HRSA Clinical Measures Training

Moderator: Heather Ngai
May 26, 2011
12:00 pm CT

Operator: Ladies and gentlemen thank you for standing by.

Welcome to the HRSA Clinical Measures Training webinar.

During the presentation all participants will be in a listen only mode.

Afterwards we will conduct a question and answer session via the phone lines only. If you are listening via the audio broadcast and would like to ask a question please dial in on 1-800-916-9263. Once you are connected you can press the 1 followed by the 4 to register for a question.

If at anytime during the conference you need to reach an Operator simply press the star followed by the zero.

As a reminder this conference is being recorded Thursday, May 26, 2011.

It is now my pleasure to turn the conference over to Heather Ngai. Please go ahead.

Heather Ngai: Good afternoon and welcome to the HRSA 2011 UDS Clinical Measures Training. We're very pleased that you can join us today.

My name is Heather Ngai. I'm a Public Health Analyst in the Data Branch of the Office of Quality and Data at the Bureau of Primary Health Care at HRSA.

A few logistical items before we get started with our two speakers today. If you don't have a copy of the slides in front of you or if you've not logged onto the web portion of this call you can download the slides immediately now from the UDS web site. The URL for that is http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html.

So please go ahead and go onto the web site to download the slides now if you're not able to access the web portion.

If you have any difficulty with the web portion of this call again repeating what the announcement said, you can call 800-843-9166 and let them know if you're having any problems with the audio or web portion.

A recording of this Clinical Measures Training will be available on the same URL that I just announced in a few days. So if you're not able to make this call or your colleagues are not able to make this call or if you'd like to hear this call again we will be posting a downloadable audio file onto the web site.

So I'd like to introduce our speakers for today. We have two speakers today. Our first speaker is Quyen Ngo-Metzger, our Data Branch Chief in the Office of Quality and Data at the Bureau of Primary Health Care at HRSA. Dr. Ngo-Metzger's research has focused on racial and ethnic health disparities. She conducted several studies on the quality of medical care for racial ethic minorities focusing on Latino and Asian patients with language barriers.

She was one of the first investigators to examine optimal ways to collect data among limited English speakers and has developed rigorous research protocols to achieve equivalent cultural and linguistically comparable access across different languages.

Today as Data Branch Chief in the Bureau of Primary Health Care at HRSA Dr. Ngo-Metzger's current work involves evaluating clinical quality of care, access and cost of care for approximately 19 million patients seen at over 8000 federally qualified Community Health Center sites. She has oversight over the Uniform Data System, UDS, a standardized reporting system that provides data on Community Health Centers, migrant health centers and homeless and public housing patients.

Dr. Ngo-Metzger received her Medical Degree and Internal Medicine Residency Training at the University of Chicago, Pritzker School of Medicine.

She received her Bachelor's of Public Health at Harvard School of Public Health and Fellowship Training at Harvard Medical School.

Our second speaker today is Art Stickgold. Many of you might be familiar with Art's work with us. Art has worked with Community Health Centers and the Bureau for over 30 years and today due to the Bureau of Primary Health Care's contract with JSI, he coordinates the UDS Training and UDS review process. He has worked with Bureau staff to translate the current and future clinical measures from the language of NQF and CMS to the UDS process and has helped us in the design and implementation of new tables.

We're very pleased to have both Dr. Ngo-Metzger and Art Stickgold with us here today.

Quyen Ngo-Metzger: Good afternoon. Thank you so much for joining us today. So today we're going to be talking about the objectives for today's presentation.

So today's presentation is designed to help grantees understand what the new measures are and why they're being added. We want to talk to you about how to complete and submit clinical measures data on Table 6B and Table 7 of this 2011 UDS.

So just to give you a little bit of background and overview of the clinical measures, the 2011 UDS Clinical Measures Enhancements were vetted in the same way as earlier measures. Initially we published them in - as a PAL, in the PAL 2010-12 on August 30th.

Subsequently we announced this in the Federal Register. We received comments and recommendations from the Health Centers, PCAs, PCOs and the general public. Comments were then reviewed and the package was approved by OMB on January 3, 2011 and they were introduced in the 2010-2011 UDS Training.

So there are currently four clinical measures that are being added in three clinical areas. These include weight assessment and counseling for children

and adolescents, adult weight screening and follow-up, tobacco use assessment and cessation counseling, asthma and pharmacological treatment for those with asthma.

There are two existing measures that are being modified. We're updating the vaccine for children to the current standards and the hemoglobin A1c goals for diabetics are expanded.

And today we're going to talk much more about these four new clinical measures as they're being collected in Calendar Year 2011. There's really no new data over and above what's needed for rigorous charting that's necessary. Hopefully the electronic health records may be used.

And chart reviews may still be used as appropriate. We're hoping that we use CPT Category II Codes to simplify this process.

The data will be submitted in the 2011 UDS.

So just to talk about the clinical measures and the data strategy, first of all we just wanted to - we're doing it to focus on quality. These new clinical measures will allow Bureau Primary Health Care and the Health Centers to demonstrate the quality of patient care using an enhanced set of measures which are part of the CMS Meaningful Use data sets.

These new measures will focus on preventive healthcare. Most have already have AMA CPT Codes and all qualify under Meaningful Use rules.

The new clinical measures also focus on comparability. They're being adopted by a wide range of non-330 organizations and they will allow the Bureau of Primary Health Care to demonstrate the quality and the value of care that's provided at our Health Centers.

They will also permit the Health Centers to obtain comparable information in states and in the nation. And the Bureau of Primary Health Care will continue

to provide reports which permit Health Centers to identify appropriate individual targets for quality improvement.

We want to focus on integration and integrating these new clinical measures into the SAC and BPR grant applications. Therefore the first year will permit its use as baseline data and in the future the baseline data can be edited.

And finally we want to focus on Meaningful Use so that 2011 Clinical Measures will further prepare grantees to meet CMS's Meaningful Use implementation requirement. These additional measures promote and support the implementation of EHR data collection and reporting procedures by the Health Centers and all the measures are recognized by the National Quality Forum.

So now I'm going to turn it over to Art Stickgold who will actually go into the details of the measures.

Art Stickgold: Okay and welcome. We're going to be talking about these new measures one at a time. And we will start with just an overview of the measures.

The new measures will all be included on Table 6B. And that means that there are quality of care measures and they're going to be reported consistent with the way you've been reporting quality of care measures to the Bureau in the past.

These measures are all process measures. And what that means essentially is that based on the knowledge of researchers and the evidence that's been collected in the United States we're confident that if patients receive timely routine preventive interventions then we can expect overall statistically improved health status.

So to look at each one of these measures, just quickly the first, weight assessment and counseling for children and adolescents, and what we're looking at is the demonstrated hypothesis that if clinicians ensure that patient's Body Mass Index Percentiles are recorded and if the patients or

their parents are counseled on nutrition and physical activities and that's regardless of whether the patient has a weight issue or not, then the likelihood of obesity will be reduced and its sequelae will be reduced and the overall health of these children will be improved.

We don't stop there. We continue on in adulthood. And if clinicians routinely calculate and record the BMI for adult patients and have that available to them, if they identify patients with weight problems and develop a follow-up plan to work with overweight and underweight patients, then again the likelihood of debilitating sequelae of serious weight problems can be reduced.

We have what we called a health - a measure but it's actually a pair of measures. So for tobacco the first critical measure is simply if patients are routinely screened for their tobacco use then providers will be able to identify them, to intervene more quickly and more effectively and to reduce the incidence of both cancer and emphysema, asthma and other tobacco-related illnesses.

