Table 6B: Quality of Care Measures (part 2)

Table 6B: Quality of Care Measures (part 2)

Hello and welcome. Thanks for checking in to learn about Table 6B: Quality of Care Indicators.

You may have just completed the Part 1 training for Table 6B but if not, I should start by explaining that since this table covers a lot of information, we have split its materials into two separate trainings:

- The Part 1 training covers the clinical measures listed in Sections A through G; and
- This one, Part 2, covers the rest of clinical measures in Table 6B, Sections H through N.

If you have a particular interest in learning about a clinical measure included in Part 2 you *may* complete Part 2 of the training, whether or not you have previously completed Part 1. Otherwise, I'd encourage you to complete Part 1 first, and then Part 2. You can access Table 6 (part 1) through the RESOURCES link in the upper right of the screen.

Please click the START button to begin.

Welcome

If you have attended one of these trainings before, we may have already met. But, in case you haven't, I'm Steve - your UDS Report expert, and I am here to help you complete this second part of Table 6B. Overall, this table covers a variety of quality of care measures that have historically been viewed as indicators of overall community health.

Introductions

Let's start with introductions.

- If you'd like, please let me know who you are by typing your name in the box. This information is just used as we interact during this session and is not saved.
- If you don't want to enter your name, just click **Sign In** to begin.

Get Started or View Navigation

If you've been here before and know how to use the navigational features, you can go straight to the training by clicking on the **LET'S GET STARTED button**.

If you'd like to learn more about our training's navigational features - click on the **HOW TO NAVIGATE button** to continue.

Navigation: Table of Contents & Transcript

Before I go on - if you are interested in hearing the audio narration, please be sure to adjust your computer speakers so that you can hear me. If you would like to read the transcript, you can see it over here in the "TRANSCRIPT" tab on the LEFT of your screen. Also ON THE LEFT of the screen, you'll see a tab that says "TABLE OF CONTENTS." You can use this tab to go anywhere you want within this course. You may find it useful if you want to review something specific about Table 6B. In that case, you can just click on any of the topics listed and jump to that particular section of the course. If you would like an overview that covers all the topics, just stick with me.

Navigation: Play, Previous, Next

AT THE BOTTOM of the screen, you'll see a control bar with navigation controls and buttons that will let you adjust your viewing experience:

- If you want to stop the video, just hit the play button once (to pause), then hit it again to resume.
- You can also slide the progress bar to the left if you would like to repeat some of the material, or slide it to the right to jump ahead.
- To go to the slide just before or to proceed to the next slide, use the buttons to the right of the control bar labeled "PREVIOUS" and "NEXT."

Navigation: Resources, Main Menu, Exit

There are several links AT THE TOP RIGHT of your screen:

- If you click on the RESOURCES link, you will see additional files and links to websites that will help you in completing your Report. You can also download a copy of the Transcript here;
- If you click on the MAIN MENU link, you can return to the UDS Learning Center's library; and
- When you're done, click on the EXIT link, and you will exit the course entirely.

Navigation: Icons

Throughout the course you will see icons that you can click on to:

- View or print the UDS tables;
- Refer to the UDS Manual;
- See helpful hints that should help you with your UDS Report; or
- Take you to a Case Study example to see how all of the UDS data works together.

One last thing before we begin - if you need to leave this training early and return to it later, you can do that. When you come back next time, we will remember where you left off and ask you whether you want to continue from there or start again from the beginning. I think that covers the details about how to move through the course. Let's get started!

What is Table 6B?

So, what is Table 6B?

As we start, if you would like to see a close-up of this table, please click on the VIEW THE TABLE icon IN THE LOWER RIGHT OF THE SCREEN to view (and even print out) Table 6B. You may find it helpful to have it available to you as we go through the training.

What is Table 6B?

Table 6B is one of the tables that make up the Clinical Profile for the UDS Report.

Every health center will complete it each year as part of their Universal Report.

Overall, it consists of a total of 14 quality of care outcomes (or indicators); with each indicator reported in its own section.

Table 6B (part 2)

Again, remember that we have split the training on Table 6B into two parts. In this second part, we will cover the last seven indicators in Sections H through N; those are:

H. Use of Appropriate Medications for Asthma

I. Coronary Artery Disease (or CAD)-Lipid Therapy;

J. Ischemic Vascular Disease (or IVD)-Use of Aspirin or Antithrombotic Therapy; and,

K. Colorectal Cancer Screening.

L. HIV Linkage to Care;

M. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

N. Dental Sealants for Children between 6-9 years

We will walk through each of these sections, and what you will be reporting in them, as we move through the course. However, if you're interested in reading more about each of these sections now - click on the VIEW THE MANUAL icon on this screen.

