuals diagnosed with IVD including myocardial infarction or those discharged after cardiovascular surgery - CABG - cardio -- help me -- CABG - coronary artery bypass graph and a PTCA...

Quyen Ngo-Metzger: Percutaneous - percutaneous -- you caught me off guard.

Art Stickgold: Yes, I tried to tackle -- it's a graph; it's a stenting.

Quyen Ngo-Metzger: Yes.

Art Stickgold: Basically its stenting by PTCA is what it says here; and was seen as a medical patient during the year, so either those or the diagnoses and was seen as a patient, that is our universe.

Okay. And then documentation of compliance is a prescription for the drug or dispensing of the drug or the use of the drug by a patient. So if you have those in evidence in your charts; in your electronic health record or in your pharmacy data, any of those qualify to demonstrate that the patient is in compliance.

And again, the table will continue in the same format -- column A, how many IVD patients do you have that meet the criteria? Column B, is it that same number if you're using an EHR, or 70 charts if you're doing a sample. And column C, how many of the patients demonstrate that they were compliant with this regime or that sorry -- how many times can you demonstrate that the clinic was compliance in prescribing this regime.

Finally, our third new variable -- sorry, we went past - -so I have this wonderful thing here that gives me a pop-up every time one of you try to chat to somebody and it blocks my next key. So if I'm stuttering all over the place here, my apologies.

Colorectal cancer screening, NQF-0034 -- and our measure is the percent again of patients in the universe who received appropriate screening for colorectal cancer.

And this requires documentation of tests performed, and please be clear, by the grantee or by another caregiver so, we're looking for either of those.

And our numerator -- and here's where we get complicated again -- we're calling this measure colorectal screening in patients 50 through 75.

The measure itself is defined if you go into that NQF document, as all people who have had the colorectal cancer screening within 365 days of having turned 50 which means that if on December 31 you have a patient who is 50 year, 180 days old, they still have 185 days in which to be screened. They're not part of the universe.

So even though we're talking about people 50 to 75, they have to have been screened by the time they turn 51 in the measurement year. And if they were there up through 74 in the measurement year then plus one year, they qualify to be in the universe.

Exclusion of course, anybody who has already been diagnosed with colorectal cancer is not part of the universe.

And then compliance is documentation in the charts -- and when we say chart we mean in the electronic chart or the paper chart -- of having performed or received -- the clinic has performed or the patient has received a test, and the clinic has the clinical records in their system.

So it is not required that this test be done by the health center, it is required that the health center have documentation of the test.

Specifically a colonoscopy which was done in the ten years ending December 31, 2012, so any colonoscopy dated January 1, 2003 through December 31, 2012 means that that patient is fully compliance.

Or a Flex Sig within five years which 2008 through 2012, or a Fecal Occult Blood Test, and that includes the Fecal Immunochemical Test -- the FIT -- during the measurement year, during 2012. That's our compliance.

So that's our enumerator. The denominator is everybody who fits the age and medical patient requirements.

And again our table, column A, how many adults aged 50 through 74 - 51 through 74, were seen. Column B -- sorry yes, were seen column B, either that same number or 70 in column C, how many had evidence of screening.

This is one of those situations where if you cannot in your EHR, adequately retrieve the information that the screening was done by another provider elsewhere, you'll probably end up using a sample and looking at the details in either the EHR or in the paper chart to find a notation that this service was provided elsewhere.

Finally, the last change that we're making to the UDS this year, and this is to the last table -- the unnumbered table which relates to EHRs and which is a series of questions.

And of course every year the certified EHRs change because every year Medicare certifies a different group. Most commonly it certifies the next version, so your current version is likely to be in there. But you've seen that before.

What's new this year is that beginning in -- beginning with 2012 we'll continue to collect information. And okay, I should have gone to the next one -- and then ask about quality recognition and there are a series of questions.

First, has your center received national and/or state quality recognition? And that doesn't mean that you got a trophy, it means that you have accreditation or patient centered medical home certification and recognition for one or more of your sites for the year 2012.

Not has that ever happened but has that happened in a manner which is consistent with 2012 operations.

So yes, if you have a JCAHO Accreditation which is a multi-year accreditation and you're in that multi-year period, then you would answer yes. But this isn't were you ever accredited by JCAHO -- I remember in '70 we -- no, do you have current recognition?

If yes, who did it? And some of you may have had it for more than one. The Accreditation Association for Ambulatory Health Care -- still located in the same building in Skokie I think, that they've been in forever, The Joint Commission on the Accreditation of Healthcare Organizations- - JCAHO. NCQA, the National Committee for Quality Assurance, or some state recognized initiative or private payor initiative or other recognized body in which case, write it in.

So we're going to ask do you have recognition, if so, from whom? Now we know all of this is new and there are documents that you can follow through with: the PAL that was mentioned.