And then the paired variable if tobacco users are identified and then for the identified tobacco users an effective mix of counseling and pharmacological interventions take place, then tobacco users will be more likely to quit and will therefore have a lowered incidence of cancer, asthma, emphysema and other tobacco-related illnesses.

Our fourth measure addresses asthmatics. If patients who are identified with persistent asthma, we'll talk more about that concept later, are provided with appropriate pharmacological intervention, then they'll be less likely to have asthma attacks. They'll require fewer emergency room visits and less likely to develop complications related to asthma including death.

Now those are the new measures. In addition childhood immunization which was actually one of the first measures that we had and one that we've been using consistently is being updated and modified in order to remain consistent with the recommendations of CDC, the AAP and other

professional bodies. So we'll see a revised measure on childhood immunization.

So let's go and talk about each one of these measures and get very specific about what we're talking about. Note on the title slide here. It says Childhood and Adolescent Weight Assessment and Counseling. And then it says in parentheses NQF 0024. All of these guidances, all of these guidelines are National Quality Forum consistent guidelines and greater detail about them will be available if anybody wants to research them in - under this NQF number.

They're also identified using this number in the CMS Meaningful Use Measures that Quyen's already mentioned.

So childhood, adolescent and weight, and let me just say that for each of the measures we're going to first describe what the measure is. We're then going to describe the universe.

Who are the patients whose clinical care we're going to ask you to review?

We'll discuss what is the documentation that will be necessary and then show you the UDS Table and define it so for this first one what is the measure.

The measure is the percent of patients in the universe with weight assessment and counseling documented. And that means there are three elements and they all must be documented during the measurement year.

So has the BMI Percentile been recorded in the chart?

Is there documentation in the chart of the patient - that the patient or the patient's parents have received counseling on nutrition? And is there documentation that the patient or the patient's parents have received counseling on physical activity? And that would be during the current year.

The universe is all children and adolescents. And this is just a little confusing so let me take a second to comment on it. The measure technically is considered children and adolescents who are between 2 and 17 years of age. But in fact there's a one year look back period.

So a child who is say 2 years old today still has 365 days during which their chart may be documented with all the appropriate information.

So for the purposes of this measure for practical purposes when looking at charts, you're going to be looking at charts of children who are actually 3 years old through 17 years old because of that one year look back period to answer the question about children who are 2 through 17.

These children have to have had a medical visit during the measurement year. So you'll be excluding from the universe any child who's only contact with the clinic has been for a dental visit or only contact with the clinic has been for an immunization with no further medical care.

Further, this visit has to have occurred in an environment which had the appropriate equipment present. Those of you who operate homeless programs or migrant programs know that often you're out in the field and do not have equipment which has capability of accurately recording weight and height. And if that's the case, then the patient would not be in the universe.

And of course these are all children and adolescents who were first seen prior to their 17th birthday. So if at the end of the year somebody is 18 years old and the first time you saw them was when they were 18 even though at some point during the year they were 17, they would be excluded.

As far as documentation and compliance is concerned, first, the requirement is that the BMI Percentile is noted in the chart or the EHR. And of course it's almost universal that when a patient presents their height and weight are recorded. But this needs more than just the recording of the height and weight.

The provider, the clinician who is treating that patient should be able to see on the chart, on the template what their actual BMI Percentile is.

And then there must be documentation that they counseled the child, the adolescent or the parent on both nutrition and physical activity. This can be either a narrative note or a box checked or some other way of recording in an electronic health record that the service was provided.

When it comes to completing the UDS you can see in sort of microscopic form at the bottom of the slide here what the actual UDS Table is going to look like.

Column A is going to ask the number of children and adolescent medical patients meeting the age criteria and all the other criteria who were actually seen during the measurement year.

This number will be roughly the same as what we call the adjusted age from Table 3A. That is when reviewing your UDS report we're going to look at how many patients were reported on Table 3A in the appropriate age range but we will adjust it to the percent of your total patients that were medical patients.

So if only 80% of your patients actually received medical care we would be looking at 80% of the patients on Table 3A in that age range.

Column B is going to be the number of those patients that you reviewed. Or and sorry, that can either be all of the patients that you reported in Column A because you have an electronic health record that permits you to do that or it will be a sample of 70.

And basically Column B will either be 70 or will be equal to Column A and Column B will always be less than or equal to Column A.

And then Column C will be the number of those who were reported in Column B that is the number of patients whose records were reviewed, whose

records showed full documentation of a BMI Percentile, counseling on nutrition and counseling on physical activities.

So Column C will be less than or equal to Column B. Column B will be less than or equal to Column A.

Just to give you an idea of some information about the population we're looking at, national data show that 16% of all children are overweight or obese. And the Health Center Patient Survey conducted by the Bureau has shown that 21% are overweight and obese consistent with findings that the problem is greater in low income populations; healthy people 2020 has a target of 14%.

So that's our first measure. Our second measure continues looking at weight and moves to adults. This is NQF 421 and begins by asking the percent of patients so the measure is a percent in the universe with a calculated BMI recorded and with appropriate follow-up if indicated so it requires possible documentation of two different elements. And both of these within the past six months or during the current visit.

So it doesn't have to be done at every single visit but it has to always be done within six months of the last visit.

And we're looking at documentation of BMI again, not weight and height but the actual calculated BMI. And that must be visible and if the patient is overweight or underweight documentation of a follow-up plan by a referral provider.

And here overweight is equal to 25 or over for patients under 65 and here the only good thing about turning 65, you get five more points; 30 or under for people over age 65 or underweight if the patient is - has a BMI of less than 18.5.

Our universe all adults 18 or older during the measurement year so if at anytime during the measurement year they were 18 years or older and had a

medical visit during the medical - measurement year, so again a patient who just came in for mental health services or substance abuse services is not in the universe. Their medical visit took place where there was equipment present to measure weight and height and they were ever seen after their 18th birthday which means that you may have seen a patient when they were 17 and by December 31, 2011 they in fact had turned 18 but you had not seen them since they turned 18. This indicator does not apply to them.

Compliance we're looking for the BMI again. And again it's a vital sign. Everybody gets their weight and height recorded. But what we need is that the BMI be visible to the provider. This is an important distinction because what we're looking for is that there are queues readily available to make sure that a provider is triggered to go further if BMI is outside of the normal range.

And then if the BMI is outside the normal range was there documentation of a follow-up plan. It may be with the provider. It may be by referral. There is no specific follow-up plan which is required by the Bureau. It has to be consistent with the Health Center's protocol.

And note that we're not asking you to be able to identify the successful completion of the referral or of the plan, only that the plan was provided to the patient.

Completing the UDS again Column A, how many total medical patients 18 and above that meet all the criteria were seen by the Health Center during 2011? It's going to be a very large number.

Column B either going to be that same number or a sample of 70 and Column C will be the number of those reported in Column B who have a recorded BMI and if appropriate the recorded follow-up plan.

So again Column C is less than or equal to Column B. Column B is less than or equal to Column A.

And again back to the nation and to - we've got to have one mistake in every slide set, right? That should of course say data on overweight or obese adults not children. Sorry about that.

And for adults the national data is 68%, 68% of adults are overweight or obese. Our National Center - Health Center Profile showed 75%. And we have a goal in healthy people 2020 of 61%.

Okay, then tobacco use assessment. And this is our third measure. You'll notice it's NQF 0028a because it's one of a pair of two separate measures that you'll be reporting on this year. So we'll talk about assessment now. Then we'll talk about intervention in NQF 0028b.