Why are these data important?

Throughout these trainings, we emphasize how important the UDS data are to the Bureau of Primary Health Care (BPHC) and to the Bureau of Health Workforce (BHW) and how they are used in so many ways; Table 6B is no exception. The information reported on this table can also be very useful to you and your community.

The quality of care measures included in Table 6B report on services that are correlated with good long-term health outcomes and have been shown to be indicators of overall community health.

What exactly do we mean by that? Well, we know when people receive timely, routine and preventive care; they are more likely to have better health status. For example:

- If patients identified with persistent asthma are provided with appropriate pharmacological intervention, then they will be less likely to have asthma attacks, will require fewer emergency room visits, and will be less likely to develop complications related to asthma, including death. So, by increasing the number of health center patients that receive preventive and routine health care services, you likely improve the future health status of your patient populations and, therefore, your community.

Why are these data important?

With that in mind, realize that you can use data from Table 6B to:

- Calculate the percentage of patients receiving preventive or routine health care services;
- Track performance achievement for these services over time;
- Compare your rates to state and national averages to design and target continuous quality improvement (or CQI) efforts; and
- Use data to communicate with stakeholders.

How you use the information is up to you. Just don't forget that the data is an important resource available to you to help support your work!

How can this training help me?

We hope that this training will help you in completing your UDS report as accurately and as efficiently as possible!

How can this training help me?

By the end of this training on Table 6B, we hope that you will be ready to:

- Accurately report quality of care outcomes (in Sections H through N);

How can this training help me?

- Report the patients that meet performance standards for each indicator;

How can this training help me?

- And, complete Table 6B so that it is consistent with the other Clinical Profile tables and the rest of your UDS report (especially Tables 3A, 5, and 6A).

Key Terms

Before we get into the details of Table 6B, let's go over some key terms that will be important in understanding this table. While we'll go over each of the indicators in detail throughout the training, also remember that you can click on the icon to see all of these definitions in more detail in the UDS Manual.

Let me start by briefly running through a couple of the more general definitions here:

- As always - we'll ask you to report about some of your "patients." So, the UDS definition of a patient holds true for Table 6B as well, meaning that you will only report on people who have had one or more UDS-reportable visits at your health center during the reporting year.
- And, the same definition of a "visit" applies here as well - with a "visit" being a face-to-face contact between a patient and a provider during which the provider exercised independent, professional judgment. To be included as a visit, the contact needs to have been documented in your health center's charts.

With both of these definitions, it is important to further clarify that the focus for this table is on medical patients and visits.

Key Terms

- We'll also talk about patient "universes" - and this refers to the patients who meet the criteria to be evaluated for a particular indicator.
- Relatedly, as we go through each of the indicators, we'll talk about the inclusion and exclusion criteria that you will use to define who you will include (or exclude) in your count for each indicator. Though the criteria you will use to include or exclude patients will vary across indicators they generally speak to: a specific age range; number of medical visits; specific medical conditions; and sometimes gender (for women's health indicators).

Table 6B (part 2): Instructions

Let's go ahead and talk about the detailed steps involved in completing this second part of the table accurately.

Quality of Care Measures: Part 2

Again, the indicators we'll be covering in this Part 2 training are the last seven in Table 6B and include:

- Use of Appropriate Medications for Asthma
- Coronary Artery Disease (or CAD): Lipid Therapy
- Ischemic Vascular Disease (or IVD): Use of Aspirin or another Antithrombotic Therapy
- Colorectal Cancer Screening
- HIV Linkage to Care

- Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan
- Dental Sealants for Children Between 6-9 years

OK, let's dive in!

Struggles with Table 6B?

If you struggled a little bit with Table 6B last year, you're not alone. Did you know that, in a recent reporting year, almost half of the UDS Reports submitted had to have corrections made on Table 6B? Table 6B was recently noted as the UDS table with the highest percentage of "questionable" ratings. Meaning that the data reported was in question (e.g., unusually high or low numbers, out of sync with the other tables of the UDS, significant variance from the previous year), and the data could not be corrected or adequately explained.

Remember, what we hope to accomplish through this course is to make the data submission process smoother for everyone, while still getting accurate and complete data that can be used to support your programs!