Also available on the Bureau's Web site is the second document which is the document that went to the Office of Management and Budget, and that has some information about it.

And of course later this year there will be information in the UDS trainings. I'll remind everybody that the posting of UDS trainings will occur late in the summer and then actual trainings will occur in the winter of this year.

In addition, further assistance, you can get information on UDS content questions from the Helpline, the infamous 866-UDS-HELP or by emailing to the address on your screen.

The Bureau's Helpline can assist you with further information on how to use your reporting and the electronic reporting process, the electronic handbook. And then the Bureau posts information about UDS data, UDS statistics, all of those statistics that you want to look in the forms of rollups.

You can see those for years 2010 and before that either for your state or for the nation.

And then mid-summer you'll be able to see the 2011 rollups. And again, to get PALs you have a hot link here for the 2012-03 -- is there a hyphen; I don't know, there may be a hyphen missing there. But that's the right -- 2012-03 okay, for the most recent PAL.

So at this point we are going to thank you all for your participation and open up the lines for further questions.

Jim Macrae, the Bureau Director is back in the room with us, and we will open up the phone lines at this point to questions.

Operator: Ladies and gentlemen if you would like to register a question, please press the 1 followed by the 4 on your telephone. You will hear a three-toned prompt to acknowledge your request.

If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. Once again that's 1, 4 to register for a question.

And our first question comes from the line of (Susan Wilson). Please go ahead.

(Susan Wilson): Good afternoon and thank you for the presentation. It was very helpful. My question pertains to the question about patient centered medical home recognition. Do you anticipate any sort of requirement that the state-based or private payor home health initiative have standards as stringent as NCQA for the others?

Jim Macrae: Hi (Susan). This is Jim. We are looking at that. You know, there have been several requests in terms of looking at what states are doing with respect to patients in our medical home and health homes. We're trying to develop a process in terms of whether that wouldn't meet the national standard in terms of what we're looking at. We're trying to come up with some review criteria.

(Susan): Okay.

Jim Macrae: The biggest thing I think from where we sit is that we really are looking at patients in our medical homes and recognition that really happens across the state not just in selected communities and really if it's recognized in terms of in particular payment methodologies that different states have been able to utilize. But that's something that, you know, we're going to work on with you so if you have specific questions you can send that in to our PCMH inbox (PCMHHInitiative@hrsa.gov).

(Susan): Okay. Thank you.

Jim Macrae: Yes.

Operator: Our next question comes from the line of (Meredith Moorman). Please go ahead.

(Meredith Moorman): Yes. I was wondering on slide 54 you had said that it should read age 51 to 74, but then it also said 51 to 75. So I didn't know if that was intentional or just an oversight.

Man: It's persons who were 54 scheduled to turn -- sorry, 74 who will be 75. So anybody who turns 75 during the measurement year is in the pool.

(Meredith Moorman): Okay great. Thank you.

Operator: Our next question comes from the line of (Marian Sevarezzi). Please go ahead.

(Marian Sevarezzi): Hi. My question's really to the table fix and the quality assurance measures and it's mostly a comment and it's similar to the shallow representation of our diagnoses over the years, you know. But now with the QA measures, they don't really account for people who cannot afford the procedures like sigmoidoscopy, colonoscopy, pap smears, or for patients who are reluctant to even accept this sort of intrusion after one or two visits at the health center. So I know you don't have a solution right now, but I know as it reflects our success and care in our outcomes it also cuts us short a little bit or gives us sort of a more narrower focus we should be getting credit for.

You know, the rigorous nature of engagement and workup and the long-term. You know, how long it takes to have a homeless person accept a colonoscopy, you know. Do you understand my point?

Quyen Ngo-Metzger: You know -- this is Quyen Ngo-Metzger -- and I think that, you know, we've tried to be fairly flexible with that so that it's not just a colonoscopy but if they have a fecal occult blood test done or a fit done during the year that would be adequate as well and...

(Marian Sevarezzi): Okay.

Quyen Ngo-Metzger: ...as a standard of care. So if, you know, if you have a patient who refuses the colonoscopy but had an FOBT test during the year that would count.

Man: And I think the other piece just with respect to any of these measures and, you know, again part of what we've been talking to different reporters and other folks about over the last several weeks and months is that it's not just the measure. It's actually the story behind the measure and that's why...

((Crosstalk))

Man: ...when you not only report your UDS data, but when you have the opportunity in your grant application and other places to talk about your progress to really tell that story behind the curve in terms of what's going on with respect to the work that you all are doing. And that came out a little bit in the USA Today article for example, but we really think that's important to stress so please do that as part of your submission in the grant application and progress reports.

Man: And then be real clear about how you interpret these words. If we're talking about something like a pap test and you think that that's too expensive to provide because a way a lot of people deal with that is to coordinate with a network of clinical people in their community. Like if you're sending those people to the county health department or...