Our measure what is the percent of patients in the universe who were asked about their tobacco use in the measurement year or in the prior year?

And that's got to be documented in the chart. The provider that saw the patient does not need to be the individual who documented this. This can be done by nurse staff, others who vital patients or other means. But it must be in the chart.

Our universe is all adults who are 18 or over so they were born before December 31, 1993. That's variable number one. Who had at least one medical visit during the measurement year, so if their only visit was for a substance abuse counseling service they're not included, and three, had at least two medical visits ever.

And the NQF explains that this is to ensure that the patient has some sort of relationship with the clinic or the provider that this is not just an emergency one time contact and never seen again so two medical visits ever, who were seen after their 18th birthday.

So you have to meet all those criteria to be included. There are no exclusions. And note because this measure requires two visits unfortunately it will not be possible to use the same sample or the same group of individuals

to look at both the adult weight measure and the smoking measure because one requires only one visit ever. This one requires two visits ever.

Documentation is that in the chart there is documentation either of smoking, sorry, of tobacco use not smoking or that the patient is not a tobacco user.

So it's not adequate to have a system that just notes when the patient is a tobacco user and presumes that lacking that check the patient is not a tobacco user.

Now we'd just like to introduce and this is not in the least bit required but if you'll turn to the very, very back of your CPT Manual, the place that only people with great courage ever turn to, you'll find what are called the Category II Codes. They're a little bit after the eCodes where you find all those strange things about how to document an accident that takes place on a spaceship.

The Category II Codes are being developed and implemented specifically to aid clinicians in reporting on preventive healthcare. So there is a CPT II Code, 1000F which says the patient was queried about tobacco use.

And you either need to have that code entered into your system so you can find it electronically or have some other system.

Similarly there are three codes; 1034F indicates that the patient is a smoker; 1035F indicates that the patient is a smokeless tobacco user; and 1036F indicates that the patient is a nontobacco user.

So what we would be looking for is a 1000F and a 1036F together. That shows that you queried and you found out they weren't a tobacco user or a 1000 and a 1034 means you queried and they were a smoker.

So you can use these and they will hopefully make it easier for those of you who are both in electronic records and for those who are still using practice management systems that document CPT codes but make it much harder for

you to search on a variable like was somebody queried about their tobacco use.

Completing the UDS, Column A how many adult patients age 18 and over seen twice ever and seen once for medical use during the year were seen by the clinic. It's going to be roughly the same as the age adjusted number that we get from Table 3A but remember because it requires two visits our adjustment process is going to be even scarier.

So it's going to be harder for the EHB to electronically automatically alert you to the fact that you may have an error on this reporting.

Column B will either be the same number that's in Column A, that is you have the data on all your patients and you're checking all your patients or it'll be 70 indicating that you used the sample to look this up.

And Column C will report the number of those that you reported in Column B. It's going to be either 70 or the same as Column A for whom documentation demonstrates that the patient was queried about tobacco use so again C less than or equal to B less than or equal to A.

Then the other half of this, tobacco cessation and this is very different than the way NQF handles the weight. Remember when we were talking about weight we said is there weight outside the normal range; and if it is, did they get intervention?

For tobacco we have two separate measures. First are they at risk, are they smokers?

And secondly, a second variable did tobacco cessation intervention occur?

And what that means is that our measure is going to be the percent of the universe of known tobacco users. With weight it's conceivable though highly improbable that there'll be almost nobody who requires cessation or sorry, intervention for counseling.

But with this measure we are going to look only at those who used tobacco and therefore we will be looking at a population made up exclusively of tobacco users.

And the question is documentation that the provider or appropriate support or referral staff provided tobacco cessation counseling and/or provided pharmacological intervention for example a prescription was written or a drug dispensed for the patch or some other appropriate pharmacological intervention.

When we look at the universe all adults age 18 or older so this does not apply to adolescent smokers, all adults who were 18 or older who were known to be tobacco users who had at least one medical visit during the measurement year and had been seen at least twice.

Again as with the weight - as with other areas we want to make sure that a relationship has actually been established between the clinic and the patient and that there are grounds for and opportunities for intervention.

So there are no exclusions on this. And again they have to have been seen at least once after their 18th birthday.

Documentation of compliance, a chart note or EMR coding to demonstrate counseling or pharmacological intervention, documentation that the provider or appropriate staff provided cessation counseling and/or documentation of a prescription written or a drug dispensed.

And again we have the CPT Category II Codes. So 4000F is a code saying the patient was counseled to quit tobacco use. So we go through the whole process. They'll be a 1000F that says the patient was queried about tobacco use. Then a 1034, if I remember correctly, saying yes. They were identified as a smoker and then a 4000F indicating that the patient was counseled to quit tobacco use and/or a 4001F that the patient was given a pharmacological

intervention, a prescription written or a drug dispensed. So that's what's necessary for documentation of compliance.

Completing the UDS, Column A, how many tobacco users do you have among your adults who were seen in the medical clinic and have been your patient for at least two visits?

Column B you're going to either review that same population or a sample of 70 of them.

And Column C of those identified in Column B how many have documentation demonstrating intervention within the last 24 months.

So obviously you do not have to intervene at every single visit but there must be intervention during the program year or the prior year.

Okay, and then the last of the new ones, asthma pharmacologic therapy. Again this is one where we're going to deal with a slight problem with the charting. We want to know the percent of patients age 5 through 40 with mild, moderate or severe persistent asthma.

And of course those of you who are clinicians know immediately that there is no ICD-9 code for persistent asthma but as we go on we'll talk about the fact that there is a CPT II code for persistent asthma.

So those with persistent asthma who were prescribed the preferred or an acceptable pharmacological therapy.

And it requires documentation that the medication was prescribed or dispensed.

The universe, patients age 5 to 40, this is the lowest upper end cap that we've ever established and again it's consistent with clinical findings, that that is the age during which persistent asthma is the most problematic for patients in the populations.

So all patients age 5 to 40 during the measurement year, those born between January 1 of ’71 and December 31st of 2006, who are currently diagnosed with persistent asthma and again CPT Category II Code 1038F is persistent asthma.

1039F is intermittent asthma and the presence of a 1039F code means that this is even though it’s mild, moderate or severe asthma, if it is intermittent, they are not in the universe that we are talking about; these are patients who are more likely to be on the rescue inhalers than they are the pharmacological interventions that are discussed here.

The patients must have had a medical visit during the medical year and at least two medical visits ever.

So they could have had one medical visit in 2010 and 1000 - one medical visit in 2011. They are in the universe if they have persistent asthma and are between the ages of 5 and 40.

So far as documentation of compliance, we’re looking for a copy of a prescription or a note that the prescription was given out during the current year or for that matter evidence of dispensing the drug during the current year.

The preferred pharmacological intervention is inhaled cortical steroids. I’m very proud about how well I pronounce that.

For acceptable alternative pharmacologic therapy I will not attempt to properly discuss - pronounce them all but they’re there for your records.

Completing the UDS again, Column A how many patients 5 to 40 with persistent asthma seen during the treatment year? It’s going to be similar to perhaps maybe we think the number of patients identified on Table 6A who have a diagnosis of asthma.

In other words they'll have to be some sort of relationship but because one has a number of visit criteria and requires persistent asthma where the other requires treatment for any form of asthma. You only need to have seen them once but it has to be a primary diagnosis. The numbers are not going to be the same.

The one thing we know is that the number on Table 6A if it's exactly the same as the number on Table 6B, you did it wrong.