Reporting Format

For each of these indicators, you will report three pieces of information:

- In column a: the total number of patients in the "universe." If you remember from the beginning of the training, this is the number of patients meeting the inclusion criteria for the specific indicator being reported. You can see that the criteria is different for the IVD indicator, than it is for the colorectal cancer screening indicator;
- In column b: the number of charts sampled or the EHR total for each particular indicator. This will either be the universe (what you reported in column a), 80% of your universe, or a random sample of 70 patients drawn from the universe. Don't worry, we'll walk you through how to decide what you'll report here in just a little bit; then
- In column c: you'll identify the number of patients that meet the performance achievement standard for the specific indicator. And, again, what the standard is will differ based on the indicator. Looking at the ones above, you'll see that for the IVD measure, you'll report the number of patients with aspirin or other antithrombotic therapy in column c. But for the colorectal cancer screening measure, you'll report the number of patients screened for colorectal cancer in column c.

If you've already completed Part 1 of the training, this three-column format should look familiar, because we used it in earlier sections of Table 6B. If you are comfortable with this format and would like to skip ahead to the particular details of the measures, please CLICK the SKIP AHEAD link. Otherwise, let's go into more detail on the format and what is needed for each column.

Column a: Number of Patients in the Universe

As I just pointed out, the universe will be unique to the quality of care indicator on which you're reporting, so it will be very important for you to include the correct patients in each universe on Table 6B.

You'll use inclusion and exclusion criteria to select the patients you'll report for each indicator. The UDS Manual offers very specific instructions on who to include and exclude from your patient universe for each line on Table 6B. We'll go over them for each indicator during the training, but if you would like to read the UDS Manual for more information, click on the VIEW THE MANUAL icon.

Determining your patient universe correctly for each of these indicators is extremely important. If you have not identified the universe correctly, you will not be able to accurately report performance achievement on each quality of care measure.

- Some sites may use their EHR to determine their patient universe; while others might do so through a review of paper records (and some may do a little of both).
- In any case, to define your universe properly, you will need to be able to detect data that will help you include or exclude patients based on the specific criteria for every indicator.

Quality of Care Measures: Inclusion Criteria

Each indicator has its own set of unique inclusion criteria. Some are common across a number of measures and others only apply to some.

- For example, with the exception of the dental measure (Section N, dental sealants) all of these indicators ask you to only include medical patients. So, this means you will include only those patients who had a reportable medical visit during the reporting year.
- Some measures require you to only include patients who have had two or more medical visits. For example, the CAD measure has inclusion criteria that states patients must have been seen twice ever for a medical visit to be included.
- Unlike the other measures, for measure N Dental Sealants the indicator will ask you to only include dental patients. So this means you will include only those patients who had a reportable dental visit during the reporting year. This is the only measure in 6B that includes dental patients. We'll discuss this measure in more detail later on in the module.

Another set of inclusion criteria used by some measures ask you to include patients based on when they were first or last seen. For example:

- The adult weight measure has inclusion criteria that states the patient needs to have been last seen after age 18; and
- The asthma measure's inclusion criteria states the patient has to have been last seen while age 5 through 64.

So, while each work somewhat similarly - the specific dates and ages for each is very different.

- And, lastly, some measures will have inclusion criteria specific to a clinical diagnosis or having received treatment for a condition.

Quality of Care Indicators: Exclusion Criteria

In addition to the specific inclusion criteria for each clinical measure, there are also exclusion criteria specified for some indicators.

For many of the indicators on Table 6B, there are no exclusion criteria, but where there are, they are clearly stated in the UDS Manual and we'll review what they are for each specific measure today.
OK, so that covers the type of information you'll be reporting in column a. Let's go on and talk about column b.

Column b: Number of Charts Sampled (or EHR total)

As we mentioned, in column b, you will report either:

- The universe (what you reported in column a);
- A subset of at least 80% of the universe from your EHR; OR
- A random sample of 70 patients from the universe.

How will you decide which way to go? Let's talk about that next.

Column b: Number of Charts Sampled (or EHR total)

You can report on the universe (again, the total number of patients you reported in column a) **if** your electronic health records system allows you to identify each patient included in the universe and can identify whether each patient is meeting performance standards on the indicator.

- If your system cannot do both - identify the universe, and who is meeting the performance standard for each measure - then you will have to use a random sample of 70 patient records to determine performance achievement. If that is the case, then the number you'll report in column b will be 70.
- If you have a patient universe (in column a) that includes fewer than 70 patients, then you must report on that entire universe.

To sum this up, it is true that in all instances, column b will either equal the universe, 80% of the universe, OR 70.