Quyen Ngo-Metzger: Yes.

Man: ...to some other organization by all means having notes in your charts of the results of those tests...

((Crosstalk))

Quyen Ngo-Metzger: It's more of the refusals that are seen as non-compliance and refusals by people who are, you know, suffered trauma and they won't allow such intrusion. So, you know, we'll keep working on it.

Man: Yes. You know, and this is (unintelligible). I'm the Chief Medical Officer.

Quyen Ngo-Metzger: Hi.

Man: You know, you're talking about sort of personal preference and a lot of issues that, you know, a patient may refuse or not want to or for whatever reason, you know, they may not get a procedure or, you know, a service done. And, you know, if you think about, you know, many of these measures if somebody has a 100% rate you actually have to start thinking about well is that the right number, right? Some people -- some of these procedures may not be appropriate for people and therefore may not be 100%. So, you know, we're looking at across the board, you know, we may not even know what is the best, you know, threshold to meet. But we know that, you know, for the vast majority of people and the patients we serve these are probably the right one.

And furthermore, the list of measures that we do collect is not meant to be comprehensive. It's really for us to help, you know, make sure that overall that the health centers are doing well. I mean we can certainly start collecting very detailed and, you know, and dozens and dozens and hundreds of measures but that's not going to be helpful, you know. First of all, it's not feasible and I don't think most of you on the phone call will want us to do that. So we're really trying to be selective. What would make a difference? How do we help the program, you know, provide high quality care? How do we help you, you know, who may be serving homeless patients or farm workers or, you know, others with different vulnerabilities, you know, achieve a highest quality of care. So I hope that makes sense.

Man: And by the way...

Quyen Ngo-Metzger: Thank you.

Man: ...the bureau will once again be sending you a (unintelligible) I guess mid-summer a report listing these measures and then specifically showing if you are a homeless program what other homeless programs do so that you'll have the capacity to not only see your numbers and yes recognize that it's a homeless program (unintelligible) difficulty in (dealing this). But also to be able to compare yourself to other homeless programs...

Quyen Ngo-Metzger: Right.

Man: ...and have a reference group that is meaningful to you.

Quyen Ngo-Metzger: Thank you.

Man: Thank you.

Operator: Our next question comes from the line of (Emmanuel Nirvez). Please go ahead.

(George): Hi. My name is (George). This question is actually for (Art). It's regarding the slide presentation about the FTE positions where you indicated that if a FTE position works 12 months in the measurement year and that position leaves for example December 15 or December 20 that the count for that position becomes 0 and not 1. And the question is what happens to all that work and effort and all those patients that that position saw during that year? It's almost like that's being totally dismissed and the clinic is getting no accountable measurement for that.

Art Strickgold: Well let's be real clear about the new table, Table 5A and the current Table 5 which is totally unchanged. So on Table 5 that provider is going to show up as a .9 something FTE provider in all their visits and all their patients are going to be reported on. But for people who are saying what is turnover look like at this clinic? You know, how often are we losing and gaining new people? How long have our people been with us? It will in fact that if that person's been replaced that the new person is relatively new and that is a fair picture of

your clinic, but absolutely you're not going to lose all of the work that that provider did.

(George): Okay. Thank you.

Woman: We also have another question on the clinical like care measures - the ischemic vascular disease. You mentioned myocardial infractions, coronary artery bypass graft, percutaneous transuminal coronary angiplasty. Would you also include ischemia cerebrovascular accidents as well as transient ischemic attacks? Any other diagnosis that would fall underneath that broad category of ischemic (unintelligible).

Woman: Yes. I mean it's supposed meant to be a broad. We basically follow the meaningful use (NQF) and I think that actually is a broad ischemic vascular disease. So that would include those as well.

Man: It includes them all. The others are listed because the individual may be post-operative CABG and not necessarily carrying at that moment a diagnosis of IVD and they're included in the universe too. So that's an addition to all those people that you mentioned. The trench and the ischemic attacks I presume are also in the coding, but we'll do further review of the CPT or the ICD9 codes to determine the nature of whether or not a TIA fits that description or not.

Woman: Thank you.

Operator: Our next question comes from the line of (Dina Moya). Please go ahead.

(Dina Moya): Yes, hi. Thank you. I have a question about the colorectal cancer screening. If we have a patient who had a colonoscopy when they were 49 and they're not due for another in five years would they count in, you know, 2009 they had their colonoscopy not 2010 or '11 would they count in the measure or would they need to have a fecal occult blood test in the year after count?

Man: They would be in the population by virtue of their age and they would be in compliance by virtue of having had it within the period and...

(Dina Moya): Okay.

Man: ...you bring up an extraordinarily technical issue that I don't know if we'll ever address which is namely colorectal screening before you turn 50 has a different life span than after you turn 50. We'll try to address that relatively obscure of condition in the manual. But yes the person you're talking about absolutely would be considered to be in compliance.