In Column B the number we're looking for is either the same number that you have in Column A because you have an electronic or other record system that allows you to track them or 70, a sample that you collected for this review.

And in Column C what was reported in Column A for whom documentation demonstrates that the appropriate pharmacotherapy was provided.

And again Column C will be less than or equal to Column B will be less than or equal to Column A.

So those are new. Now we have a modification to an old friend; 2 year old immunizations was one of the first clinical measures that was added to the successful activity that the Bureau has been undertaking for the last several years.

But the immunizations that people, the 2 year-olds are to receive has changed. So the measure, the percent of children who turned 2 during the measurement year who were fully immunized on their 2nd birthday; some of you may know if you're in the immunization business that there's a catch-up protocol that talks about up through their 3rd birthday. That's not what we're talking about.

On their second birthday the grace period that's required that's looked for is built into this because essentially the vaccines that we're talking about should all have been given by 19 months.

So by looking at this at 24 months there's already a five or six month grace period built-in.

The vaccines may have been given by the Health Center but many Health Centers work in very close cooperation with Health Departments who provide the vaccines. And what the Bureau and what the measure requires is that the clinician treating this patient know the vaccination status of the child and that they have ensured that that child has had all their vaccinations.

So our universe, everybody born between January 1, 2009 and December 31, 2009, that's criteria one who had at least one medical visit during the measurement year. So if they came in for baby bottle tooth decay and only saw the dentist they're not in the universe.

And three, were first seen before their second birthday. So if their second birthday was today but you don't see them until November we won't ask you to document that as of today they were fully immunized before you ever saw them. There are no exclusions, again for this measure.

Documentation of compliance is either that you have provided the vaccinations so you have documentation that the vaccine was given or documentation of that the vaccine was given by another party.

So you have what in California we call that Yellow Card, the card that the patient carries around that shows all the vaccinations. It also shows who provided that vaccination and the date that it was provided. Or documentation that you obtained from some statewide or other registry so you go online and find in a registry that the patient was as of their 2nd birthday fully immunized.

Documentation of compliance means that they now have had all 25 of their shots. I am glad I am not the parent of a small child at this point. All 25 of these shots that can be reduced if they are receiving combination vaccines but basically there's a lot here and what we have added this year is the shot to bring us back into full compliance with the CDC and the American

Academy of Pediatrics, namely two hepatitis A vaccines, two or three retrovirus vaccines, rotavirus vaccines and two flu shots.

Oops. So far as - so let me go back to that for a second.

The completion of the UDS Column A number of 2 year-olds who were seen during the measurement year, it's going to be similar to the patients reported on 3A adjusted again for the percentage of patients who are in fact medical patients.

Column B is going to be 70 or all of the patients in Column A. And let me note that this is one of those situations where especially for our homeless programs the number in Column A and the number in Column B may both be significantly less than 70.

So there may be any number of programs out there who have seen fewer than 70 2 year-olds during the course of the year. Any general clinic that's seeing under 3500 is likely to be in this category. And as I said many if not most of the homeless programs are under this category.

So Column A total; Column B either the same as Column A, not necessarily more than 70, or 70 and Column C the number who were reported in Column B who were in full compliance as of midnight on the date that they turned 2, no later.

Okay, we have not changed the measure but Table 7 is going to look different this year. For Table 7 diabetes and this is NQF 0575, last year we reported patients with hemoglobin A1c between 7% and 9% in one category on line 12.

This year in 2011, for 2011 data we will have a category for patients, diabetic patients who's hemoglobin A1c is greater to or equal, greater or - greater than or equal to 7% and less than 8% so between 7% and 7.9% and a second category for patients who were greater than or equal to 8% and less

than or equal to 9% so between 8% and 9%. These were all included before on line 12. We now have them on lines 12A and on line 12B.

So those are the new measures that we're going to have. This is your second introduction to them. The first one was through PAL 2010-12. This is your second.

And Quyen's going to give you some idea of other places that you can get technical assistance to go on with this.

Quyen Ngo-Metzger: So thank you for being with us. And I just wanted to again thank you for your help as far as helping the Bureau keep track of our quality measures.

If you need technical assistance there's a UDS web page, http://www.hrsa.gov/data-statistics/health-center-data/index.html. This is where you can get your technical assistant call replay, online training module, data analysis tools as well as data download.

The measure specifications for the measures that we are talking about today can be found on the CMS web site, https:/www.cms.gov/qualitymeasures/03 electronicspecifications.asp.

Furthermore if you have UDS content questions you can contact the UDS Help Desk at 1-866-UDSHELP or 1-866-837-4357. The email is udshelp330@bphc, Bureau of Primary Health Care, bphcdata.net.

There's also a Bureau of Primary Care help line. These are for all electronic - UDS electronic reporting questions. And the help line phone number is 1-877-974-BPHC with the email at bphchelpline@hrsa.gov. There's also the HRSA Call Center for all technical and system issues. And this is the phone is 877-464-4772, email callcenter@hrsa.gov.

We are so delighted that you joined us today and we hope that this was helpful. Right now we're ready to take your questions. Thank you.

Operator: Thank you. Ladies and gentlemen to register for a question or a comment you must first be connected via the phone lines and you can do this by dialing the 1-800-916-9263. Once connected via the phone lines you can press the 1 followed by the 4 to register for a question or a comment.

One moment please, for the first question.

Our first question comes from the line of (Briguglio Lacona) of Public Family Health. Please go ahead.

(Briguglio Lacona): Yes. Thank you very much and thank you for the presentation.

Art I have a question for you. In regards to the measures that you stated a patient that has been seen twice ever, the question I have there are like three or four measures like that.

Is - you know after three years Medicare allows us to view a patient as a new patient. Is there any timeline exclusion that would go along those - that same parameter?

So that if I saw a patient in this measurement year and they have not been seen for five years, according to what you said I've got to count them. However they would really be considered a new patient by Medicare because it's been more than three years since I've seen them.

Art Stickgold: Let's talk about the rule and real world; the rule does not have a written exception for the fact that you saw this child when they were 2 years old and now they're coming in 33 years old but realistically speaking we have never asked anybody to check their records more than three years.

And I think for all of these we continue to say an appropriate record check would be one that looks at the current program year, the current calendar year and the prior two calendar years.

(Briguglio Lacona): Thank you.

Operator: Thank you. Our next question comes from (Susan Grummering) of Primary Care of Southwest Georgia. Please go ahead.

(Susan Grummering): Yes, I have two questions. One is related to the previous question and that is when there is a two visit requirement and there is also an age parameter to the measure, do those two visits have to occur during the eligibility as far as age? So if it's after 18 or older is it two visits within the measurement of that or do you exclude it first by age or by the two visits, is one question.

Art Stickgold: That's a very good question and let me take that first then we'll get to your second one.

The purpose as explained in the literature for the two measure - the two visits is that it indicates that there is a relationship between the Health Center and the patient.

And so it's not critical that those not go across the 18 year barrier or the 5 year barrier that we have in the category. The relationship is still documented by the two visits.

So two visits...

(Susan Grummering): Okay.

Art Stickgold: ...ever and one visit within the age parameter and you had a second question.

(Susan Grummering): Okay, very good. Yes, I did. On the pharmacological management for either the asthma, persistent asthma, CPT II code or for the tobacco usage, is it appropriate as part of your clinical protocols to have standing orders that when your assessment for tobacco use or persistent asthma indicates that there be a standing order?