Using EHR to Identify Patient Sample

Let's talk a little more about your EHR's capability to report on the entire universe. In order to use your EHR to report the number of patients in column b, it needs to meet the four following criteria:

- The EHR includes at least 80% of all clinic patients who meet the inclusion criteria; AND
- The EHR excludes every single patient who meet one or more exclusion criteria; AND
- Every inclusion and exclusion criteria item is regularly recorded for all patients; AND
- The EHR has been in place long enough to find the data required for the performance measure (in some cases, this means being able to go back several years in order to report the measure accurately).

If each of those statements is true for your EHR, then you can go ahead and use it to identify your patients (in column b) and report on performance achievement for the measure. Let's talk about performance achievement next.

Column c: Performance Achievement

In column c for each of these measures, you will report the number of records from column b (your sample or EHR total) that meet each indicator's measurement standard.

- For example, for the CAD indicator, this would be the number of patients who were prescribed a lipid-lowering therapy.

This number in column c may never exceed the number in column b (or number of patient records reviewed).

Part 2: Clinical Indicators

So, let's get into the details of the Part 2 measures and start back up with Section H.

Section H: Use of Appropriate Medications for Asthma

In Section H - you will report the number of patients (5 through 64 years old) with persistent asthma who receive pharmacologic therapy.

To start, you must determine the number of patients who make up the universe for the measure.

Column a: Use of Appropriate Medications for Asthma

There are five criteria for identifying those patients included in the universe for this measure.

1.35 Column a: Use of Appropriate Medications for Asthma

To be included, a patient must:

- Be between the ages of 5 and 64 years during the measurement year, and
- Have been seen most recently by the health center while they were aged 5 through 64 years, and
- Have been diagnosed with *persistent* asthma OR have persistent asthma as a current diagnosis on a chronic illness form or template, and
- Have had at least one medical visit during the measurement year.
-

Column a: Exclusions

There are several exclusion criteria for this measure, specifically:

1. Individuals with emphysema, COPD, cystic fibrosis, or acute respiratory failure during or prior to the reporting year should be excluded

Column b: Use of Appropriate Medications for Asthma Charts Sampled or EHR Total

In column b, you will report either the universe (what you reported in column a), a minimum of 80% of the universe, or a random sample of 70 patients. We took the same approach for Sections C through G in Part 1 of this training, so this should sound familiar to you.
This will always be the case for column b throughout the rest of this table, so I'll just mention it here and save us time as we go forward.

Column c: Use of Appropriate Medications for Asthma

In column c you will report the number of patients included in column b with documentation of a pharmacologic treatment including:

1. An inhaled corticosteroid, or
2. An acceptable pharmacological agent

An acceptable pharmacological agent could include any of the following four types:

- inhaled steroid combinations
- anti-asthmatic combinations, antibody inhibitor
- leukotriene modifiers, mast cell stabilizers
- methylxanthines.

DO NOT count patients who are receiving a form of treatment other than pharmacologic treatment, or whose only pharmacological treatment is a short-acting bronchodilator for symptomatic relief.

Performance Achievement: Asthma Treatment

Please note that some clinicians will suggest other methods for asthma relief. They may suggest, for example, that use of an air filter, a special diet, or reliance on a “rescue inhaler” is sufficient. However, these methods are NOT evidence of performance achievement with the pharmacologic therapy indicator.

DO NOT count patients who are receiving a form of treatment other than pharmacologic treatment, or whose only pharmacological treatment is a short-acting bronchodilator for symptomatic relief.

North Side Example: Section H (Asthma)

Let's take a look at a hypothetical example from North Side (our fictitious health center).

Here they identified:

- 654 patients meeting the inclusion criteria for the Use of Appropriate Medications for Asthma measure and reported that number in column a;
- A random sample of 70 patients from this total universe, and report these charts sampled in column b; and
- Finally, from review of the records for these 70 randomly selected charts, they identified 59 patients who had an acceptable plan.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (59), by the number of individuals reported in column b, the denominator (70), to obtain a performance achievement rate on this clinical measure of .843. That is, 84.3% of patients had an acceptable pharmacological treatment plan during the measurement year.
Their performance achievement rate of 84.3% is slightly higher than the average for BPHC Health Centers of about 81%, and exceeds the Healthy People 2020 goal of 37% on this measure.

Section I: CAD (Lipid Therapy)

Section I of Table 6B reports the number of patients aged 18 and older with a diagnosis of coronary artery disease, or CAD, who were prescribed a lipid-lowering therapy. This measure is important because we know that if patients with CAD, myocardial infarction (or MI) or who have had cardiac surgery receive lipid-lowering therapy, then the likelihood of CAD-related clinical events will be reduced.

Again, we'll start by determining the universe for the measure.

Column a: CAD (Lipid Therapy)

There are five criteria for identifying those patients included in the universe for this measure.