(Dina Moya): Okay. Thank you.

Operator: Our next question comes from the line of (Jeff Gabart). Please go ahead.

(Jeff Gabart): Hi. For Section 10, line 19, the colorectal cancer screening you say it'll be roughly the same as the adjusted age group on 3A. Does that mean that the criteria for the universe seen in the measurement year means it's any kind of visit and not a medical visit or should that criteria be a medical visit in which case it would be different from 3A?

Man: It is absolutely a medical visit and that's why it says the adjusted number from Table 3A. And what we attempt to do in looking at your data when it comes in or actually when you're looking at your data online to try to identify possible errors that are being made is to try to guess how many of your 3A patients are actually medical patients...

(Jeff Gabart): Right which...

Man: ...and we do that by looking at what portion of your total patients are medical patients. Sometimes we guess very wrong but...

(Jeff Gabart): Yes.

Man: ...we never do, but the computer does. But yes, we do mean to adjust it. It is only medical patients that we're talking about.

(Jeff Gabart): Okay. Thank you very much.

Operator: Our next question comes from the line of (Marisol Dela Vita). Please go ahead.

(Marisol Dela Vita): Yes. I have a question regarding some of the measurements of (unintelligible) two visits ever and for example you mentioned that some patients could have been seen in 2008 and that counts as a visit done in the past (unintelligible) (organization). So if we have a (chart) where we have three years of data would you recommend to everyone that we get a backlog from our practice management system to be able to have that data (of) 2008 or prior to that? Otherwise would not include patients that have been seen before our go live date?

Man: We are recommending that you try to use three years worth of data. That's not a requirement. The requirement is that you have all of 2012 data. We recommend it because if your EHR matures and eventually it works up to having more years of data, your universe will increase and if nothing else changes just because of statistical aberrations of what happened to that (weight) your compliance will go down. You'll be more and more likely to be able to identify somebody whose second visit was in a prior year and therefore more likely to have been missed. But the absolute requirement is that you have all your 2012 data available and our best practices recommendation is that you be able to scan three years of data to find multiple visits.

(Marisol Dela Vita): For example the other question that we had is regarding a colonoscopy that could be done in the last ten years. I mean you're not expecting anybody to go back and manually enter a search for that. It would be just for calendar year 2012, correct?

Man: 2012 -- you would have to know that they had had a colonoscopy ten years ago or have done it an FOBT in 2012. So hopefully you're able to determine for that patient whether or not they had a need for an additional FOBT but that's the data. The question is really did your clinical staff work with the data they had available to determine if this patient needed a test and if they thought the patient needed a test ordered that test. And if they and if they have the ten-year old data, they might have ordered it. But in this case if they don't have it, if they don't know the person that is tested then they should order it. So it's whatever data you have available.

(Marisol Dela Vita): Okay. Thank you.

Operator: Our next question comes from the line of (Regina Kovar). Please go ahead. (Regina Kovar), your line is open.

Man: Okay. Our question is when -- we have an EHR system that's been in place for a year. Do we still have the option to do chart samples -- do the 70 chart samples instead of reporting on the universe? We're not familiar with all the field population to find our metrics yet and we're wondering if it's still okay to do 70.

Man: Our request is that you provide us with the best data possible and we feel that at the time that your EHR matures and becomes the tool that we know it can be that will be the system to use. If you don't have confidence that it is currently able to give you the best data available and that you should be using a sample by all means go ahead and use a sample.

Man: Thank you.

Operator: Our next question comes from the line of (Maria Chavez). Please go ahead.

Man: Okay. Our question is when will we be given the ICD9 codes for the measures for coronary artery disease and ischemic vascular disease?

Man: We will publish those in the manual which will come out towards the end of the year. If you're on a certified EHR, they're already working with the codes that are in the NQF document and it is our intention to follow the NQF document so you can look there. The only caution I would give you is that frequently the NQF document because it is very broad and is for all medical providers would give you a long string of codes all of which are inpatient surgical codes and that you may need to be looking for something else other than that inpatient surgical code.

Man: Okay. Because I guess part of my question is I would think the coronary artery disease code would be very similar to the ICD code and then being able to document those who have had an AMI or a CABG or a PTCA so that our electronic system can pull that data other than just the diagnosis. I guess just kind of trying to figure out how we can do that and make sure we're prepared so when it comes time to pull these numbers that we'll at least

make sure we're using the correct codes so that we get the best data possible (unintelligible).

Man: I think you touch on a very sensitive and a very meaningful question. And again we will publish those when we get the manual out, but turn to the NQF document in the interim period and look at that. And your observation about the ICD and the coronary artery, yes those codes are very similar.

Man: Yes okay. And then the dumbest question of the day, where were the slides for this presentation?

Man: On the Internet.

Man: Oh that worldwide web?

