INTRODUCTION TO UDS CLINICAL MEASURES

November 14, 2012
3:50 pm CT

Operator: Ladies and gentlemen thank you for standing by and welcome to the introduction to UDS clinical measures webinar. During the presentation all participants will be in a listen only mode. Afterwards we will conduct a question and answer session. At that time, if you have a question, please press the 1 followed by the 4 on your telephone.

If you would like to ask a question during the presentation, please use the chat feature located in the lower left corner of your screen. If you need to reach an operator at any time, please press Star 0. As a reminder this conference is being recorded Wednesday, November 14, 2012.

I would now like to turn the conference over to Dr. Quinn (Molmesker), please go ahead.

Dr. Qyen Ngo-Metzger: Thank you, welcome everybody to today's webinar. This is the introduction to UDS clinical measures webinar. Today we are going to be talking about the new UDS clinical measures reporting for 2012. We will review reporting methods, we will discuss strategies for successful reporting, and provide information to you on available technical assistance where you'll be reporting.

At this time it's my pleasure to introduce Susan Friedrich and also Arthur Stickgold from John Snow Inc. Susan?

Susan Friedrich: Good afternoon and good morning everyone. My name is Susan Friedrich I'm with JSI and for those of you who are new to JSI, or to the UDS, JSI was contracted by the bureau to assist you with insuring that your UDS is as accurate and complete as possible when you finalize it.

I'm joined by (Art) Stickgold and we're going to be doing a tag team presentation of the clinical overview. Before I get started I really want to emphasize the purpose of this training. This training does not substitute for the day long training.

Obviously we provide substantially more information in the day long training. Including step by step instructions for all of the clinical tables. We cover numerators and denominators in those trainings and we do encourage you to have staff attend them.

Our reason for offering this webinar is we recognize it's very difficult for clinicians to get away for an entire day and we wanted to make sure that we highlighted some of the important information that would be useful to you as clinicians reviewing the UDS data that is generated from your systems and to have a way of looking at that data before you submit your UDS report to us.

One of the things that we're always concerned about is that the data we get from grantees who have electronic health records can sometimes be the most convoluted data. And that's largely because whatever comes out of the system is entered into the tables and not a lot of the thought goes into looking at that data to see if it makes any sense.

So what we're trying to do today is give you some tips and some strategies that you can use to look over your data after its generated from your systems. And evaluate whether or not it makes sense, and to the extent to which it isn't consistent with what might be considered reasonable data. Really taking the time to go back and look at your data sources.

The old adage applies, garbage in, garbage out. Just because your system is generating the information doesn't mean that the query was developed correctly and it certainly doesn't mean that the data is where you think it is in your systems. Either (EHR) or whatever your data source is.

So what we really hope to leave you with today is some ways of looking at that data to evaluate whether you think or not it's complete and accurate. And check it before you submit it so we can make sure that we're starting at a relatively good point to be able to look at your data.

So, in addition to giving you some tips on how to look at your data and evaluating how accurate it might be, obviously many of these tips are also incredibly helpful for looking at your data to determine where the opportunities are for program improvement and clearly we really do have a huge focus in the bureau on quality of care and this is your opportunity to both document you quality of care and to use this data for program improvement over the next couple of years.

So, again, we're really going to focus on a very quick overview of the specific measures. For details on the measures you really need to attend, or have staff attend, one of the in-person trainings that are being held all over the country right now. In addition, if you are unable to attend a training. There are online

modules that review the clinical tables. Which we encourage you to review before you finalize your reporting.

In addition, we're going to be going over some comparison information that you can use to be able to judge how accurate your data appears to be. Or how reasonable your data may be. Those include bureau data trends that you can compare your performance with your peers. It also includes data from national sources that allow you to look at your prevalence rate, your quality standards, to see how you perform relative to national experience.

And we will share with you some resources that are available to you at the end of the webinar to help you, again, make sure that as you are extracting your data and reporting it in the UDS and as you are reviewing your data, you can be sure it is as complete as possible.

So what we are going to do is go through each of the clinical tables and provide you with some background. So briefly the purpose of the measures, why they're important, and then specific tips for how to look at that data and assess whether or not it seems reasonable and some clarification of what is required to meet the quality standards.

There are three clinical tables that we will be going over. Table 6A provides some information on the services that you provide and some of the diagnoses that you use. This not, clearly, a picture of all of your services or all the diagnoses from your program. It's a select set of them that are somewhat representative of your overall routine and preventative primary care program.

Tables 6B and 7 provide the best proxies we have for the quality of the care you deliver. And we use these tables as a way of evaluating overall quality

using representative measures that are consistent with meaningful use and provide us an overall view of both your routine, preventive, and chronic care.

The first table is table 6A and table 6A has a list of diagnoses and services that, again, capture part of the activity of your program. Certainly not all of it. This table has undergone a major change this year and it's important to realize that in completing your UDS report. In prior years you were only reporting visits with a primary diagnosis for the selective diagnoses. That has changed this year. As of this year, you will be identifying all visits with any diagnosis.

Any diagnosis and so you're going to be able to hopefully get a much better representation of the - sorry the slide is not advancing, I apologize for the delay. You'll be getting a better opportunity of evaluating overall prevalence of certain conditions. Now this isn't an exact prevalence, it's a best estimate of a prevalence.

But if you look at the total number of visits by patients by - excuse me, total number of visits of a particular type within the universe of patients who would be qualifying for that particular type of diagnosis, it gives you a sense of the percentage of your population with a particular diagnosis. Which is a prevalence statistic, as I said it's sort of a best guess, it's not an exact number. Because it does assume that your patients are only using your services and not any outside provider. And it is also hard to estimate exactly what percentage of your patients are medical patients.

So it's a bit of an attempted calculation, but it does give you prevalence information which is very helpful in, again, assessing your overall patient profile and some of the health issues within your population.

The other statistic that comes out of this table is visits by patients. So we can look at continuity of care. So again if you look at selective diagnoses or selective services, you can divide the number of visits for that diagnosis or service by the number of patients and get an average number of visits per patient. Which is a good continuity measure.

Before submitting this table there's some very quick tests you can do to just check to make sure the data is accurate and reasonable. If your reporting visits equal to patients for every line, obviously there is something wrong with the way the data is being pulled from your system. You'd like to see that there is a certain amount of - you know, certain number of visits for chronic conditions. Three or four visits per patient, maybe more depending upon the frequency of patients coming in for selective services by diagnosis.

Some quick checks might be looking at the prevalence rate for various chronic conditions such as hypertension and diabetes and continuity of care. Average number of visits for certain diagnoses or for certain services. You know, an example, if you're seeing five (pap) tests per patient, there's probably something wrong with your data source. So just eyeballing a number of lines on table 6A to see how reasonable both the prevalence calculation may be and the average number of - visits per patient. Can help in assessing the accuracy of your table 6A.

I'm going to have (Art) pick up with the next measure.

Arthur Stickgold: Okay, and so good afternoon everyone and welcome and click-click, come on, there we go. So table 6B, which is labeled Quality of Care Indicators, is designed to measure proxies of outcomes. What we're looking at here is a series of variables, a series of areas where you can intervene. You as a health center can intervene in the healthcare life of your patients. And because

extensive research has been done in all these areas, we know that successful intervention is the equivalent to increasing the probability of improved outcomes.

So we know, for example, that if children are well immunized, then the probability of them succumbing to any immunizable disease is greatly reduced. Now the true measure of these is to wait 10, 20, 30 years. Wait until they die and see what happens. But we don't need to do that. The research has already told us that as populations, as populations go, those that have received the interventions will be more healthy than those who have not received the interventions.

And so by measuring whether or not the intervention occurs, we measure whether or not we have improved the outcome, the status, of the patients.

So the first one we are going to look at, and sorry, you were saying?

((Crosstalk))

Arthur Stickgold: I'm sorry, we both did it. The coming year, for this current UDS submission, there will be three new indicators that we'll be looking at. Lipid lowering therapy for those with coronary artery disease. Anti-thrombotic therapy, including Aspirin, for those with ischemic vascular disease. And colorectal cancer screening. And we will discuss each of these as we come up to them in sequence.

So we'll start out though with the original ones. Early entry into prenatal care. And here, of course, what we know from literature is that early entry into prenatal care does in fact lead to improved outcomes and improved life for

those children. Though we're not going to stick around and wait for it to happen. We're going to look at when those people enter care.