Column a: CAD (Lipid Therapy)

Each patient included will:

1. Be 18 or older, and
2. Have been seen by the health center after their 18th birthday, and
3. Have had at least one medical visit during the measurement year, and
4. Have had at least two medical visits ever, and
5. Have an active diagnosis of CAD OR have been diagnosed as having had a Myocardial Infarction OR have had cardiac surgery.

Column a: Exclusions

There are two exclusions for this indicator:

1. Individuals whose last LDL lab test was less than 130 mg/dL, and
2. Individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL-lowering medications.

Column c: CAD Therapy

In column b you will report either the universe, a minimum of 80% of the universe, or a sample of 70 patients; then, in column c, the number of patients included in column b who received a prescription for a lipid-lowering therapy.

Do NOT count patients who are receiving a form of treatment other than pharmacological treatment in this column. Patients involved in therapeutic lifestyle changes and/or control of non-lipid risk factors *without* concomitant pharmaceutical treatment should not be counted here.

North Side Example: CAD (Lipid Therapy)

Let's go back to our example. On this measure, North Side identified:

- 421 individuals meeting the inclusion criteria for the CAD measure and reported that number in column a;
- A random sample of 70 patients from this total universe (reported in column b); and
- Finally, from review of the records for these 70 randomly selected charts, they identified 34 individuals with a prescription for a lipid-lowering therapy.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (34), by the number of patients reported in column b, the denominator (70), to obtain a performance achievement rate on this clinical measure of 0.486. That is, 48.6% of patients aged 18 and older with a diagnosis of CAD were prescribed a lipid-lowering therapy.

This rate of 48.6% is substantially lower than the average for BPHC Health Centers of about 75% so this is an area for improvement. Healthy People 2020 does not include a goal for this measure.

Section J: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic

In Section J of Table 6B you will report the number of patients (18 and older) with a diagnosis of Ischemic Vascular Disease (IVD), **or** those who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI), who are being treated with aspirin or another antithrombotic therapy.

Let’s look at the inclusion criteria for the patient universe.

Column a: IVD: Use of Aspirin or another Antithrombotic

There are four criteria for identifying those patients included in the universe for this measure.

Column a: IVD: Use of Aspirin or another Antithrombotic

Each patient included in the IVD therapy universe will:

1. Be 18 years of age or older as of December 31st of the measurement year, and
2. Have been last seen by the health center while they were 18 years of age or older, and
3. Have had at least one medical visit during the reporting year, and
4. Have had an active diagnosis of IVD during the measurement year or previous year, **or** been discharged after AMI, CABG, or PTCA during the previous year.

And, are you ready for this? There are **NO exclusion criteria** for this measure. All patients meeting the inclusion criteria should be included in the universe reported in column a.

Column c: IVD Therapy

In column b, you will either report the full universe, a minimum of 80% of the universe, or a sample of 70 patients.

Then, in column c, you will report the number of patients included in column b who received a prescription for, were given, or have been using aspirin or another antithrombotic drug during the reporting year.

North Side Example: IVD Therapy

OK, let's see how North Side reported on this measure. Here they:

- Identified 845 adults meeting the inclusion criteria for the IVD Therapy measure and reported that number in column a;
- Identified a random sample of 70 patients from this total universe, and report these charts sampled in column b; and
- Finally, from review of the records for these 70 randomly selected charts, they identified 44 patients who were receiving therapy.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (44), by the number of patients reported in column b, the denominator (70), to obtain a performance achievement rate on this clinical measure of 0.629. That is, 62.9% of adults aged 18 and older with a diagnosis of IVD or having had an AMI, CABG, or PCI procedure were treated with aspirin or another antithrombotic therapy during the reporting year. This rate of 62.9% is somewhat lower than the average for BPHC Health Centers of about 75% so this would be an area for improvement. Healthy People 2020 does not include a goal for this UDS measure.

Knowledge Check

Let's pause here for a moment to review some of what we've learned so far.

Click on YES or NO for each of the statements on the following slides.

Knowledge Check (asthma)

For the asthma measure, unless you have a designated code to specifically identify persistent asthmatics, you will not be able to use your EHR to identify the persistent asthma universe. Instead, you will need to use a sample of 70 persistent asthmatics (or the entire universe, if less than 70 patients) and estimate the universe for column a.
Answer: No

Feedback when correct:

That's right. With the advent of ICD-10 you received diagnoses codes to distinguish patients by the severity of their asthma. All asthmatic patients should now have severity diagnosed in their patient chart for you to be able to report from your EHR.