Woman: They're posted on the UDS Web site.

Man: UDS Web site. Okay thank you.

Woman: And I think that it was actually put into the chat box as well. There's a URL put into the chat box on the left if you're...

((Crosstalk))

Man: Okay. Thank you.

Woman: Sure.

Operator: Our next question comes from the line of (Carla Bartlett). Please go ahead.

(Carla Bartlett): Yes hi. Thank you. I was referring to slide 53 on the colorectal cancer screening talking about the documentation. Do we have to have the report in there or it's patient word and we document that they reported they had the colonoscopy?

Man: The standard that we've used throughout the UDS is that there is some documentation from the provider of the test or the provider who ordered the test. Patient memory is a wonderful thing, but it is sometimes especially

if you're talking about 10 years ago not the most accurate. And we are assuming that your provider wants to know not only that they have the test, but what the results of the test were. That if we're measuring how well your system is dealing with this. It's doing two things. It is testing that patient to assure their best health and also providing your clinicians with the best information possible to treat that patient in their ongoing health maintenance. And so yes, we're looking for something other than patient memory to document it.

(Carla Bartlett): Okay. I have one more question. On the CAD is that including ASCBD?

Man: I'm looking helplessly at the clinicians in the room who are...

Man: I think we're going to have to -- if you send us the specific diagnosis that (we) are talking about, we can look at that ICD9 and confirm it.

(Carla Bartlett): Yes okay. Thank you.

Man: Thank you.

Operator: Our next question comes from the line of (Joe Abraham). Please go ahead.

Woman: Hi. My question concerns Table 5A when I'm looking at the selected positions of CEO and so forth. For example in our case we don't have a chief medical officer, we have a medical director. So do you want only those specific titles or do you want all organizations equivalent?

Man: Actually if you look on the slide before, you'll see that it says CMO parentheses medical director. And it says CEO/executive director on slide 11 and CFO/fiscal officer. We want the person who is the senior officer in the corporation who fulfills that obligation as...

Woman: Thank you.

Operator: Our next question comes from the line of (Anya Van Burkleer). Please go ahead.

(Anya Van Burkleer): My question has been asked and answered. Thank you.

Operator: Our next question comes from the line of (Carla Sigura). Please go ahead.

(Carla Sigura): Hi. Our question is regarding Table 7A where it's saying that (grantees) are required to follow up with (unintelligible) out in (unintelligible) delivery and birth outcome. I just wanted to know best practices or how people are doing that or how we're expected to capture that data?

Man: So this is not one of the new tables. This is the old Table 7. And the question is, you know, how in an organization that aspires to be a medical home do you keep track of what happens to the women you refer out. And best practices are all over the map. If you'd refer them out, I should certainly hope that your referral agreement with the doctor you refer them to calls for and has all the signed releases for the automatic transfer of that information. But sometimes it's nothing more than a give me the phone number you'll be at when you get to Texas so I can call you and find out what happened. And a medical case manager who has the obligation of doing that follow up so that you know how well your health center delivers pre-natal care even for those women who move from one location to another.

(Carla Sigura): So we have a large number of migrant farm workers who might not have a phone number and might not have a stable address. So we're having to handle this population and having difficulty. So we just wanted to know what would be the recommendation in that case.

Man: And again, you know, we certainly -- we more than anyone are aware of the problems of migrant health workers obviously and they do migrate, but generally when they do we hope that you are helping them to move into healthcare at the next location down the migrant stream and that you are facilitating that transfer and that you have the data of who they're going to so you can contact that person. And let me also suggest that if clinical talks to billing sometimes the billing people know exactly what those people's downstream address is because that's where a bill is sent to and where the migrant patient pays the bill. So check internally, but develop procedures that facilitate for the migrant -- forget about the UDS -- for the migrant the effective transfer of that patient into their new system.

(Carla Sigura): Thank you.

Operator: As a reminder to register a question press 1, 4 on your telephone keypad. And our next question comes from the line of (Maria Diaz). Please go ahead.

(Maria Diaz): Hi. My question is related to the IVD that (unintelligible). You said the use can be measured by prescribing, dispensing, or use. For use is self-reported count again the self-reporting thing. And I am especially interested on this one because aspirin is an over-the-counter medication and some patients they just say okay I am taking it and I am not using your pharmacy. So it's not in the electronic records of our pharmacy and the provider might recommend it, but not necessarily prescribe it.

Man: Yes. The use of is in fact self-reporting...

(Maria Diaz): Okay.

Man: ...and if your patients are being disingenuous with you, you can do I'm afraid nothing more than pass on their information to us. But I would suspect that question of are you using aspirin contains in it the implicit statement I think you should be using aspirin and that is the ordering of aspirin and ordering of aspirin is in and of itself one of the three criteria. So you would -- the very fact that you asked the question I think implies that you also met the criteria.