And of course obviously going through all your clinical approval processes but have a clinical standing order for a pharmacy prescription unless there are any contraindication for that that is the standard of care that we do issue understanding order for a prescription for that patient for particularly for the tobacco use, that they exit not just with counseling but with a script in hand. We know we can't make them fill it. But if they leave and it's issued as part of the electronic prescribing, ePrescribing, is that acceptable?

Art Stickgold: Yeah, the - that they have the prescription is acceptable. That it is in the protocol that it should be given to them is not sufficient.

So standing (unintelligible).

((Crosstalk))

(Susan Grummering): Right. No, I understand.

Art Stickgold: Yeah.

(Susan Grummering): But for it to be generated as so that everyone that it is automatically generated as a standing order and it prompts that opportunity that when they leave with that script in hand issued, that it gives an opportunity to issue that counseling. I just wanted to make sure that that would count in terms of the pharmacological management script issued. Not just it being in the protocol but the script issued at a visit when indicated and there are no contraindications for it.

Quyen Ngo-Metzger: Yes. And especially if you, you know, if you have ePrescribing.

(Susan Grummering): Right.

Quyen Ngo-Metzger: That - yeah, that would count.

(Susan Grummering): The automation of that would count as compliance. Okay, thank you very much.

Operator: Thank you. Our next question comes from Bob Edwards, Northwest Human Services. Please go ahead.

Woman: Hi. On Slide 27 where you do the patient - the adult patients with the BMI and the counseling, the first Column A is the total patients 18 and over with the two visits or the one visit appropriate.

But the second column for the 70 chart samples are they supposed to be 70 people who are age 18 and older with BMI charted and a follow-up plan if they were overweight or underweight or just 70 18 and older?

Art Stickgold: It's 70, obviously if it was what you had just said then they would all be in compliance. It's 70 who meet the age and visit criteria. And then you're going to check to see whether they have the BMI listed and the counseling is appropriate.

This by the way is a very common problem that people seem to run into that they somehow give the instructions to the people in IT and then the people in IT mistakenly say oh what they want is a 70, a sample of 70 people who meet that criteria. I don't know why they're asking for it but I'll give them 70 people who meet the criteria.

And then you come out with 100% compliance rate which we will always challenge not because nobody's perfect but because so many people make that technical error in communicating between IT and clinical and administration.

So it's a very good question. Thank you for asking it. And yes, it is of the people who meet the criteria.

Woman: Of being over 18 only.

Art Stickgold: That's correct.

Woman: That's the only criteria it has to be.

Art Stickgold: Correct. And that they had to have - and they had a visit during the year.

Woman: Yeah, and they had a visit, correct.

Art Stickgold: Next.

Operator: Thank you. Our next question comes from the line of (Janet Shelton) of Winston Hills Medical and Health Centre. Please go ahead.

(Janet Shelton): Yes. We had a couple of questions. The first one pertains to the childhood immunizations.

Some of these immunizations are age-related for example the rotavirus. So if somebody only comes to us after 7 months of age there is no way even if we do all the other immunizations that they will be compliant when it's time for us to do the UDS audit.

Art Stickgold: And...

(Janet Shelton): So is there a reason for including that particular vaccine in there?

Art Stickgold: Let me...

(Janet Shelton): And secondly pertaining to that same issue is many parents refuse the flu shot particularly if there's no history of asthma or chronic disease.

And that again will put us in noncompliance.

Art Stickgold: Let me deal with the second one first because that's easier. Many places have parents who refuse any number of these shots. There's an article in the paper today about another large measles epidemic which is related 100% to failure to vaccinate.

So parents who refuse to vaccinate their children that child is out of compliance. And you're asked to do everything you can to get them into compliance but you're not miracle workers. You're just doctors and mid-levels and nurses. You'll do what you can and that's the best.

The other question is even more complicated than you asked because there are some children who if you see them after a certain age the protocol tells you not to give as many shots as we specify here.

And we recognize that. It's why we don't think 100% compliance is likely. The standard is developed on the assumption that the patient enters care with their pediatrician the day they're born and stays in care with that pediatrician for the full two years and therefore it's reasonable to ask the provider about their services for two years.

We know the Community Health Centers have a far more, I was going to say transient. Let's just say mobile population and that we see many children for the first time when they're at an age where both CDC and the American Academy of Pediatrics would not recommend this many shots to be given before they turn age 2. That child will be out of compliance.

And we recognize that. That's why the Bureau does not set a standard saying you must immunize X percent. Rather it uses these numbers to help you compare to how your changes are occurring and how well you're improving over time.

So yes, you will be out of compliance. It won't be your fault. And that's the way it is.

(Janet Shelton): I suspect that there'll be Health Centers who decide not to take patients because it will adversely affect our compliance.

And if we're reporting this on our 330 grants and we're reporting this on UDS you can't help but feel that there might be some adverse effects particularly with regards to funding.

So I just...

Quyen Ngo-Metzger: Well we...

(Janet Shelton): ...raise that issue. The second issue that I wanted to raise was on the tobacco use of cessation intervention. Many patients are self-pay and can't afford the pharmacological intervention so us just giving them a prescription is not going to help them to be able to achieve tobacco cessation.

So has there been any thought given to interventions that can help facilitate coverage for payment for these interventions?

Art Stickgold: First off, tobacco use cessation counseling and/or pharmacologic intervention so you are not required to do pharmacologic intervention, okay.

(Janet Shelton): Okay.

Art Stickgold: So that's the first thing. The second thing is yes, you can help them and we just got passed across the table 1-800-QUITNOW is one way to help people get medications.

But the requirement is not that you provide the medication. Providing the prescription is sufficient as is providing counseling and referring to smoker cessation programs.

Let me back up to what you started to say before. I do not pretend to speak for the Bureau so I'll ask Quyen to comment on this too.

But there is no tie between the numbers that you report on your UDS for the clinical measures and your grant. I know of no instance where anybody reported any number that caused them to have even a reduction in a grant let alone a loss of a grant or even eligibility for a future grant.

And the UDS is not a policing tool. And your numbers here should never stop you from seeing the most needy patients, those that can't gain access to the care and are in fact sick.

And I think that would be the condition that the Bureau would have concern about.

Quyen.

Quyen Ngo-Metzger: Yes, I mean I would agree with Art completely. I think as far as the immunizations it's just documentation that they have had it. It doesn't have to be with you. We realize that there are patients who are coming in kind of, you know, in the middle of their years and that you're doing catch-up. I mean we're following the Center for Disease Control guidelines for catching patients up. And patients are caught up all the way up to 5 before they enter Kindergarten.

So there are opportunities here for catching up even after age 2. We are following the CDC guidelines to make sure that at least for patients 2 and under, they are receiving the immunizations that are required and again it doesn't have to be at your Health Center. It could have been at different places as long as there is documentation that they receive this.

Art Stickgold: Thank you.

(Janet Shelton): Thank you.

Art Stickgold: Very good questions though.

Operator: Thank you. Our next question comes from (Robert Lane) of Community Health Center, Inc. Please go ahead.

Woman: Yes. Hello. My question is regarding the criteria where we have to do the two visits ever. We've only been on EMR for approximately a year. And so would

we use the criteria of 70 charts or would we use the criteria of complete EMR look backs?

Art Stickgold: If - there's no hard and fast rule. But in general if you haven't had your EMR operational for three calendar years many if not most of these measures are hard to completely categorize and report on through an EMR.

But you can use your EMR in part to identify the universe, to then get your sample of 70 and then you can return to your EMR to look up the patient and to see if there's documentation in the EMR that the condition has been met.

Only if after you have done that you can't show that it was met would you pull one of the legacy charts and find out whether it happened in the year before you got onto your EMR.