Feedback when incorrect:

No, sorry. With the advent of ICD-10 you received diagnoses codes to distinguish patients by the severity of their asthma. All asthmatic patients should now have severity diagnosed in their patient chart for you to be able to report from your EHR.

Knowledge Check (IVD)

There are NO exclusion criteria for the IVD therapy measure.

Answer: Yes

Feedback when correct:

Right! The IVD therapy measure is one of the UDS clinical measures for which there are no exclusions.

All patients meeting the inclusion criteria for this measure should be reported in the universe.

Feedback when incorrect:

Actually, this is true. Although most UDS measures have at least one exclusion criterion, the IVD therapy measure is one for which there are no exclusions.

All patients meeting the inclusion criteria for this measure should be reported in the universe.

Section K: Colorectal Cancer Screening

Section K of Table 6B reports the number of patients aged 50 through 75 at the start of the measurement year with appropriate screening for colorectal cancer.

The first thing you must determine is the number of patients who make up the universe for the measure.

Column a: Colorectal Cancer Screening

There are two criteria for identifying those adult patients included in the universe for this measure.

Column a: Colorectal Cancer Screening

Each patient included in the Colorectal Cancer Screening universe (reported in column a) will:

1. Be between the ages of 50 and 75 as of January 1st of the reporting year, and
2. Have had a least one medical visit during that year.

Column a: Exclusions

There is one exclusion criterion - patients who have or have had colorectal cancer or a colectomy.

Column c: Colorectal Cancer Screening

Again, in column b, you will report either the full universe, 80% of the universe taken from your EHR, or a sample of 70 patients; then, in column c, you will report the number of patients included in column b who had one of the following three procedures:

1. A colonoscopy during the measurement year or in the previous 9 years, or
2. A flexible sigmoidoscopy during the measurement year or in the previous 4 years, or
3. A fecal occult blood test (or FOBT), including the fecal immunochemical (or FIT) test, during the measurement year.

Performance Achievement: Colorectal Cancer Screening

The fecal occult blood test (FOBT), including the fecal immunochemical test (FIT), can be used for screening purposes, but to count as having met the measurement standard, the test must be administered *every year*.

For patients who do not physically come to the clinic, the test may be mailed to the patient. However, a sample must be received and processed. Evidence of mailing is not, in and of itself, sufficient to demonstrate performance achievement on this measure. The results of the test must be documented in the patient's record.

Stool specimens for FOBT, including FIT, should be collected as recommended by the manufacturer. An in-office obtained stool specimen obtained through a digital rectal examination does not meet the measurement standard, nor does it comply with manufacturers' recommendations or national screening guidelines. However, stool collected from a spontaneously passed stool during an office visit using an FIT does meet the measurement standard.

North Side Example: Colorectal Cancer Screening

Let's look at how our friends at North Side Health Center reported on this measure. North Side identified:

- 9,563 patients meeting the inclusion criteria for the Colorectal Cancer Screening measure and reported that number in column a;
- They were able to use their EHR and look at all 9,563 for column b; and
- Finally, they identified 1,790 patients who received an appropriate screening on the measure during the year.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (1,790), by the number of adults reported in column b, the denominator (9,563), to obtain a performance achievement rate on this clinical measure of 0.187. That is, 18.7% of adults aged 51 through 74 during the measurement year who had appropriate screening for colorectal cancer.

This rate of 18.7% was only a little more than half of the average BPHC Health Centers performance achievement rate of about 35% so this would be an area for improvement. The Healthy People 2020 goal is 70.5% for this measure.

Section L: HIV Linkage to Care

Section L collects information about the number of patients whose first HIV diagnosis was made by the health center staff between October 1st of the prior year and September 30th of the measurement year and who received treatment within 90 days of that diagnosis.

The first thing you must determine is the number of patients who make up the universe for the measure.

Column a: HIV Linkage to Care

The criteria for identifying those patients included in the universe for the HIV Linkage to Care measure are as follows.

Column a: HIV Linkage to Care

Each patient will:

- Have been newly diagnosed, for the first time ever, by the health center, and
- The diagnosis will have been made *by the health center* between October 1st of the previous year and September 30th of the reporting year, and
- Have had at least one medical visit during the measurement year or the year prior.

A couple of important notes about these inclusion criteria:

- First, the person needs to have been newly diagnosed – that means diagnosed as having HIV for the first time ever--not just newly diagnosed by your health center; and
- There needs to have been two tests that both identify HIV. In other words, a preliminary positive test alone is not adequate to consider the patient "diagnosed" with HIV - they must have a second test to confirm the first.