(Maria Diaz): Yes, but it has been recommended previously.

Man: Yes.

(Maria Diaz): Yes. So ideally you would have to actually that you recommended it and the patient is taking it.

Man: And it would be nice if you gave them a bottle of 100 aspirin that cost you only 59 cents. But again so you have all three.

(Maria Diaz): Yes.

Man: But any one of the three is quite fine.

(Maria Diaz): Yes okay. Sounds good.

Operator: Our next question comes from the line of (Renesh Nago). Please go ahead.

(Renesh Nago): Yes. I was -- (Art) and I have discussed this, but Northeast Valley is a very large clinic and we have 14 contractors that do homeless care and we also have the community health cluster money so both cluster money and homeless money and our UDS is combined with these 14 other agencies. And I was wondering if the bureau would ever consider separating it so that we could do our UDS for or excuse me the clinical measures for just the clinical cluster which is all Northeast Valley community health clinics and then our homeless clients would be a different UDS that we'd report just because it's all mixed. It's 21,000 homeless patients mixed with 64,000 primary care clinic patients. Anyhow, it doesn't have to be answered now. It would be very helpful and be more meaningful to us if the homeless population was separated out from our primary care patients.

Art Strickgold: And the generic question about organizations that have multiple funding streams either homeless and public housing or migrant and community health or any of those have all talked about that desire. To some extent on some of the tables they are split out. On Tables 3A, 3B, 4, part of Table 5, and on 6A the data are collected separately and they do provide a different snapshot.

We have at this point taken the position that unless you're a clinic who has 20,000 homeless and who -- sorry, there are very few clinics that have large enough populations in multiple streams to make it possible for them to in any meaningful way report on Table 6B and 7. So as much as eyes might light up around here when we figure out more interesting data we could ask you to submit practicality has to enter into it then no that's not something on the agenda.

(Renesh Nago): Just a question. That's helpful. Thanks.

Operator: Our next question comes from the line of (Joanne Andeolio). Please go ahead.

(Joanne Andeolio): Thank you very much. A couple of questions. One is when I look at the requirement for a medical visit within any of these disease entities that are

now listed can that be for anything not necessarily related to the particular CAD or IVD or all those things that they could be coming for anything and that would be qualifying them for that quality measure?

Man: The issue that they have one visit during the year is any qualifying medical visit and it doesn't have to be for the particular disease entity that's being discussed. They must also have had the diagnosis of that disease at some point.

(Joanne Andeolio): Right.

Man: But if a diabetic comes in 2012 with a sprained ankle, they're still a diabetic. They're still in your diabetic pool and they qualify for 2012 by virtue of the sprained ankle.

(Joanne Andeolio): Okay thanks. Another is that is there any -- I'm understanding that the description or the expectation of quality is whether or not the center is really documenting these qualifiers as presented. Is there any effort somewhere along the way to also document non-compliance as a quality measure for an organization?

Man: I'm sorry, patient non-compliance or...

(Joanne Andeolio): Right, patient non-compliance, yes. So I mean all the documentation may be there, do we get 100% or 92% or 80% for actually providing high quality because we did all these things. But what if there's a high non-compliance rate on the part of the patient, does that figure into quality measures?

Man: I will let you deal with that internally yourself, but let me suggest that one of the real qualities of community health centers is the ability to have Bureau-supported positions like health educators and...

(Joanne Andeolio): Right.

Man: ...case managers to help us with helping patients understand why they should be compliant and following up with them so that they are compliant. And in every population there will be a group that is non-complaint. We recognize that and that is why when the Bureau uses these data to look at

you as an individual grantee, it always compares you to yourself in prior years rather than to some abstract external variable. But the opportunity for us to make our patients better patients is almost as interesting and important as to make them healthier patients.

(Joanne Andeolio): Right and I appreciate the answer and I certainly understand. I just was curious as to whether or not that was any kind of an indicator that we might do it locally of course, but if that were going to be any kind of a more universal indicator.

Man: You know what? I'm sorry. This is (unintelligible) actually. Measures of a non-compliance or non-adherence is a very tricky thing to measure and, you know, clinicians and evaluators and what not around the globe have been trying to sort of get at that. If you look at the range of measures that we collect some of them are process measures whether you did something or not and then some of our outcome measures like, you know, is the diabetes controlled or hypertension controlled. And within those things you can actually begin to tease out, you know, some of the non-compliance issues or ineffectiveness issues or what not. And I don't think that even the most smartest people who collect measures can actually accurately come up with a measure for, you know, an non-adherent because so much of it is, you know, patient report or, you know...

((Crosstalk))

Man: ...and what not. So, you know, we don't have any plans right now to create or to adopt something like that.

(Joanne Andeolio): Is the comparative data strictly compared against yourself or against other of our, you know, colleagues around the United States and so on?