So you need three years to be fully dependent on the EMR. But the EMR can be incredibly positive and useful in reducing the workload and letting you get the compliance for large portions if not nearly all of those patients who are in compliance.

Woman: Thank you.

Operator: Thank you. Our next question comes from (Beverly Mills) of St. Joseph Mercy Care Services. Please go ahead.

(Beverly Hills): Hi. We have a question in regards to the tobacco counseling. Is there a button or checkbox that's appropriate when assessing compliance for tobacco counseling like it is for the BMI for children and adolescents?

Art Stickgold: There is CPT II codes. They're on Slide 37 if you have the printout.

And 4000F on CPT II codes indicates that the patient was counseled. 4001F indicates that pharmacologic therapy was provided. And either one of those two being present would indicate compliance with this particular measure.

(Beverly Mills): Okay, so (thank you).

Operator: Thank you. Our next question comes from Linda Ridlehuber of Minnesota Association for Community Health Centers. Please go ahead.

Linda Ridlehuber: Thank you. Actually I have a couple of questions. One is on the two, the child and adult weight measures.

If the eligibility for the measure is that they've been seen in the last 12 months and they were seen seven months ago then they're going to flunk being - having a BMI in the last six months. And I'm wondering why that is (unintelligible).

((Crosstalk))

Art Stickgold: This may be one that we need to fine tune. It is the BMI was received at the latest visit or within six months of the latest visit but in the measurement year.

Linda Ridlehuber: Okay. So it can be further than six months back, got it.

Art Stickgold: It can be further than six months back from December 31st, yes.

Linda Ridlehuber: Yes. Yeah, okay I misunderstood that one.

And then my only other one is I very, very much appreciate the Bureau aligning with the Meaningful Use measures.

But my concern is with the asthma measure it's a noncore measure for Meaningful Use. It's an optional measure.

And a lot of the vendors will not have opted to certify on that measure so that won't be available.

Art Stickgold: One of the - and I don't want to be seen as advertising anything. But one of the advantages that PCAs and other large groups have in negotiating

contracts with vendors is that they require that the vendor provide all data necessary to comply with BPHC reporting requirements.

So if you're one of those states that have worked together to get a group of your members to purchase the same system, that's probably an element of the system, the BPHC reporting requirement.

And similarly a lot of the large national vendors have that in their contract that they will provide any BPHC required reporting variables in their system.

Linda Ridlehuber: So clinics that have negotiated their own we should have them check with the vendor to see if perhaps they have agreed to that anyway.

Art Stickgold: Yes.

Linda Ridlehuber: Okay, thank you.

Operator: Thank you. Ladies and gentlemen as a reminder you can press the 1 followed by the 4 on your telephone if you would like to register a question or a comment.

Our next question comes from Kim Savage of Eastern Shore Health. Please go ahead.

Ms. Savage your line is open.

Kim Savage: Can you hear me?

Operator: We can now.

Kim Savage: Okay. So sorry, I was sitting here talking away.

My question is on the adult obesity assessment piece where and I couldn't write it down fast enough but it was talking about counseling and/or referral to a provider.

Does that have to be a clinician or can that be a health educator?

Quyen Ngo-Metzger: We leave it open that it could be a nutritionist, health educator.

Kim Savage: Okay, just one...

Art Stickgold: And it's not obesity. That's not just political correctness.

Kim Savage: I'm sorry. I'm so sorry, because it's obesity. It's either overweight or underweight.

Art Stickgold: Correct. And we don't want - and...

Kim Savage: Sure.

Art Stickgold: ...as much as I want to say anorexic we don't say anorexic either. That's another number.

Kim Savage: Right.

Art Stickgold: So it is overweight or underweight.

Kim Savage: Right. Thank you.

Operator: Thank you. Our next question comes from (Carol Varchia) of (Scenic West) Health Center. Please go ahead.

(Carol Varchia): My question has to do with the BMI. Are we not excluding maternity patients or prenatal patients from the BMI?

Art Stickgold: Yes, we are.

(Carol Varchia): (Unintelligible).

Art Stickgold: So let me put in at this point a plug that obviously when the manual comes out it will have far more details on some of these things including CPT codes, ICD-9 codes and the like, it will also carry with it the statement that both for adolescents and for adults pregnant women are excluded from the universe and if you want to go there for adults, frail elderly within six months of anticipated demise are not included in the universe.

We just sort of made it a little quicker here. This will obviously be in the manual and we will also cover in greater detail when we do our trainings in the winter of 2011, we will go into these some greater depth at that point.

But thank you, yes, for pointing out that there is still more to be learned about these measures.

(Carol Varchia): Thank you.

Operator: Thank you. Our next question comes from (Joe Applebell) of Community Pediatrics Health Center. Please go ahead.

(Joe Applebell): Hello. Our question is on the pediatric measure for weight measurement.

Would that visit be a well child visit? Because that is really where we're measuring heights regularly and if a child came in for strep throat for instance we wouldn't necessarily be getting a height at that visit.

So is that a way we can pull charts on children who have had, from 2 to 17 who have had a well child visit over that measurement period?

Art Stickgold: No and the reason...

Quyen Ngo-Metzger: Well let me say this. You can pull - I mean it can happen during the well child visit. You have to document that there's more than just a well child visit.

So I guess what I'm trying - what we're trying to say is that the height and weight may be documented but you have to - would have to document more

because we're talking about nutrition and exercise counseling. And we're not saying that it could not have occurred during a well child visit.

But just because it's a well child visit does not mean that it automatically occurred.

Art Stickgold: It's - this is a constant problem that we have with many of our preventive measures is that people come into Health Centers not with a preventive measure presenting symptom but with in fact a disease presenting symptom.

The Bureau is committed to Health Centers seeing patients as part of a medical home. And the fact that the patient came in for a strep throat does not mean they're not in the universe.

Normally that occurs in the well child visit but we would hope that that child who came in for a strep throat will then be followed up with a well child visit so that you will have it documented.

But we know that the child who comes in for a strep throat comes in again for a follow-up and is never seen again. If you do not do height and weight on that child that child is in the universe and would be out of compliance.

There are many other situations where this occurs. Obviously the same would be true of an adult who came in for strep throat...

(Joe Applebell): Right.

Art Stickgold: ...who wasn't counseled or given height and weight. So we're talking - we're making the assumption. We know that there are limits to it but that we're the making assumption that when patients enter your facility they're becoming your patients and you have a responsibility for ensuring that they're well care, their preventive care is taken.

Operator: Thank you. Our next question comes from the line of Marie Wisely of Community Healthcare, Inc. Please go ahead.

Marie Wisely: Hello. I have a question about Slide 48 and it's the number of immunizations.

Is it two Hib or three?

Quyen Ngo-Metzger: It's actually three Hibs, most of the time it's three Hibs. There are special Hibs that special kind of Hibs that are - that you could get by with two. But generally it's mainly three Hibs.

Marie Wisely: Okay. Because in the program assistance letter on Page 4 under the immunizations it specifically says two Hibs so you just might want to clarify that...

Quyen Ngo-Metzger: Yeah.

Marie Wisely: ...because we've changed our audit to just include two.

Art Stickgold: Yeah. The - it said two or three Hibs in the Meaningful Use criteria but we have subsequent consultation with our physicians here on staff. And their recommendation was that we go with three. So we will...

Marie Wisely: With three.

Art Stickgold: With three, yeah.

Marie Wisely: Okay, thank you.

Operator: Thank you. Our next question comes from Brooke Gomez of Crescent Community Health Center. Please go ahead.