So, what we are evaluating is the percentage of patients who enter prenatal care in the first trimester. And by first trimester, we mean entry during the first 13 weeks. And for those of you who keep your records post last menstrual period rather than post conception, that's up to 15 weeks post last menstrual period, post LMP. We're looking at when do they get their first visit, which is a complete exam with a physician or an NP, or a PA, or a (CNF).

We're not talking about a pregnancy test. We're not talking about a nurse assessment or when they got labs. We're talking about when they got that first, full examination. And once they have that examination, they're considered to be one of the prenatal patients who are in your medical home. And we're talking about all of them. So when we're reporting here, we're reporting all patients with any prenatal care. Regardless of when it started, whether it was transferred or completed, or who did the delivery.

So our quality standard is first trimester entry into care. We collect information on first, second, and third but the quality indicator is entry into care in the first trimester. And what we're asking is, when did they start, how many started in that trimester? This includes patients who began care with another provider. So we're asking in Column A, how many patients started with you. And in Column B, how many patients first started somewhere else and then transferred to you.

Included in this number will be a small number of women whose only service in 2012 was that they delivered. That will include a bunch of women who had their last visit in the last week to 10 days of 2011 and then came in for their

delivery. They're counted. We also count all the women who were transferred or risked out.

So if you routinely refer all your patients at a certain point. Or if you routinely refer all (preeclampsic) women, or all gestational diabetes patients, or if you occasionally refer some who are moving to another area. In all cases, transferred women, you are expected to track them and to keep track of the outcomes as well.

Your total population includes women who started in 2011 and then delivered in 2012. Women who started in 2012 and delivered in 2012. As well as women who started in 2012 and delivered in, well who didn't deliver. Who won't deliver until next year. All three of those (cadres) are included in your statistics for this indicator.

We want to look for accuracy at the universe. Is it a reasonable universe? Are those prenatal patients by age equal to the prenatal patients by trimester of entry? Is there a large number of late entries to care with somebody else, because it's very unusual for a patient to start their care in the third trimester and then transfer to you. It's quite common, unfortunately, for people to start somewhere else and then transfer to you in the third trimester. But we're recording when they started care.

And we have some national comparisons. We know that nationally about 70% of all women served, start their care in the first trimester. At least in community health centers. Healthy people 2020 has a goal of 77.9% starting in the first trimester. So if you want to talk about where you are versus what is looked at versus what is targeted, you have some national comparisons.

Okay, the second of our measures is childhood immunization. And obviously the goal is to have fully immunized children. To do this we are looking at what percent of children who received medical care during the measurement year, were also fully immunized by their second birthday.

So, again, every child who turned two in 2012, who you saw for medical care during 2012 is a part of our universe and there are no exclusions to that.

And then, so far as our quality standards, so far as what we are looking at to call it success. We are going to look at the number of children who, by their second birthday, are fully immunized. That's going to be most that you count in compliance. Or, have evidence that they already had the disease and therefore didn't need to be immunized. Or have a (contraindication) for the vaccine. They're allergic to eggs, they're allergic to baker's yeast, whatever.

And there are 14 diseases immunized. A lot of shots, we know that. And full immunization means receiving all of these vaccines on or before their second birthday. And we can then look at that number and compare it to some things to see if it looks reasonable.

We do know from Table 2, sorry from Table 3A, the number of two year olds that you served. Of course 3A is going to measure them by a slightly different birth date. And not all of the children that you served are medical patients. Some of them are dental patients. So the last thing we expect to see is that the number on Table 3A of two year olds is exactly the same as the number on Table 6B. But those numbers should be close. When they're far off you should look to see if you're missing something.

Then comparisons, well nationally last year 43.8% of all two year olds had been fully immunized. That compares to 74% in the prior year. And we know

there was a tremendous drop as you were required to provide three additional, vaccines against three additional diseases. We'll talk more about that later. But clearly, everybody dropped there. But the 43.8% is an average that you should be looking to meet or beat. And of course your own average from last year is a good number to look at.

Okay, our next measure is pap tests. The goal is to have pap tests for all of the women that we are looking at in our medical homes as it were. We have a measure that is titled Women Age 21-64 but actually, as the footnote indicates here, we're going to be looking at women 24-64. Recognizing that the measure means that they could have gotten their pap test as early as when they were 21.

So what we're asking is the number of women age 24-64 who had one or more pap tests during the measurement period. And our quality standard for this specifically is that women should have had a pap test in the measurement year, that's calendar year 2012. And these are all calendar years. Or in the prior two years. So, in 2010-2011, or 2012. And what we're looking for is a copy of the lab test in your charts, in your records, that could be from somebody else.

So the requirement is not that you provide a pap test to all those women. The requirement is that as the host in their medical home, you are insuring that they have received that service during the current year or one of the two prior years.

Not sufficient is a note that said the patient was referred or that the patient reported receiving the pap test. If a patient goes somewhere else for their pap test that's fine, but then we need some sort of an official response saying that it happened. Ideally this is a copy of the lab test forwarded to you. But we will

also accept a, say, phone call between your staff and the staff of the office where the pap test was done. Saying that the pap test was delivered. Where we have the date of the pap test, the provider, and the result of the pap test.

Patients who refused to receive a pap test are considered as having not met the quality standard. As is a patient who you schedule the test for, but then who failed to come in for that pap test.

Susan Friedrich: So the next measure is child weight assessment and counseling. And the purpose of this measure is to insure that all children have a BMI percentile assessed and that they are counseled regardless of their BMI percentile on healthy eating and active living. So the universe of patients, or the total number of children who you need to include in this measure are all children age 2-17, excluding pregnant adolescents.

To be considered to have met the quality standard the expectation is that all of those children 2-17 who had at least one medical visit, so these are medical children. Had both a BMI percentile documented and recorded in the chart and visible to the provider. It doesn't do any good if this measure is calculated by the (EHR) but not viewed by the provider at the time of the visit.

And in addition to having the BMI percentile documented, that the patient received counseling on nutrition and physical activity. It is critical that you understand that this is all children who receive counseling. Not just those children who may have a high or low BMI percentile. It's also important to know that to meet this quality standard it's not sufficient to just document height and weight in the chart. Nor is it sufficient to say a well-child visit was performed.

Even if your protocol is that all well-child visits, a child BMI's percentile is calculated and counseling is provided. You need to have some documentation in the chart to confirm that both occurred.

In evaluating whether or not you've captured the data reasonably from your system to report on this measure, there are some quick tests you can do that will highlight potential problems. First of all this is all children age 3-17, we know how many children 3-17 you have, it's on Table 3A. That sort of is your upper limit. We wouldn't necessarily expect you to be seeing a lot more children 3-17 having their BMI percentile assessed than total children that you serve.

So obviously knowing that your total number of patients on Table 6B shouldn't exceed your total number of patients reported on 3A. But even more so, these patients had to have had a medical service. So not all of your children 3-17 will be medical patients. Some of those patients may be dental only patients or receive enabling or mental health services and would not be included in your total universe.

So a quick eyeball of the total number of patients 3-17 from Table 3A and the proportion of your patients on Table 5 who are medical patients. Will give you a sense of what the maximum universe might be for this measure. And if you're reporting a much higher or lower number of patients for this measure than might be predicted, it's important to go back and look at your data source to see if you're identifying those patients correctly.

The second thing that we recommend you do is you look at your calculation of your quality standard. What your measure was when you divide your total number of children who were assessed and counseled divided by the total number of children in your universe. What is that percentage? Last year

(unintelligible) funded programs reported about 39% of their children 3-17, had a BMI percentile calculated and were counseled.

Again, if your number is substantially higher or lower than your last years' experience and unless you did something different in your practice, you might not expect large shifts from year to year. Again, it gives you an opportunity of highlighting potential problems with how data is extracted.

It may also be helpful to know that the healthy people 2020 goal, which unfortunately is not identical to the UDS measure, the healthy people 2020 goal sets a goal of 55% of primary care providers assessing children for their BMI percentile. So that's only part one of this measure. There's a second healthy people 2020 goal that sets as an expectation that at least 15% of children will be counseled for healthy eating or nutrition.