Woman: There is -- the comparison data actually compares you against there's, you know, the past years the trends in 2008. There's also comparison with others like health centers like your size and also with others in your state and then also with others, you know, within, you know, if there's a lot of homeless patients or migrants. So that comparison is there in multiple ways for you to take a look at.

Man: But that's data for you to use in your health center to help you design, change, and grow.

(Joanne Andeolio): Right.

Man: The data that are specific to you and the bureau evaluating you are the data associated with your grant application and those are trend data right now. You against you over a multi-year period.

(Joanne Andeolio): Very good. Thank you very much.

Operator: Our next question comes from the line of (Jackie Stevenson). Please go ahead.

(Jackie Stevenson): Hi. My question is twofold. But my first question is we were recently given a designation for status January 25 of this year and we're making this assumption, but we just wanted to get confirmation that will then push us to the reporting period as of January 1, correct?

Man: Correct.

(Jackie Stevenson): For...

((Crosstalk))

Man: It is for the calendar year regardless of when you first began as a community health center and the same is true of any organization who changes scope during year and brings into scope a site which was previously operational, but was not in scope. That site is back to January 1 of the year.

(Jackie Stevenson): Okay. And then my second question it was somewhat asked by (Regina), but our situation is a little bit different. We're implementing an EHR with an expected go live to be around June to August depending on the department. So my question is in regards to the reporting basically half of our data would be (PMS) and half of our data would be implemented EHR. So I guess we're wondering in regards to providing the best data possible for you guys would it be best to just sample 70 amongst the charts and the EHR or if it's feasible maybe do chart instructions for our clients for the entire calendar year?

Woman: I think that what we are encouraging is as (Art) has said to get the best most accurate reliable data...

(Jackie Stevenson): Right.

Woman: ...and that can vary from clinical measure to clinical measure.

(Jackie Stevenson): Right.

Woman: But there are things that are easier to get, you know, with such as the diabetes and the hypertension that's part of, you know, diabetes and hypertension -- those outcomes that should be entered as soon as the patient is seen for whatever visit or whatever the lab. You know, if you can do with an electronic health record that would be much better. If there are other clinical measures either that you can't do that requires more years going back. So I think measure by measure, we would like the best data available so you shouldn't have to feel like you have to do all 70 charts or all electronic health records. I think it should be dependent on the quality of each of the clinical measures.

(Jackie Stevenson): Right, yes. Our concern is just because if we did just EHR as our universe, it would only be clients basically seen from our go live date of June onward to December. So we would theoretically be excluding everybody from January 1 all the way up to our go live date. So we're trying to just brainstorm and strategize what would be the best way to gather all the data so that we have an entire universe that's comparable to what we've actually done.

Man: Let me sympathize with you and the roughly 100 to 200 community health centers who every year change the system that they are on.

(Jackie Stevenson): Right.

Man: It is a nerve wrecking process which you will have to go through. I would suggest that you dry run this in November or December to see how you're going to have to do it because it's not just your clinical measures. It's everything in the entire system from...

(Jackie Stevenson): Right.

Man: ...from who are your patients and when were they born to how much your charges were and what you collected on. So it is a very difficult process and the clinical measure is no different than any of the rest of it. Sometimes people for example if they're perinatal care, it's a small enough population that when they go live they abstract all their current natal records and bring them all in immediately and their system is perfect. Others when it's a question of every patient 18 years and older and you're talking tens of thousands of records, you're going to have to figure out a way to get information from (unintelligible). Remember we want to know about the patient who was seen in January, February, March, and April but never when your new EHR was in place.

(Jackie Stevenson): Right.

Man: And they've got to be in the universe too.

(Jackie Stevenson): Right. Okay. Thank you so much.

Man: My sympathies.

Operator: Our next question comes from the line of (Rachel Eberhardt). Please go ahead.

(Rachel Eberhardt): Thank you. My question's related to the colorectal cancer screening measure. The end date for measuring screening compliance for the colonoscopy and sigmoidoscopy is the last visit, but the end date for measuring FOBT compliance is basically December 31 of the measurement year. And I was wondering why those dates are not in alignment?

Man: You've been looking at the NQF materials. We are going to in our materials I think align them to the end of the year in which it will be ten years from the last visit in the year ending December 31. It's essentially the same. Did they have -- were they at the time of the last visit that they had in 2012 current and if not was that rectified. And the way it's stated in the NQF is a little bit

awkward, but it has the same impact as for any one individual whether they're in or not.

(Rachel Eberhardt): Great. Thank you.

Operator: The next question is from the line of (Tracy Hook). Please go ahead.

(Tracy Hook): Hi. When you're talking about patients have one visit in the year or two visits ever are you including visits to specialists?

Man: We are talking about all medical visits and all medical specialties be they endocrinologists, or obstetricians, or pediatricians. It's all medical visits.

(Tracy Hook): Okay. Thank you.