Brooke Gomez: Thank you. My question is kind of a two part question about the smoking.

Is there a way that somebody might be reported twice? If you put them down at one visit as a smoker and you counsel them and they come back in three

months and they quit smoking which one do you use? Is it the most recent? And do they get reported twice then?

Art Stickgold: So they will be reported once. And if you could mute your phone we're getting a lot of feedback here.

They will be reported. There are two different measures. If they are identified as an adult you're going to count them in that measure to ask whether or not they were identified as a smoker.

Then the second question is smoker, yes/no. And that is presumed to be a current status. So if they are not currently smoking then if you have evidence that they are not currently smoking, then they would not be in the universe for the second of these two measures.

Operator: Thank you. Our next question comes from (Michael Krell) of HCN. Please go ahead.

Woman: Hi. The - I mean children immunization measure, the NQF 0038 was updated by CMS. And you're using the older version, which one would you like us to report on, on the older version or newer version?

Art Stickgold: We believe that 38 is the new version. CMS - CDC is constantly changing this.

But to the best of our knowledge NQF 0038 is the current version. If you have some information that that's not the case, if you could get in touch with us, give a call at the help line and ask to speak to Heather, we'll follow through on that and try to find out what's going on.

But to the best of our knowledge this is the current measure.

Woman: I will. Thank you.

Art Stickgold: Thank you.

Operator: Thank you. Our next question comes from (Joanne Wilson) of Indian Health Center. Please go ahead.

Ms. (Wilson) if you're on mute, please remove your mute button. We are still unable to hear you.

(Joanne Wilson): Hello?

Operator: Now we are. Please go ahead.

(Joanne Wilson): Okay, great. Thank you. Sorry.

I have a question regarding immunizations. And I think it was asked a little earlier. We have a large walk-in clinic for our immunizations. So a lot of these children have providers outside our center as primary care. But they only come here for vaccinations.

Should we include these patients in our pool?

Art Stickgold: Good question and there are a lot of Health Centers out there who provide very critical community services by providing vaccinations to at risk and needy children and adults especially with the flu shots.

The criteria for being considered a patient in the UDS is that the patient has received a clinical visit with a clinician at which clinical decision making is taking place and it explicitly says that if the only contact has been for a vaccination they're not to be considered a patient.

(Joanne Wilson): Okay.

Art Stickgold: So if the only contact you've had with this patient is your once a year flu shots or your get kids ready for school immunizations or any...

(Joanne Wilson): Yeah, right.

Art Stickgold: ...other type of immunization clinic you would not count them as a patient on Table 3A. They would not be a part of the universe.

(Joanne Wilson): Okay.

Art Stickgold: And I would caution you that you want to make sure because many of the Health Centers that have these systems are set up with VFC Programs and the Cocosa reporting system that requires them to report on everybody that they vaccinate...

(Joanne Wilson): Yes.

Art Stickgold: ...but that's not the population that you will be reporting on. You'll be reporting on patients who have had at least one medical visit and that doesn't include just vaccinating them or giving them a TB test or something.

(Joanne Wilson): Great. Thank you.

Art Stickgold: You're welcome.

Operator: Thank you. Our next question comes from Lee Klammer of Open Door Health Center. Please go ahead.

Lee Klammer: Hi. Thanks for taking my question. I have two questions actually, one general and one specific. The specific one is related to the tobacco cessation measure starting let's say Slide 36. The organization that I'm with has a paper-based environment so we don't have an EHR or EMR.

Do you have any suggestions as far as how to establish the universe of tobacco users where all of that information is within the chart and not within the system?

Art Stickgold: Again that's where that CPT code, that CPT II code, becomes very useful because you can add that to your super bill or your encounter form or whatever and have it checked off. It doesn't have a charge associated with it.

But that CPT Category II Code goes into your system and then you can query a practice management system for that code to identify those patients.

Lee Klammer: Sure. Okay. And then my other one is a more general one. With the two measures, the childhood and adolescent weight and the adult weight, you mentioned some of the - like the national averages and the Health Center averages and the 2020 goals.

Do we have any sort of resources that could help us establish baselines for compliance for some of these other newer measures as well?

Art Stickgold: I don't have those baselines. So far as whether or not they exist I am not certain.

If - obviously once the UDS report is completed we will be feeding back to you as we do with all the clinical measures what the variables are and what the state and national averages are.

But so far as this first year, do we have anything for Health Centers or for the nation, I'm afraid we don't.

Lee Klammer: Okay sounds good. Thank you.

Operator: Thank you. Ladies and gentlemen again as a reminder it is a 1 followed by the 4 if you'd like to register a question or a comment.

Our next question comes from Mika Aoki of Asia-Pacific Healthcare Venture. Please go ahead.

Mika Aoki: Thank you. It's a follow-up question to the one that it just previously asked. I understand about that we can actually add a CPT code to identify those potentially in a universe for both the tobacco users and persistent asthma.

But, you know, we're already kind of halfway into the year. And even if we started using those CPT codes from this point forward some patients - some clients having already met their two visits in a year or one visit, whatever is the requirement for those measures. And potentially we're not capturing those.

And is that okay? I guess our universe through this process is not going to be perfect even we started use of CPT code right away at this point.

Art Stickgold: Well I hate it when reality enters the world; we have fine rules (and haven't) made the real world.

But obviously we are not going to ask you to open up the chart of every single patient between the age of 5 and 40 or under - over the age of 18 to determine whether they have the condition. In these instances you'll have to go with the less than perfect data that you have effective, you know, everything from June 1st forward.

You'll footnote that in your notes in the UDS and for the table you'll indicate for the notes that you did not have the information prior to this date. What that will generally do is that the reviewer will indicate then when they review the UDS report that there wasn't an issue, a problem.

And the question that we then ask ourselves is, is the error that's occurring here a random error or is it a systemic error that might overall distort the data that you're presenting?

What you're talking about here a date specific variable, it's probably a random variable. So we would note it as such.

But if you could go forward using codes that allow you to capture these individuals, that's what we would like.

Mika Aoki: So I guess we really don't have any other alternative except to use a CPT code, CPT II, Category II Codes, correct, to identify those unit of people who are in that universe other than what you said which is to open every single chart that fits the age category and potentially have that bigger diagnosis that will put them into that category.

Art Stickgold: Yes. That's the only thing other than if you have things automated like a problem list for example or whether you specifically query about things and code them as well.

But short of that I don't know of any tool that you can use that will readily jump into any reporting system easily. You know you could set up special fields in your system.

But again that's going to be idiosyncratic, difficult and expensive.

Mika Aoki: Thank you.

Operator: Thank you. Our next question comes from the line of (Carrie Lydon) of Health Access Network. Please go ahead.

(Carrie Lydon): Yes. I have a question regarding the tobacco cessation. And you might have actually answered it with this last question that was just on the line.

But we do not currently use CPT II codes. For tobacco cessation therapy we do use E&M codes within our electronic medical record. I believe it's 90846 and 90847. We are capable of reporting out based on those codes.

So do we have to switch over to using the CPT II codes or can we continue to do our current process which is using the tobacco cessation E&M codes?

Art Stickgold: You can...

Quyen Ngo-Metzger: Yeah. You can just use what you are using now. I think the CPT codes are just suggestions.

(Carrie Lydon): Okay.

Art Stickgold: Well the problem is those codes tell you that you provided the service. What we want to know is who is the universe of persons who needed the service.

So those E&M codes will substitute perfectly for the CPT codes that talk about pharmacological intervention occurred. The talk about counseling intervention occurred.