So, again, neither of those measures is an exact measure that relates to the UDS measure. But if you're reporting 70%, 80% of your patients in compliance in this measure, you're obviously performing well above healthy people 2020 and you may want to make sure that your system is in fact capturing the data correctly and that it's an accurate reflection of your program performance.

The next measure is adult weight assessment and follow-up. And again, the goal of this one is to make sure that all adults are assessed for their BMI. And for those adults who have a high or low BMI, that appropriate counseling and intervention is developed for them. A plan is worked up for that patient to help them address their BMI.

Note that's very different than the child measure which does not require, excuse me, the childhood measure which requires all children to be counseled

regardless of their BMI percentile. This measure, for adults, only requires the follow-up intervention or plan development for patients with a high or low BMI.

Again, to be considered to have met the quality standard for this measure you need to identify and have documented in the chart, visible to the provider, the BMI for all adults. At very least that's part one. Any adult who has a normal BMI is considered at that point to have met the quality standard. So you want to be sure to include them in your numerator.

So your numerator not only includes all adults with a normal BMI, assuming you documented in the chart, but it also includes all those adults with a high or low BMI for whom you developed a plan and have a documented plan in the chart. So there's two components that sum up to the numerator.

Again, for this measure it's not adequate just to do a height and weight in the chart. You have to actually calculate the BMI and it should be visible to the provider. Because the intent here is that the provider follows up with that information with the patient. Because we know as a best practice the provider who addresses BMI with a patient is much more likely to have an impact on that individual's behavior.

Again quick checks for this one, there's no reason you should be reporting this measure with a universe of adults in this measure that's greater than your total number of adults. So again, looking at Table 3A for your 18+ population, that becomes your upper limit of how many patients you might expect to be in this universe.

However, it doesn't - this measure is not appropriate for all adults. It's only for adults who receive at least one medical visit. So the number is going to be

less than your total population. Assuming you have some patients who may be dental only, or mental health only, or some other service.

So, again, looking at the proportion of your population that receives medical services allows you to get some sense of how much smaller than the total number of adults 18+ might be included in your universe. We don't have an exact way of calculating that, only again, if you're seeing a number that is much larger than you might expect. In other words, almost 100% of your adults appear to be in the universe. Or a much smaller universe. You may want to, again, look at what is being used to pull that data to identify those patients for this measure.

After evaluating your universe, and again, one of the other statistics that's helpful to have is, you know, the proportion of the population that you can anticipate may be overweight or obese. And it's up to 2/3 of the total population depending on where you are in the country.

So if you're reporting a very high prevalence rate, or excuse me, a very high number of patients who are meeting the quality standard. And you know that you're not doing work up plans for high and low BMI, then you're again doing something wrong in terms of extracting this information. Because as many as 2/3 of your patients need to have a plan, because they're likely to meet the requirement for a plan for being overweight or obese.

In addition to looking at just your general universe, the other step you should take is to look at what ends up being your calculated quality standard. So you divide the total number of your adults who you appropriately assessed and had a follow-up plan for, if appropriate, by the total adult population in the universe.

And if you're getting a standard that's very different than your prior year or in this case compared to the national average for other federally funded programs, (330) funded programs which in 2011 was 39% of total adults in this measure who were assessed and in compliance in the measure, if you are getting a number quite different than that. Again, you may want to look at your data sources to make sure that your system is correctly identifying those adults who should be included in the measure and doc- and confirming that the documentation is being correctly identified in the chart for follow-up plans.

As a comparison, Healthy People 2020 goal for this measure, again there's not an exact one. The closest Healthy People 2020 goal is 54% of primary care providers assess patients for BMI. Remember that's just Part A of this measure. And then the second part, the second Healthy People 2020 measure that's relevant, is that 32% of obese patients receive counseling.

Now again this doesn't include the underweight patients which are included in the UDS measure. So we're already close it appears in terms of meeting some of those healthy people 2020 goals, when you think of having to have both those expectations in the same measure.

The next measure is tobacco assessment and the goal of this one is that all adults 18 years of age or older who are medical patients of the health center are assessed for their tobacco use. To be included in the total number of patients for this measure not only do they need to be medical patients but there's an additional criteria that they have at least two medical visits in the current year.

Which allows us to consider these patients to be probably regular patients of the health center, because they haven't come just once for an episodic visit,

but are in fact coming for routine care. So there's this expectation that you have developed a relationship with the patient and therefore can address their tobacco use with them.

The quality standard for this measure is that any patient 18 years of age or older who has at least one medical visit in the current year, that that patient two medical visits in the current year if that patient has documentation in the chart that they have received, that they have been queried about their tobacco use. And that that information is made available in the chart for the providers to see.

That query can be performed by a number of different providers. Obviously the expectation is potentially your medical provider may have assessed their tobacco use. But if the chart doesn't show that the medical provider has assessed the patient's tobacco use, it is perfectly acceptable to look at the dental chart or the vision chart to see if a provider in the health center in one of the other services has done a query on the patient and documented it in the chart.

To assess whether or not you are seemingly picking up correct data for reporting this measure, again, you can look at the total population of adults on Table 3A and the proportion of your patients who are medical patients to see if it appears that you're in the right range in terms of the overall size of the universe for this cal- this particular measure.

It's probably helpful to know what you're local state's prevalence rate for tobacco use is. And every state has sort of different average percentage of the adult population that are known to be tobacco users. Nationally it's about 20%, but depending upon your state that number can be quite a bit higher. We

do provide you a (reference) at the end of this presentation for looking up your own state's tobacco use.

The second part of the assessment that you really should do is looking at that rate, or the proportion of your population method standard measure. And for last year, for example, (330) funded programs, about 80% of adults were reported to have been assessed for their tobacco use. And that compares to Healthy People 2020 goal of 69%. Which means we are doing very well relative to the Healthy People 2020 goal.

The next measure is tobacco (cessation) intervention. And this measure, unlike the prior measure, is focused on tobacco users only. So this measure looks at the percentage of tobacco users for whom you have some intervention. Either a cessation counseling or a pharmacological intervention.

It includes all patients 18 years of age or older who had two or more medical visits and were identified as a tobacco user. So, again, if you're reporting a very large or small number of patients in your universe of tobacco users it may very well be that you are incorrectly identifying your patients as tobacco users.

A very small number of patients in this universe we found last year often was due to the fact that you were using a tobacco (ICB9) or (CBT) code to identify your patients, or basically a patient who had requested cessation counseling assistance or cessation intervention as your identifier for the tobacco universe. And, of course, that would be wrong because basically you're identifying those individuals that are coming in for cessation services as your tobacco users.

And the intent of this measure is to identify all of your tobacco users and then identify what percentage of those you have engaged in some intervention with them.

So that quality standard is defined for all tobacco users. For each individual tobacco user, was there evidence that they either received tobacco use cessation service such as counseling intervention. Or they received an order for cessation medication, or they were on a medication. So any of those three is acceptable as having met the quality standard.

But looking at that total patient population that you're reporting, again, you want to realize that it's not your total adults. It's your total tobacco user adult population, which based on that rough estimate of 20% of the population, may be somewhere in the range of 20% of your population. But again it varies dramatically by state depending upon what state you're in that number can be substantially higher.

So if you're seeing 2% of your adults in this measure as being identified as tobacco users, it very likely means you are not accurately identifying or assessing your patients to know who your tobacco users are.

If you're understating your populations, then you're compliance rates can be really misrepresentative. Because it could look like you've done a really good job of getting your tobacco users on cessation, some sort of cessation intervention, largely because you really haven't identified most of your tobacco users.

So by looking at that universe you can get a sense of whether you're effectively identifying your patients who should be in the measure and then looking at the compliance, of the quality standard to see whether or not you've

met it. Being able to get a sense of whether you're effectively addressing the problem.

Last year, as an example, the bureau funded programs averaged about 53% of their tobacco users who were receiving some sort of counseling intervention. But you should note that only 15% of our adults were identified as tobacco users. Which is probably an understatement of our overall prevalence rate, which means that relatively high intervention rate may be more a function of selective identification of our tobacco users as people who are looking for intervention.

The Healthy People 2020 goal for example is at 21% of tobacco users are receiving a counseling intervention. Which is substantially less than the (330) funded programs are currently reporting. So we're doing very well in this measure, assuming we're identifying our tobacco users patients.