And, with regard to exclusion criteria, this is another easy one - there are no exclusions; all patients meeting these criteria should be included in the universe reported in column a.

Column c: HIV Linkage to Care

In column b, you will report either the full universe, a minimum of 80% of your universe taken from your EHR, or a random sample of 70 patients; then, in column c, you will report the number of patients included in column (b) who were seen for follow-up within 90 days of that first-ever diagnosis by the health center. Specifically, this means:

- A visit with a health center provider who initiates treatment for HIV, or
- A visit with a referral resource who initiates treatment for HIV.

Note that *actual treatment* must be initiated within 90 days of the visit where they tested positive. Providing a referral or education does not count.
Specific CPT and ICD codes provided in the UDS Manual will be useful in identifying clients meeting the measurement standard.

North Side Example: HIV Linkage to Care

Checking in with North Side again, we can see that they:

- Identified 2 patients meeting the inclusion criteria for this measure and reported that number in column a;
- Reported on the total universe of 2 patients in column b; and
- Finally, from review of the records for these charts, they identified that 1 patient was seen within 90 days of the first diagnosis of HIV.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (1), by the number of adults reported in column b, the denominator (2), to obtain a performance achievement rate of 0.50. That is, 50% of patients were seen within 90 days of their first-ever HIV diagnosis by the health center. Their rate of 50% is much lower than the average BPHC health center performance achievement rate of about 77% so this would be an area for improvement.

Section M: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

In Section M, you will report the number of patients aged 12 and older who were:

1.Screened for depression with a standardized tool; **and**

2.Have a follow-up plan documented *if* they were considered depressed.

The first thing you must determine is the number of patients who make up the universe for the measure.

Column a: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

The criteria for identifying those patients included in the universe for the

Screening for Clinical Depression and Follow-Up Plan measure are as follows.

Column a: Screening for Clinical Depression and Follow-Up

Each patient will:

- Be age 12 or older, and
- Have had at least one medical visit during the measurement year.

Column a: Exclusions

Patients will be excluded from this measure if they have an active diagnosis for depression or bipolar disorder or if they are already participating in ongoing treatment for depression. Patients who refuse to participate in screening, which are in urgent or emergent situations, and patients whose functional capacity or motivation to improve affects the accuracy of results are also excluded from the universe for this measure.

Column c: Depression Screening & Follow-up

In column b you will report either the universe, a minimum of 80% of your universe, or a random sample of 70 patients; then, in column c, you will report the number of patients included in column (b) who had either:

- A standardized depression screening test during the measurement year which was negative, or
- A standardized depression screening test during the measurement year which was positive (meaning that the patient has screened positive according to a standardized screening tool - provider judgment alone is not sufficient to identify depression) AND have a follow-up plan documented. The CPT-II code 3725F will be useful in identifying patients meeting the measurement standard. It's also important to note that the standardized test used must be age appropriate.

Remember, your EHR must be able to identify a minimum of 80% of the universe and must not be restricted by any variable related to the test measure. For example, you may not use a separate database for “behavioral health” programs only since it would be restricted to only behavioral health patients.

North Side Example: Depression Screening

Once again, we'll look at an example involving North Side Health Center. Here they:

- Identified 39,753 patients meeting the inclusion criteria for this measure and reported that number in column a;
- Identified a random sample of 70 patients from this total universe, and report these charts sampled in column b; and
- From review of the records for these charts, they identified 34 patients who were screened and a follow-up plan was documented as appropriate.

From these reported numbers, we can compute the performance measure by dividing the number of patients reported in column c, the numerator (34), by the number of patients reported in column b, the denominator (70), to obtain a performance achievement rate on this clinical measure of 0.486. That is, 48.6% of patients were screened and had a follow-up plan if appropriate.

This number is higher than the average BPHC Health Centers performance achievement rate of about 39% so North Side is doing well here.

Section N: Dental Sealants for Children between 6-9 Years

In Section N (Dental Sealants) you'll report the number of patients who were 6 through 9 years old and received a sealant on a first permanent molar during the reporting period.

This is the first dental care measure on Table 6B; so that means that you'll be reporting on only dental patients instead of medical patients, for this measure.

The first thing you must determine is the number of patients who make up the universe for the measure.

Column a: Dental Sealants

There are three criteria for identifying those children included in the universe for this measure.

Column a: Dental Sealant Inclusions

Each patient included in the Dental Sealants universe (reported in column a) will:

1. Be between the ages of 6 and 9 as of January 1st of the reporting year,
2. Have had a least one dental visit during that year,
3. Have had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement year, and
4. Have been documented as being at moderate-to-high risk for caries.