But they will not help you identify who were all the smokers. And if you looked to all the people who had those codes you would find a 100% compliance rate which of course is not the case. So you still need a way to find out who the smokers are.

(Carrie Lydon): Okay. We do within our system have what we call certain findings for a current tobacco user, a former smoker or nonsmoker. And we're able to report based on that as well.

Art Stickgold: Excellent.

(Carrie Lydon): And to also report on patients that were never asked.

Quyen Ngo-Metzger: That's excellent. I mean it sounds like you have all the data elements that you need.

So I mean I think that...

(Carrie Lydon): Okay.

Quyen Ngo-Metzger: ...you know, suggestions that as long as you can get all the data, we're not prescribing how you get them. But it seems like you do have the capabilities to identify who are the smokers.

(Carrie Lydon): Thank you very much.

Operator: Thank you. Our next question comes from (Connie Laws) of (unintelligible). Please go ahead.

(Connie Laws): Hello. Thanks for taking my question. I have a couple of comments. But let me just deal with my first one which is on the overweight reporting for the UDS.

And I'm really glad that BPHC is doing this because it ties in with the First Lady's Let's Move Initiative to reduce childhood and they use the term obesity.

But research tells us and this is some research by Rebecca Poole at the Center for Food Policy and Research at Yale University is that overweight or obese, I don't care what in this situation, they don't like to be referred to in those terms.

And that the term that their research has found that people are most comfortable with is when you're talking to someone and this could be the medical provider, nutritionist, health educator, nurse whomever, is to talk to them about their unhealthy weight.

And their research says that - found that if you don't use terms that the individual is comfortable with that actually they don't come back for care which is not what we want to enforce.

And I'm wondering if BPHC had thought about, you know, doing some education around some of these more acceptable terms to the population because we know it's a really big issue. And we want to have an impact. We

don't want to, you know, turn - have people not coming back for care. That's one comment.

And then the other one has to do with I think we know that in some cases height and weight measurements are still not done accurately. They're not using the proper equipment.

And is there anything in the guidance that tells people the right equipment to use to take accurate heights and weights because we know that garbage in is garbage out?

Thank you.

Art Stickgold: Well let me respond to the second part of that first in that if they do not have calibrated equipment available to them because they're in a remote location, they're seeing homeless patients under a bridge of course we understand that. And those individuals if they've never been in a place that has calibrated equipment would not be in the universe.

So far as making sure that everybody has adequately calibrated equipment I think that's a level of review that the Bureau is not, you know, interested in taking on at this level.

Your comments about how to effectively and efficiently communicate with patients are very well taken. And of course we're all concerned about this. It's all too convenient for those of us who are just using data to apply labels and hopefully you will not follow our example and actually communicate it.

Quyen Ngo-Metzger: Well I think what we're trying to say here is that, you know, we're defining the BMI greater than 25 as being overweight or less than 18. I mean it's - this is not really our definition per say. This is the definition, you know, that's to define, what is a BMI? What's considered overweight or underweight?

We're not necessarily actually advocating that you should communicate with patients using those terms. But they are in some ways scientific terms that

have been established by other bodies and we're just - so we're defining it adequately.

But we definitely understand your comments and we appreciate that and we understand that it would be, you know, great to communicate to patients in a more general way.

But I think what we're trying to say is because we're defining, you know, this is what BMI of greater than 25 has been identified as overweight and greater than 30 is obesity. That's why we're using this type of language. Not necessarily that you would use the same language when you're speaking to patients.

(Connie Laws): Well I know that. And I'm not criticizing you at all for that. I'm just talking about medical providers and what happens actually in the Community Health Centers. That's what I'm talking about. The sensitivity on how we talk to patients.

And there's research. And I mean overweight and obesity are huge issues in this country. And so, you know, they've done some research at the, you know, this Rebecca Poole, you know, has done. She's at the Center for Food Policy and Research at Yale. And, you know, they have a good web site.

And I was just encourage people to think about, you know, and they're talking to patients using terms that are - that the populations are more comfortable. It's nothing about this and how you're referring to it for the UDS. That's appropriate.

Quyen Ngo-Metzger: Okay, thank you so much. We appreciate that. That's a great comment.

Operator: Thank you. Our next question comes from Christine Bianchi of StayWell Health Center. Please go ahead.

Christine Bianchi: Hello?

Art Stickgold: Yes go ahead.

Christine Bianchi: Hello?

Art Stickgold: Yes, we can hear you.

Christine Bianchi: Oh fabulous. Thank you. So I have a follow-up to a question that someone asked a couple people ago regarding the immunizations where you noted that we are excluding a patient who would come in and did not have a formal medical visit.

So we have always been challenged by the fact that we see a large number of children for dental only. And so in this new measure in effect those children who are seen for dental only but not medical would be excluded.

Art Stickgold: That's correct. And this is...

Christine Bianchi: Great.

Art Stickgold: ...not new. This is the way it has been from the beginning. They are not part of the universe...

Christine Bianchi: Right.

Art Stickgold: ...that we look at.

Christine Bianchi: Okay, all right, great. Thank you.

Operator: Thank you. Our final question comes from Eric Southard of Vermillion-Parke Community Health Center. Please go ahead.

Eric Southard: Hi. Thanks for taking my comment. I certainly appreciate the Bureau's effort to, you know, standardize our data collection method so we can document the excellent that I think we all do.

Taking into consideration the many challenges that you face the Bureau, I mean I can't even imagine the struggle you have, the only thing I would add is that the sooner that we had the specification in the reporting year it helps to develop the most accurate documentation and reporting technique and it allows us to educate our staff on the uniform documentation technique so we can ensure that we get the, you know, the best numbers and deliver the best quality of care.

Art Stickgold: And to which everybody here I think adds an Amen. Unfortunately all these things have to go through many, many rounds of approvals and reviews. There's been a general rule that the Bureau has applied and that is that any time a UDS variable is going to require you to collect something which you've never collected before. For example when we added veteran's status that there was a commitment to make sure that you had that information by July, August of the prior year to make sure that there's time to get it set up.

For those variables and unfortunately these are considered to be in part of these variables where it is presumed that all that's being asked is that you report things differently on data that you are already collecting much later dates have been seen as appropriate.

But we have just talked about the very fact that identifying who is a smoker for example is going to be difficult unless you change your systems. So yes, we appreciate it. We continuously endeavor to work on it. If there are going to be more changes to the clinical measures and there probably will be over time, we will once again work as hard as we can to get that information out as soon as we possibly can.

Eric Southard: Thank you very much.

Operator: There are no further audio questions at this time.

Art Stickgold: Well thank you very much and thank everybody who was on the call; we actually still have about 90% of the people who logged on still listening so we really appreciate you're staying with us all this time.

And again you'll have opportunities to get further information from the training that takes place in the fall.

Heather.

Heather Ngai: And just another reminder if you weren't able to ask your question today on today's call please send your questions to the BPHC Help Line at bphchelpline@hrsa.gov. That's B-P-H-C-H-E-L-P-L-I-N-E@H-R-S-A.G-O-V or you can also call 1-877-974-BPHC.

So feel free to use those resources if you have any further questions after this call. Again like we stated this - an audio recording will be able to be downloaded from our UDS Bureau web site several days after the end of this call.

Art Stickgold: Thank you very much.

Quyen Ngo-Metzger: Thank you.

Operator: Ladies and gentlemen that does conclude today's webinar. We thank you for your participation and ask that you please disconnect all lines. Thanks and have a good day.

END