Arthur Stickgold: So we go from here to asthma. And our goal for the asthma indicator is that asthma patients receive therapy. Specifically we're evaluating the proportion of patients who are aged 5-40, so that's the first criteria. With two or more visits, at least one of which was medical. Who have a diagnoses for persistent asthma. And then we're going to look at those who received or were prescribed accepted pharmacologic therapy.

And you'll notice the word persistent is in bold type. That's to make clear that we understand that there is no diagnostic code for persistent asthma. Persistent asthma is recognized as an admitting, or an initial code. And may be present in a problem list as opposed to a diagnosis list, and that's fine.

If you don't have a system that routinely and regularly identifies all patients when they start as being either persistent or non-persistent, or situational.

Then you will need to actually be able to have to pull a much larger group of patients. All patients with asthma and then actually go through the charts to find a sample of 70 with persistent asthma.

And we know this is an issue, and we know that it takes work. You need to set up a process to handle this.

Arthur Stickgold: The same process by the way can be used to find tobacco users. So just as we look at all our asthmatics to find our persistent asthmatics. We look at all our patients in the age range and search until we find tobacco users. Tobacco users are more and more likely to be noted in some sort of intake process where you're checking a box that's retrievable in (EHR). Persistent asthma is not going to give you that advantage, you are going to have to search for these patients.

And of course, our quality standard is for those patients with persistent asthma, how many of them had a prescription for inhaled cortical steroids, or received or had a prescription for an approved alternative medication - and there is a list of alternative medications in the UDS manual - or you had evidence that they were on the medication.

Now, when we describe the data on the UDS we ask you for the universe. We ask you how many patients you had with persistent asthma. As I just explained, the only way to find out the persistent asthma patients may be to keep looking at asthma patients until you find 70 of them.

If you have to look though, for example, 210 charts before you find 70 with asthma. You then know that 70 over 210, 1/3 of your asthma patients have persistent asthma and you can work backwards. Take 1/3 of the universe of all

patients with asthma to give us the universe number. Or whatever that ratio is. And then what we want to look at is for those patients, were they receiving, were they using, or have you prescribed the cortical steroids or the appropriate alternatives.

So this, just to look at some numbers, you can of course look at the total number of patients by comparing them by age to the patients on Table 3A. We know that there is a prevalence rate for asthma, not necessarily persistent asthma but asthma, of 8% nationally. And it varies by race, it's up to as high as 12% for blacks or African Americans. It's slightly higher for children than for adults and so on.

So you have some comparison for your asthma universe to compare it to the nation. Nationally, with community health centers reporting on the UDS, last year 69% received appropriate pharmacological intervention. The prevalence was 6%.

And there are no, unfortunately, National standards or goals that have been established for this as of yet.

Our next, our next. Our next variable is coronary artery disease. Now we're getting into the new ones. The ones that are being reported on for the first time this year. And obviously, the goal is that patients that do have coronary artery disease should be receiving lipid lowering therapy. At least some of them.

So, what we are going to be evaluating is what portion of coronary artery disease patients aged 18 and above, who have been seen at least twice, were prescribed lipid lowering therapy? We are going to include in our identification the people who had coronary artery disease, anybody for whom

we have a history of a myocardial infarction, or a history of cardiac surgery in the past.

And we are going to exclude individuals who though they have a diagnosis of coronary artery disease, now have an LDL of less than 130 mg per deciliter. So what is being said quite implicitly here is anything over 150 is an indication to start therapy. And the goal is to reduce it to below 130. And once it is below 130, it is the clinicians decision as to whether or not maintain lipid lowering therapy. But so far as the measure is concerned, once their LDL is below 130 they are no longer part of the universe.

So for those (unintelligible) patients, what we want to look for is a prescription for, or the provision of or evidence that they are taking lipid lowering medications. And again, this is all patients 18 and above. But we really don't have a good way of estimating what that number should be. Other than it can't possibly be greater than all the adults.

But we will be collecting information, we will be getting an idea for next year the percent of coronary artery disease patients. And we will be then publishing information on what our expectations are. Right now there aren't comparable national data standards.

Okay, the next disease stays with cardiology. And what you'll see is that we're very clearly this year focusing on adults and adult preventive and follow-up care for those problems that are the most serious among the total population of adults that aren't already being reviewed.

So now we're going to look at ischemic vascular disease and the use of aspirin or other antithrombotics in serving these patients. The goal is that patients

who have ischemic vascular disease should be on some antithrombotic therapy and aspirin, of course, is by far the most common and least expensive.

So what we'll be evaluating is what portion of these IVD patients, aged 18 and over, who had at least one medical visit, have a documented use of aspirin or some other antithrombotic. And one way to identify IVD patients would be to include all patients who have been discharged after an acute myocardial infarction, and no there is no difference between the myocardial infarction of the last standard and the acute myocardial infarction on this standard other than we are consistently using the same language that the meaningful use standard uses to make clear that that's what we're dealing with.

So discharge after a myocardial infarction, after a heart attack, after a coronary artery bypass (graft) (unintelligible), or after a percutaneous (transliminal) cardio angioplasty, did I get it right? PTCH. Stenting, that they had a bypass or a stent, that's the point. And did they have it 14-24 months prior to the end of the year? So this is not did they have it this year but included in your universe, anybody who had one of these hospital procedures 14-24 months prior to the end of the year. Which means January 1 and November 1 of 2011.

And then the standard you're looking for is documentation of the use of an antithrombotic, aspirin first, being prescribed, dispensed, or used. Again you can look at the number and it can't be bigger than your total adults. The number is probably going to be similar to the coronary artery disease numbers.

But again, we have no data yet to make these conclusions. So we're going to be looking with you and of course that means that the computer isn't going to flag you unless your number, like I said, is totally outrageous. Namely, more

patients with ischemic vascular disease than you have patients. But we will be calculating national comparisons and we will be publishing those for use in the future years.

Then our last new measure is for colorectal cancer screening. And this is for all patients aged 50-74, through 74 means up to one day before their 75th birthday, it's very hard to state these ages because they have to take an entire year.

So everybody 50-74, with at least one medical visit, who had appropriate screening for colorectal cancer. Which means you can leave out those who have already had colorectal cancer. And the quality standards here are that they must have had one of the three routine procedures for detecting colorectal cancer screening. They must have had a colonoscopy during the reporting year or the previous nine years. So in 2012 or any year from 2003 through 2012.

Or, a flexible sigmoidoscopy during the reporting year or the prior four years. So in 2012, 2011, 2010, 2009, or 2008. And it's highly unlikely that very many of your patients would have had those. Those generally are not procedures that most health centers can do. So we're going to be looking mostly at those who have had a fecal occult blood test either by that name or as a fecal immunochemical test, FIT as opposed to an FOBT during the reporting year.

And here it's important to note that we're talking about prevention. We're talking about a patient in your medical home. So the issues has come up, well, if a patient was last seen in March of 2012 and they had been seen with, they had an FOBT in December of 2011, that's within three months. But as a medical home it is your obligation to continue to provide necessary, not only treatments, but prevention for your patients.

And that means that at some point during 2012 you still should have received that FOBT, that FIT, you should have mailed out that card. You should have gotten it back.

So in all of these instances we're talking about, they're current as of December 31. Again, we don't know what we're looking against. But it's all patients aged 18-75, so it's a large population we know. And I'm sorry, it's 18-74, or 18-75. No, 50-70. 50-70. Everything else is 18, its 50-74 and we will be getting information out about what we're seeing in community health centers. There is a Healthy People 2020 goal and that is 70.5% of all patients aged 50-74 will have been screen for colorectal cancer and would have a current screening in this measurement year.

Susan Friedrich: I have a couple of questions, can they...

((Crosstalk))

Arthur Stickgold: There's a question that seems to be relevant here.

Susan Friedrich: So we have a question whether or not the colorectal screen, whether the patient can report the information or if it has to be based on a consult.

Arthur Stickgold: And as in the case of all of these. Where the colonoscopy or the sigmoidoscopy was done elsewhere, you need to have a report back from that elsewhere. And that does not mean send the patient elsewhere to go get a copy of it. It means we have this great invention it's called the telephone. And we call that source or we mail a release form to that source. It's extraordinarily easy for patients to not remember precisely when it was when they had invasive testing. Especially when it's up to ten years ago.