Operator: As a reminder to register for a question press 1, 4. And our following question is from the line of (Maria Chavez.). Please go ahead.

Man: Okay. Another wonderful colorectal cancer screening question. Now somebody just made a comment a few minutes ago that are they in compliance according to the last visit they had in 2012. Now and then if it was rectified. Now as far as being rectified if you were to order a fecal occult blood test, then that would show up then. But would it be considered rectified if at that last visit you sent them to get a colonoscopy or is just when they follow up and you find out they actually got the colonoscopy?

Man: We clearly want the test to have been performed. I think what we're talking about is the question of somebody who had a colonoscopy on September 1 of 2000 -- I hate date math -- of 2002 and came in on July 15 of 2012 and therefore was in compliance when they came in, but went out of compliance in the months that followed. Basically in all the measures that talk about not treatment but prevention and screening and immunizations, the issue is is the health center doing everything it can to maintain the health of a patient. And if a patient needs a pap test or a colorectal screening or a vaccine which they didn't need at the time of the last visit then were they successfully recalled for that test during the measurement year.

(Rachel Eberhardt): Okay.

Man: It's a high criteria. We want...

((Crosstalk))

Man: And then one thing I was going to mention is if I see a patient let's say September 1 of 2012, I send them to get a colonoscopy, they get the colonoscopy. What I'm thinking is for our electronic system, the only way we'll get credit for that is if that patient comes back before the end of the year and reports that they had that test done. So we may see that there is some gap where patients have got the screening, but they haven't reported back to the clinic about the screening. So therefore its going to show non-compliant, but in all reality they had it and it'll probably be picked up the following year for the report. But that was just more (unintelligible) I was going to make.

Woman: Well I think that if you order a test, you need to find out the results of the test not just for the UDS compliance, but for good clinical quality care. So I mean I think that that's, you know, that's the idea behind this is that if a colonoscopy is ordered you need to follow up as so as possible to see if the patient received it and what the results are. So I think, you know, our intention is to have the best care for the patient.

Man: But remember that the UDS isn't due until February 15 so you've got six weeks for the test to come into you and then though I hate anybody who says it between February 15 and March 30 you'll be working with your reviewer in catching any mistakes that were made and correcting them. And if during that period the test comes in, but for some reason your test agency takes two months to get the results back you still have the opportunity of correcting that variable. I think what we're talking about is of more theoretical interest than practical interest in terms of how many such individuals will actually show up in our samples, but whenever they do it's painful to see them there. I recognize it.

Man: Yes. Well one idea (unintelligible) had for our electronic system is the place that we refer for colonoscopies will send us results and so as practice I guess what we could do to capture those is when those come in create non-billable encounters, document the day they had the colonoscopy so therefore when

we run our reports it's capturing those. And I think that may be a solution for some people with electronic systems. Thank you.

Man: If you actually have the date that the test was conducted, we're saying you need to have the evidence back in your shop if it was done by a third party and we're hearing only by hearsay that it was actually done. And then the test evidence shows you that it was done. But if in fact you ordered the test, you know the test was done, and that's how somebody wanted to spend their New Year's Eve fine. I think that's adequate to know that the test was in fact done during the calendar year.

Man: Okay.

Operator: Our next question is from the line of (Marisol Dela Vita). Please go ahead.

(Marisol Dela Vita): If we -- I'm sorry, this is a (unintelligible) typical blood test -- if we see the patient three times in the year and we ordered it three times. So we have to put it in the visit that we ordered it three times, but the patient only got a result once at the very end would we have to (unintelligible) visits column would we only count one because from the three visit attempt we only got a result once although we counted three times that we had it ordered (unintelligible)?

Man: In this case we are recounting not tests or orders but patients. So the question is regardless of how many orders you did was one of those orders fulfilled during the year.

(Marisol Dela Vita): And that would (count) for the patient's column, but you also have the visits column?

((Crosstalk))

Man: We're not...

(Marisol Dela Vita): No?

Man: I'm sorry. On table -- and now you're back to Table 6A on lines 21 through 26 and I don't think we're collecting that information on Table 6A.

(Marisol Dela Vita): Okay. Thank you. Yes. I (unintelligible).

Operator: And there are no further questions on the phone at this time. I'm turning the call back over to you.

Man: Well thank you again very much for participating in this and for bringing up some really good questions. I think that your questions were shared with a lot of your colleagues. For what it's worth to you nearly 1000 were on this call today and over half of you stuck it through to the bitter end.

The transcript of this call will be available shortly through the bureau's Web site. So you'll be able to get the transcript and you will be able to replay the call if other people in your organization want to hear it a second time or a first time. So thank you for your participation. Try it early so you'll know your systems work and we look forward to seeing you during the training this year. Thanks a lot.

Operator: Ladies and gentlemen, that does conclude the webinar for today. We thank you for your participation and ask that you please disconnect your line.

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