Okay, there's another one. My accuracy test check?

Susan Friedrich: Excuse me.

Arthur Stickgold: Okay, so we'll move on to Table 7 and Susan will take over on Table 7.

Susan Friedrich: So Table 7 is called the health outcomes and disparities table and like we mentioned with Table 6B, both Tables 6B and 7 are used as proxies for quality of care. Table 6B looks at processed measures. Measures where we're trying to say if we do something now we can anticipate better health outcomes at some point in the future. The Table 7 uses what we refer to as intermediate outcome measures.

And these are quantifiable points in the patient's care that we can document some degree of achievement of intended outcome. But obviously the ultimate outcome we're still looking for is that long, healthy, happy life. And rather than waiting that long we're trying to find some intermediate point that we can make an assessment that is predictive of better care, good care or good health outcomes in the long term.

The three intermediate measures, outcome measures that we use on the UDS are normal birth weight, controlled hyper tension, and controlled diabetes. We know, for example, that children born with normal birth weight are less likely to suffer mental or physical delays or organ damage. We know patients with controlled hyper tension are less likely to develop cardiovascular damage, have a heart attack, have a stroke, or organ damage as a result of high blood pressure. And similarly with controlled diabetes, a patient who has their diabetes under control is less likely to have an amputation, or have blindness, or organ damage.

So, again, if we're able to manage the care of the patients, maintain some level of control, or in the case of normal birth weight a good birth outcome. We can be predictive in the future of better health outcomes for that patient long term.

So the first measure is birth weight and the goal of this measure is that all of our newborns are born with normal birth weight. A difficult goal to achieve, but so we're looking to increase overall the percentage of our patients with normal birth weight at the time of birth. We basically are reporting birth weight in three categories. Very low birth weight is less than 1500 g, low birth weight is 1500-2499 g, and normal birth weight is considered 2500 g or greater.

To, again, to be considered to have met the quality standard an infant has to be born with a birth weight of greater than 2500 g. Particularly important with this measure to understand the expectation for health centers is that you have identified and documented birth outcomes for all of your prenatal patients. Regardless of whether you happen to be present at the delivery. So for those patients who you may risk out or may get transferred to another provider, you are expected to develop a relationship with those providers. Those hospitals where your patients may deliver, to be able to track those results.

Now we recognize you may lose some, but where it's unacceptable is if all of the missing birth outcome data is for your high risk infants. Again, the measure is the percentage of your patients with a low birth weight or very low birth rate. And if you've risked out all of your at risk babies or you're at risk prenatal patients, your birth weight may look very good but it is not representative of your population. Because you're missing some of the key data.

In looking at this particular measure, there are some ways that you can check to make sure that it is complete and also accurate. One of the first things you need to make very careful care in reporting is the race and ethnicity data for your prenatal population by delivery. And this race and ethnicity data has to be consistent with the racial and ethnic profile that you have used on Table 3B to report your patient population.

If you're using different data sets and you don't have race and ethnicity associated with your prenatal patients, or if the race and ethnicity for you prenatal patients isn't the same as it is designated for your patient registration system that's used to generate 3B, you'll get all kinds of flags in reporting of your prenatal data. Because your prenatal population won't look like we expect it to look like compared to your total population.

So make sure that your race and ethnicity data is comparable for the two tables at the same source. And that way you can make sure that there is a consistency in the profile of the two populations, your prenatal patients and your total patients.

The other thing you need to make sure of is that you're reporting all birth outcomes for live birth. You do not report still births. You do have a delivery for still birth, but no birth outcome. But you do report all multiple births for deliveries where there were twins, or triplets, or more. And as a result, if you're showing your deliveries equal to your birth outcome, you should consider it something you need to look at more closely as potentially an error. Because it's not the case that every delivery always ends up in a single birth outcome.

Especially when you start having more than 100 deliveries, the statistics would say that you will experience some multiple births or potentially a still birth. So the number of birth outcomes will not necessarily equal the number of your deliveries.

Similarly the number of your deliveries will not equal the number of your prenatal patients. Not every woman deliveries during the reporting years. Some of your prenatal patients will have started their prenatal care in the prior year and deliver in the current year. Some of your patients may start their prenatal care this year and won't deliver until next year. So if you're reporting prenatal patients equal to delivery, equal to birth outcomes, there's something wrong with the table and you need to revisit it.

Arthur Stickgold: There's a question that came up. Race and ethnicity, the mother or the baby? And the answer of course is yes. Please report separately the ethnicity and race of the mother and the child and it is of course entirely likely that in some of your cases the child will have a different designated race and or ethnicity than the mother.

Susan Friedrich: We received a second question asking that is it true that it's the responsibility of the health center to track the birth outcomes for patients that were not delivered by the health center or by patients who may have been transferred or risked out to another practice. The answer is absolutely yes, the expectation is if you provided any prenatal care to a patient, that is one or more prenatal visits. You have a responsibility to track that patient to the end. Whether you were there at the time of the delivery or not and to report the birth outcome for those prenatal patients.

Again, we recognize you may lose some. They may move out of state. They may no longer be available to you, but it is not acceptable to have all of the

patients who you risked out or transferred out missing from your final reporting on your UDS report.

So the question, there's a question on Table 7. Is the baby's race and ethnicity reported separate from the mother? The answer that (Art) just gave is yes. Table 6B, the race and ethnicity is the prenatal patient that you are reporting on.

So, again, once you sort of make sure that you've captured race and ethnicity correctly for your prenatal patients the other thing that you need to be aware of is just national statistics in terms of proportion of birth weights that are low or very low birth weight.

The bureau funded programs last year, and pretty typically it's been historically the same for many years, is about 7%, a little over 7% of all birth outcomes are low birth weight or very low birth weight. This is lower than the national average which is about 8% of total births. And the Healthy People 2020 goal is 7.8%. Which we're already apparently doing better than the Healthy People 2020 goal. Again, in part that may be because we're losing some of those critical birth outcomes.

If you're reporting, you know, a lot of your low birthrate at 1%, 2%, or 3%, again you need to make sure you're not missing data. That you're not failing to report those birth outcomes for multiple births and for your at risk prenatal patients who may have been transferred to other providers.

The next measure on Table 7 is controlled hyper tension. And this is the percentage of your adult patients age 18-85 who have a history of hypertension and who's blood pressure was controlled. Which is considered to be a blood pressure of less than 140/90 during the reporting year. And that is

the last reported blood pressure for the year. No the best reported blood pressure for the year.

This measure does have a slight qualifier, it only includes in the universe of patients, adults who were diagnosed with hyper tension prior to June of the reporting year. So if the first time you saw a patient was after June, say in August or September of the year, you would not include them in the universe for this measure this year. Hopefully you would be including them the next year if they came in for a medical visit, or excuse me, two medical visits. But there's an expectation that you're identifying all of your medical patients who had a history of hypertension.

So to identify this group of patients it is not appropriate to just do a query of patients who had a visit with a diagnosis of hypertension in the current year. Because some patients may come in for other reasons but still have hypertension. So optimally you have some way of flagging all of your hypertensive patients in your electronic health record or in your patient record. So you can identify those patients who were seen, regardless of whether they came in for their hypertension during the reporting year.

Note that the requirement here is that the patient has to have at least two medical visits in the reporting year, not just one. This is a chronic condition, we're giving you sort of the benefit of the doubt by indicating that as a chronic condition patients would be likely to come in to see you more frequently if you were their primary provider. These are not patients who came in only once and may have used you only for sick care on a more episodic basis, for example with an urgent care center or something.

So these patients came in at least twice during the year to get medical care. Again, it may not have been specifically for their hypertension, but the fact

that they have a history of it and you saw them twice during the year sort of puts the (unintelligible) on you to insure that they're receiving appropriate treatment and have their blood pressure under control.

Note that there are two exclusions to the universe, pregnant women and patients with end stage (renal) disease. So again, your total universe should be patients age 18-85 with a history of hypertension who are not pregnant or have end stage (renal) disease. And were seen at least twice during the reporting year.

The quality standard for this one is that the patient had a blood pressure of 140, less than 140/90. We recognize this is probably not optimal control for a dually diagnosed patient, but again this is the sort of standard that you would use to be able to complete this particular table. Don't necessarily consider this your optimal care for your own internal purposes.

Note that if you did not have a blood pressure documented anytime during the year and the patient was seen for medical services, that you have to assume that the quality standard was not met. So you make the assumption that their pressure was greater than 140/90 if there was no documentation. And you are looking at the most recent documented blood pressure. Whether that was at the last visit, or a prior visit, as long as it was the last recorded blood pressure during the year. That's the one you use for assessing the quality standard for this measure.

Again, there's some quick checks that you can do to make sure that your universe makes sense. We know how many adults age 18-85 you have on Table 3A so be able to recognize that's your upper limit. You also know that these patients have to have had at least two medical visits, so again that number we're going to expect to be less than the total adult population. Given

that not all adults will be your medical patients. Some of them will be dental only and not all patients will have come in at least twice.

So if your universe appears to be much larger or smaller than you might expect, it's worth looking a little more closely to see what that query is that's identifying the universe.

Keep in mind the national prevalence for hypertension is 29% of adults have hypertension. So again, if you're reporting 5% of your adults with hypertension, maybe you're not picking up all of your patients. Again, that sort of depends upon your age mix of your patient population and it may be correct. But it is a flag that you may want to investigate a little bit further to make sure you're picking up all the patients you should in the universe.

The other check you have to be aware of is this data is reported on Table 7 by race and ethnicity. So if you're racial and ethnic profile for your hypertensive patients is very different than your total population, again that may not make sense. It may be that your race and ethnicity profile is not coming from the same data fit for your table 3B and your Table 7.

Obviously there are disparities in racial and ethnic groups and their prevalence of hypertension. But again, if you look at that overall proportionality of your population relative to your hypertensive population, if there are distinctly different profiles. If it doesn't make sense, you need to look a little more closely and confirm that the data source is pulling the data reasonably.

Some more things you can check, just looking at your quality standard and seeing whether or not what you're calculating is the proportion of your patients with controlled hypertension is expected relative to your prior experience. If you have a three year trend and you're showing big swings in

your performance from year to year, unless you're doing something dramatically different, that may be an indicator of some error in how the data is pulling.

Last year, for bureau funded programs, 63% of our adults were identified as having controlled blood pressure. And it should be noted that only 22% of our adult population was identified in the universe as hypertensive. So hopefully that doesn't mean that we're understating our hypertensive population, it may be a reflection of a slightly younger population than the national average is.

But again, if you're not seeing that prevalence rate appearing to capture all of your hypertensive patients, or if your quality standard seems to be unrealistic, either too high or too low. Looking a little further into the data just to make sure it's pulling correctly is a good thing to do.

The Healthy People 2020 goal, just for your reference is 61% of hypertensive patients with controlled blood pressure. So based on that, if you know, we're really identifying our patients accurately we're doing extremely well having already met the Healthy People 2020 goal.

Arthur Stickgold: All right, so those are the measures.

((Crosstalk))

Arthur Stickgold: I forgot diabetes.

Susan Friedrich: That's okay. So diabetes. So the last one for Table 7 is controlled diabetes. This measure is the percentage of patients age 18-75, so slightly different age group, with a history of diabetes and two or more medical visits during the year, who have a hemoglobin A1C result of less than or equal to 9%. So

again, just looking at the proportion of your diabetic patients who have hemoglobin, a controlled hemoglobin A1C.

So looking at this measure, if you see the reporting, you actually need to report the results for each patient of the hemoglobin A1C test results. And again it's the most recent hemoglobin A1C, if there's multiples in the current year. You're reporting a hemoglobin A1C less than 7%, between 7% and less than 8%, between 8%, equal to or greater than 8%, and equal to or less than 9%, and greater than 9%.

And if you note there is no unknown test result action here. So if you have not, do not have a documented hemoglobin A1C result in your chart. You have to assume the patient does not have a controlled, does not have controlled diabetes and you have to include the missing data result as assuming the patient has a hemoglobin A1C of greater than 9%. You're including them in the last column, or uncontrolled.

So the quality standard, as I mentioned, is a hemoglobin A1C less than or equal to 9%. That's obviously not optimal controlled. So keeping track of that less than 7%, in between 7% and 9%, and sort of striving to lower that overall rate for your patient population. But for this particular measure, the percentage of your patients with a hemoglobin A1C less than or equal to 9% is considered having met the quality standard.

To check this one some of the same, you know, sort of approaches apply. Looking at your total age population, 17, 18-75 on Table 3A, looking at your race and ethnicity profile on Table 3B to make sure that who you're identifying as your diabetic population appears to be reasonable compared to your total population. Looking at the proportion of your total adult population you have identified as diabetic.

Nationally 8% of the adult population is diabetic, so if you're reporting a significantly higher or lower prevalence rate is that because you're not identifying your diabetic patients or are you really, truly not seeing patients with diabetes proportional to the overall population.

And then looking at your quality standard over time, the proportion of your patients who are meeting that quality standard, last year bureau funded programs reported 71% of their diabetic patients were under control with a hemoglobin A1C less than or equal to 9%. We did identify 12% of our adult population as diabetic, adult population as diabetic. Which is a bit higher than the national average, so it doesn't appear that we're underreporting this particular measure.

And the Healthy People 2020 goal is 85% of diabetic patients have a hemoglobin A1C less than or equal to 9%. So we're a little bit lower than that and that 59% have a hemoglobin A1C of less than 7%, which is certainly what we're striving for ultimately.

Arthur Stickgold: Now?

Susan Friedrich: I'm checking.

((Crosstalk))

Arthur Stickgold: So those are the measures. Yes I agree this is one of the important ones, one of the original ones. And we're going to talk a little bit about measure selection and reporting methods. To be clear, the measures that are included in the bureau's clinical measures are selected as essentially proxies to measurement of overall clinical care.

They've been selected to include pediatric, adult, and moving towards geriatric. They've been selected to include preventive treatment as well as chronic and acute treatment. And they've been selected so that essentially the full range of clinical activities will be covered. Which is to say, that though it may be a shock there will be no new clinical measures next year. We are pausing for a moment.

Clinical measures can be reported on in two different ways. Most health centers are developing or implanting electronic health records and are beginning to get more and more of their clinical information into those electronic health records. And over time is of course the goal that electronic health records will provide you with information not only to report to the bureau but also to manage your own practices on a much more discreet level on all of these types of measures.

But right now, what we are doing is trying to first follow national quality forum and meaningfully used criteria. So that the variables that you're using are the variables that you will continue to use as you report to CMS and others on quality of care.

And second to whatever possible benchmark these against national data. And especially against national data which we expect will be coming out more and more as the affordable care act and the meaningful use process is more and more implemented.

Reporting can be done based on that electronic health record. And for those of you who have been using electronic - go back one...

Susan Friedrich: No its forward one actually, I skipped one.

Arthur Stickgold: Oh, okay...

Susan Friedrich: ...you can go back to it. I'll skip the 2013 and go back.

Arthur Stickgold: Okay, I'm sorry.

Susan Friedrich: We're modifying on the fly.

Arthur Stickgold: We're modifying on the fly because I turned a page that was stuck together. So options still include reporting on the entire universe of 70 patients, of people who have the specific criteria met or in a sample of 70 patients. And you'll be able to select that independently for each of your variables that you're working with. So you can use a sample for one and then the universe for the next and so on.

To go back. There are no new measures for 2013. There are two changes that are occurring in 2013. Now these are not changes that you are reporting on currently. These are criteria that you will report on in 2014, based on data that you collect during 2013. So these are two you sort of file away but changes will occur.

The first change is going to be with the childhood immunizations. And for childhood immunizations we're going to be reporting on a revised set of vaccines. Hepatitis A, Rotavirus, and Influenza immunizations will be removed from the panel and we're going to be reporting on a revised population. So instead of on or before the second birthday, it will be by age three. Those of you who work in the vaccination area will know these in part as the catch up schedule.

So by age three will the new set of vaccinations have been received. Which means that your report in 2014 will basically be reporting on approximately the same population that you're reporting on this year when we're looking at age two. So change one, different age, different immunizations.

Change two. Pap tests, during the current year the United States Preventative Services task force has come out with revised recommendations for the frequency of pap tests. So for women aged 24-64, have they had a pap test during the current year or the prior year, or the year before. Or for women age 30-64, if they've had a pap test accompanied by an HPV test. Then the criteria will be, have they had that test in the current year or one of the four prior years?

So again, not for this year, but for 2014 the standard is changing. And for what you're reporting in terms of data in 2013, it will be (subset) to a new standard.

Okay, we talked about choosing a universe or a sample and what you report - take it back just one slide.

Susan Friedrich: (Unintelligible).

Arthur Stickgold: What you're reporting is three numbers for all the reports on Table 6B. First, the universe, how many individuals meet the criteria? And remember we said for asthma and tobacco use, you may need to estimate this based on a sample. But for all the others, they should be based on clinical data demonstrating all the people who meet the criteria.

You will then need to either look at that sample and see if every single person in that sample meets the criteria, or select a random sample of 70 and see if

they meet the criteria. You may not do something like take ten from each site or ten from each doctor, or leave out sites. This has the effect of biasing the sample. So first, describe the universe, Column A. Second, Column B is either going to be the same number as Column A or 70. And Column C is going to be of the patients reported and counted in Column B, how many of them meet the quality standard.

For Table 7, the standard, the process is different. We're looking not only at the intermediate outcomes. But also how those intermediate outcomes vary by race and by ethnicity. So you are reporting, again, the universe. All your hypertensive patients, how many of them were Latino Asians, or non-Latino Asians. Latino blacks, non-Latino blacks. Latino whites, non-Latino whites and so on.

So you're going to describe the universe of hypertensive, or diabetic patients, or women who have delivered in terms of their race and ethnicity. And then you will be reporting on the intermediate outcome. The measurable impact of the preventions that you have provided. And you're going to be reporting on their blood pressure, or their hemoglobin A1C, or the birth weight of the child.

And, again, you may use the entire universe or you may use a sample of 70.

((Crosstalk))

Arthur Stickgold: Susan is reminding me, birth weight as in women who are pregnant, both require a universe to be collected. And that's very simply because the BCRR, the predecessor to the UDS, had demonstrated for a decade or more that it is perfectly possible to report on the entire universe. So there is no sample option for the prenatal measures.

Now, why 70? The first reason, perhaps, is that it's an approved number that is resolved between the bureau and OMB who has had a say in all the data collection that goes on in the UDS. But, more importantly, a sample of 70 is considered adequate to give a good picture of what it is you are doing at your health center. And a good picture of what it is that you are doing in terms of performance.

Note that when we get to Table 7 and we're breaking into a large number of categories. These numbers are still quite valid at the national level when the bureau adds everybody's numbers together and adjusts them for the size of the universe.

So, the number 70 is pretty darn good for everybody. And when added together to get numbers for states, or for the nation, for all community health centers the sample size is excellent.

We are going to be talking more about the sampling process in a webinar that is scheduled for December 19, and so those of you who are involved in actually pulling samples, this might be a good one for you to participate in. And if that person isn't around now, if you would mention to them that that webinar will be available for them, we'll look forward to talking in greater depth to the sampling process in about a month.

Susan Friedrich: Before we wrap it up we wanted to share some references with you. Some sources that may be helpful as you begin the process of reporting the clinical UDS measures. The following Web Sites or URLs on this PowerPoint slide provide some national statistics and benchmarks that may assist you with evaluating your data.

The Healthy People 2020 goals, obviously, are relevant to some of the measures. We shared them with you during the presentation. The United States Preventative Services Task Force report has also got some great information in terms of recommended clinical practice. The state tobacco statistics and state diabetes statistics, we provide those just in case you're interested in knowing what the average tobacco use is in your state. Or the prevalence of diabetes in your state, you can look it up using these sources.

Again, it's helpful to know whether it appears that you're identifying your patient population correctly in your state. Or if you may be under capturing or over capturing, which is not necessarily a bad thing. Maybe you're drawing more of the patients from the overall population. But those statistics will allow you to compare your prevalence rate to see if it seems your data may be complete.

There's also a reference for the (PAL) for the changes for 2013 and 2012. Again, we want to encourage you to not make a mistake in implementing the 2013 reporting requirements this year, but have a heads up for how they will change next year.

As a quick reminder, the UDS report is submitted, your clinical tables will be submitted to the electronic handbook. Which becomes available in January. You must have your data entered and ready to submit February 15. Once your report is received, it is assigned to your JSI reviewer who will be working with you from the date you submit it through March 31.

Your reviewer's job is really to look at your data and see if there is any potential unexpected or reported data elements that suggest potential problems with your data. It's not necessarily the case that there is a problem with your

data, it's just that your performance seems to be an outlier in some way and we want to make sure that it is accurately capturing your actual performance.

We recognize that for some of you the vendors may be a little bit slow in getting the data to you to allow you to do the sampling and reporting of the clinical measures. And given the very large number of charts that you may have to sample if you're doing any sort of paper samples, it's challenging to get your clinical tables completed between January 1 and February 15.

At the same time the later you submit you reports after that February 15 date, the less time we have to work with you to make sure your data is correct. So while we don't want you to submit your report on February 15 if it is incomplete and you haven't gone through the trouble of looking at it to make sure that it is reasonable and makes sense, we certainly encourage you to get it in as close to that date as possible so we can work with you over that month and a half to finalize your report.

You know, you have probably no more than a week's grace period before we'll start hounding you for your report. So we encourage you to get it in as early as possible, but do take the time, use some of the tips that we've talked about as we've done this presentation to check to see the reasonableness of your universe and your prevalence.

I can say, as a reviewer, we are always surprised at what some of the data says when it's submitted. Which implies that somebody didn't look at it before they sent it in because it would be physically impossible to be correct. So quickly do an eyeball before you submit it. Take the extra time and you'll save a lot of time on the back end when we're trying to finalize your data with you.

The bureau does provide you with some very useful reports after the UDS data has been finalized for the year. Those reports usually become available around August. And they provide you with trends, calculated performance measures, comparison with your peers, Healthy People 2020 goals, and some ranking opportunities for your data.

So again, this is extremely important that you're UDS clinical data is accurate. So when those reports are available to you, you have excellent baseline data to work with. And you can use that data to help you identify where you're performing well, where some of your problems are, where you need to focus on for your own internal quality improvement initiatives.

One thing we really need to emphasize, we are resistant to having a clinical training that's sort of separate all by itself because the reality is that the clinical tables are not produced in a vacuum. They are part of a broader UDS report. And what is reported on your clinical tables has significant implications for other tables. You know, how you reported your patients by age and gender on Table 3A and your race and ethnicity on 3B is directly related to some of the clinical data that we will likely see on Table 6B and 7.

So when you are working on preparing your UDS report, you need to work with those members of your team in your health center who are working on other parts of the report. To make sure how you captured information, what your data sources are for being able to report race and ethnicity, and age, and gender. Are consistent with the data sources that are being used to complete some of those other tables.

Your reviewer will be working with you to make sure that those tables are consistent across the clinical and the patient tables. And certainly where we see there are those potential inconsistencies we'll be asking you to go back

and just confirm that the data is an accurate representation of the quality of the care and the services that you're providing.

So we are here to help you and our goal really is to make sure that your report is as complete and accurate as possible by that March 31 deadline. I will say that built into the electronic handbooks, the tool that you use to submit you data are many, many edits that are designed to flag potential inconsistencies or problems with your data. It's not necessarily the case that a flag means there is a problem with your data, it's just that the data is no what we predicted might be.

If those flags are triggered, it is worth your time to take a little effort to read those flags, figure out what's causing it and come up with either rational explanation that assures us that you understand what your data is saying and why it's saying it. Or, in the case where the edit is a surprise and apparently is not what you would have expected your data to show. Go back, take the time, look at the sources of the data, and address any potential errors in the data before you submit it on February 15.

There are a number of ways that we can help you between now and when your data needs to be finalized on March 31. Obviously there are regional trainings that are happening all over the country right now. If your state has already conducted its UDS training, you are usually welcome to attend a training in another state. If you were unable to attend one of those trainings and would like to, the list of trainings is available at the bureau Web Site.

There is a series of webinars that we're having and of course they're all being recorded, so if you want to listen to this webinar again or any of the other webinars. For example, if you can't make the sampling webinar which is

scheduled for December, then we would encourage you to download and listen to that webinar after the fact.

There is also a series of online training modules that are posted to the bureau training Web Site - the UDS training Web Site. Those online modules include a module on the clinical tables. So again, if you're unable to go to one of the instructor led trainings it would be very worth your while just to listen to the clinical training modules about an hour or two hours long at most. We try to make them relatively short but contains all the information you'll need to accurately report the clinical tables.

Also at the training Web Site is a copy of the manual. I know we've seen a lot of questions about when the final manual will be available and how to get a hold of the manual. If you'd like a copy of the draft manual you can call the 866-UDS-Help number and we can email you a draft copy. The final approved manual is due out by the end of the year. So it will be posted to the bureau and the UDS training Web Site by the end of this year. But if you need sort of a head's up copy, they're being passed out both at the instructor led trainings and you can get it through the help line.

The help line, as I mentioned, does exist. It's available to answer any questions you have about the content of the UDS. The UDS help line, the 1-866-UDS-Help number is available year round. Not just February 15. So please call us often and early. We can answer almost any question you have about data definitions, where data goes, how you interpret the UDS data, if you're getting flags in the EHB about your UDS data and you're wondering what it might mean, what sort of the implications are for the potential error in your data. Call the help line they'll be happy to help you.

If you are having any issues around the content, you should call the 866-UDS-Help. If you are having problems with the EHB functionality, password issues, access issues, then you call the (Herza) call center number that's on your screen. And the BPAC help desk gets you in touch with BPAC staff and that number you would call if you're having questions about your scope. Or if you log on, for example, it suggests you have a grant program that you don't think you have. So you need to clarify some reporting expectations.

That brings us to the end of the clinical webinar. We know that there were lots of questions that got posted. We tried to keep up but I know it flew by us faster than we answered all your questions. So we are happy to answer questions now and I believe there was a mechanism where the person will come back on and coordinate that.

So if you're interested in asking a question I think we'll just get an instruction in a minute...

((Crosstalk))

Operator: Thank you. 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 tone 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.

You can also ask questions by using the chat feature located in the lower left corner of your screen. One moment please for the first question. Ladies and gentlemen, as a reminder to register a question please press the 1 followed by the 4 on your telephone.

Our first question comes from the line of (Robin Walton), please proceed.

(Robin Walton): Yes, you mentioned earlier about using (ICB9) or (hickspicks codes) to identify patients for tobacco. And when to use that and not to use the (unintelligible), can you repeat that again?

Arthur Stickgold: There is an (ICB9) code that is, (unintelligible). There's a (CBT) code and an (ICB9) code that both relate to tobacco pathology. But not necessarily to smoking. So it is very easy to have someone who is a smoker or user of smokeless tobacco who has never been diagnosed with the specific (ICB9) code that is used for people who have a tobacco problem.

So if you look at the national data you will find that there are very few people seen by community health centers that have a primary diagnosis of tobacco use. But there are a lot more that use tobacco.

(Robin Walton): So I guess what I'm hearing (Art) say is that you cannot rely on the (IBC9) codes and (CBT) codes only to identify your tobacco. Because it's unlikely that that's the reason for the diagnosis. It may occur, but you're not going to find all of your smokers just using (IBC9) and (CBT) codes.

Arthur Stickgold: Not only that, you might also be selected the most problematic tobacco users. Which means that then the intervention rate would be very different than if you were identifying all tobacco users. So you need a mechanism other than that.

On the other hand we've (unintelligible) a number of people whose electronic health records has a question and a box that gets checked. Does the patient use tobacco? And while that may not map to a specific (ICB9) code, it absolutely may be used to identify the tobacco users in your clinic population.

(Robin Walton): That's what we're using, thank you that answers my question. But that's what we're using when we document it in the social history to ask about. Okay.

Susan Friedrich: We have a question clarifying the weight measures and the tobacco measures and the requirement of two medical visits. The weight measure, both the child and the adult weight assessment measure only requires one medical visit. So that one medical visit could be for a sick visit, it's not necessarily for a well-child visit. But the expectation is the weight, BMI percentile, or BMI needs to be calculated for both children and adults. Even if it's only one visit during the year.

The tobacco measures have a two medical visit minimum requirement. So there is a difference between the two and the expectation is one visit regardless of what kind of medical visit it is. It doesn't have to be a routine visit, it can just be an episodic sick visit and the patient would still be included in the universe for the weight measure.

Operator: We have a question from the line of (Shelby Peterson), please proceed.

(Shelby Peterson): Yeah, can you tell us, we have a walk-in clinic at our facility. Individuals who come through the walk-in clinic and fully might only be seen one time at the walk-in clinic and do not come back and see a primary care provider. Do we report those just as an encounter? Or do we report them as an encounter and a user and then are we required to be held to the clinical measures for that population?

Arthur Stickgold: So the answer is yes it is a visit, yes that is a patient, and yes that is a patient for whom the clinical indicators apply.

(Shelby Peterson): Okay.

Arthur Stickgold: Basically, long before it became popular the bureau of primary health care identified community health centers as medical homes. And said that individuals who entered community health centers are to be considered patients who have essentially established this as their medical home.

And so yes the person who comes in for a first visit it to be encouraged to become a regular patient. And yes you're required to include them in the universe.

Susan Friedrich: And it's understood that if you have afterhours clinics, urgent clinics, there will be some number of patients who may be community members who would not use you as their primary care provider because they have their own primary care provider. But you can't exclude those from your universe. At some point you need to make a determination if it's appropriate or reasonable to track down their charts to be able to sort of have full compliance, or full (unintelligible) those quality standards at the ideal 100%.

But if you're focusing on your own patients, those patients who really do see you as their primary care provider, and insuring that you are meeting those quality standards for those patients. You really are meeting the spirit of the quality measures.

(Shelby Peterson): Okay, thank you.

Susan Friedrich: They'll be some patients that, you know, it's not reasonable to spend a lot of time tracking down data results when they are going to be well cared for by somebody else.

(Shelby Peterson): Right, okay, thank you.

Susan Friedrich: Sure.

Operator: Ladies and gentlemen as a reminder, to register a question please press the 1 followed by the 4 on your telephone.

We have a question from the line of (Janet Esnoda), please proceed.

(Janet Esnoda): Yes, thank you. I apologize, I was not able to pull up the webinar so I've just been listening and I was trying to write down what you said the changes to the pap measure would be for next year and I didn't get all of that down. So I didn't know if you would mind reviewing that again?

Arthur Stickgold: Sure. The one change that will occur for patients seen in 2013 and reported on in 2014 is that for women 30 years of age and older who receive a pap test and a simultaneous HPV test, the interval is extended to five years.

So if they have had those two tests at the same time, then they do not need to get another test for five years. Or, taking it backwards, if you can demonstrate that five years ago they had a pap test and an HPV test they would be considered to be in compliance.

((Crosstalk))

Susan Friedrich: Otherwise the three year period still stands.

(Janet Esnoda): Still stands if they don't have both.

Susan Friedrich: ...one or the other.

(Janet Esnoda): Okay perfect, thank you.

Operator: We have a question from the line of (Diane Feferoni), please proceed.

(Diane Feferoni): Hi thank you. I'm new to this and I want to make sure that I understand this properly. Our FQHC has multiple sites. When we are pulling our universe of data or our sample of 70 for data. We should be pulling from all sites, not individually from each site. Is that correct?

Susan Friedrich: Correct. So the aggregate. You have to identify the universe across all sites. For example the total number of children age two, who turned two during the reporting year for the immunization measure.

And then if you are reporting on a sample, you are drawing a random sample of 70 across that universe. Which would cover all of your sites, all of your programs. So it's not per site, or per provider, it's for the universe. One random sample of 70 from that universe.

The universe will be different, you know, that you're drawing the random sample from every one of these measures. There's no overlap between the measures.

(Diane Feferoni): Okay, thank you so much.

Operator: There seems to be no further questions on the phone.

Arthur Stickgold: Okay, well again, thank you very much for your participation and just a reminder again of the sampling webinar, which will be conducted in December. The information is available in this presentation and

(unintelligible) from 1:30 to 3:00 pm. So we look forward to hearing from some of you then.

Susan Friedrich: Additionally this webinar has been recorded and you can access these slides on our Web Site. Thank you very much for your participation and we look forward to seeing you as you submit the UDS.

Operator: Ladies and gentlemen that does conclude the webinar for today. Have a great day everyone.

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