Unlike the other measures, when defining the universe, you will include all patients who have had a qualifying dental visit; and exclude patients who have had medical but no dental visits during the reporting year. As we mentioned before, this is the only measure on Table 6B where dental patients are included.

Column a: Dental Sealant Exclusions

And, there is only one exclusion criterion for this measure - children for whom all first permanent molars are non-sealable; meaning that their molars are already sealed, decayed, filled, or un-erupted/missing.

Column c: Dental Sealants

Again, in column b, you will report either the full universe, a minimum of 80% of the universe taken from your EHR, or a sample of 70 patients; then, in column c, you will report the number of patients included in column b who had:

- A sealant on a permanent first molar tooth in the measurement year.

Cross-Table Issues: Tables 6A & 6B

Sometimes, the diagnoses listed in Table 6A and some of the Table 6B, Part 2 measures that we just talked about can cause confusion. Some measures only look like they're the same across both tables, but are really only covering a similar diagnosis or service and are not the same- so the patient universes reported on Table 6B will likely be very different from the total patients with that diagnosis or service reported on Table 6A.

- One example involves asthma. On Table 6A, you'll be reporting all patients with a documented diagnosis (for a visit) of asthma (on Line 5). Although there is an "asthma" measure on Table 6B, the universe there is asking for you to report only the number of patients with *persistent* asthma. So, while the numbers across the two tables will be related (persistent asthmatics being a sub-set of all asthmatics), they are obviously not the same. Additionally, Table 6B only asks about patients between 5 and 64 years of age - a smaller age group than on Table 6A.
- A second example is depression. On Table 6A, you'll report all patients with a documented diagnosis (for a visit) of depression and other mood disorders (on Line 20a). Although Table 6B has a depression measure - Screening for Clinical Depression and Follow-Up Plan (Section M, Line 21) - the patient universe (in column a) will include all of your patients aged 12 and older, whereas Table 6A reports the number of people diagnosed with depression. These are two very different groups of patients, so almost nothing can be assumed about the relationship between them.

So, while you should be aware of the relationships - know that you will need to pay close attention to the inclusion criteria on each table before considering how they should be related.

Knowledge Check

You have reached the end of Part 2 of the Table 6B training module. Before leaving, please take a moment to again test your understanding of some of what we've covered today.

Do the same thing as before - click on YES or NO for each of the statements on the following slides.

Knowledge Check (colorectal cancer screening)

For the Colorectal Cancer Screening measure, there are no exclusion criteria when reporting the universe.

Answer: No

Feedback when correct:

You are correct. You will need to be sure to exclude patients who have been diagnosed with colorectal cancer or colectomy.

Feedback when incorrect:

No, actually there is one, and it is important - any patients who have been diagnosed with colorectal cancer or a colectomy will be excluded from the reporting universe.

Knowledge Check (HIV linkage to care)

For the HIV Linkage to Care measure, the patient's diagnosis of HIV means first diagnosed ever by the health center, and not some other provider.

Answer: Yes

Feedback when correct:

You are correct. The performance measure is the percentage of patients first diagnosed by the health center who were seen for follow-up within 90 days of that diagnosis.

Because the 90-day follow-up window is with respect to the first-ever diagnosis, that diagnosis must have been made by the health center.

Feedback when incorrect:

Sorry, no. The performance measure is the percentage of patients first diagnosed by the health center who were seen for follow-up within 90 days of that diagnosis.

Because the 90-day follow-up window is with respect to the first-ever diagnosis, that diagnosis must have been made by the health center.

Knowledge Check (depression screening)

For the Depression Screening measure, you will report the number of patients aged 12 and older who were screened for depression with a standardized tool, and have a follow-up plan documented if they were considered depressed. The phrase “if they were considered depressed” refers to a clinical judgment by the medical provider.

Answer: No

Feedback when correct:

That's right! There are a number of standardized depression screening tools appropriate for either children/adolescents or adults; each standardized tool will have specific criteria for determining whether the patient's score is indicative of depression.

If the patient meets the criteria indicative of depression, then the patient is "considered depressed."

Feedback when incorrect:

Sorry, no. There are a number of standardized depression screening tools appropriate for either children/adolescents or adults; each standardized tool will have specific criteria for determining whether the patient's score is indicative of depression.

If the patient meets the criteria indicative of depression, then the patient is "considered depressed."

Knowledge Check (dental sealants)

For the Dental Sealants measure, all patients are included: both medical and dental.

Answer: No

Feedback when correct:

You are correct. Your Dental Sealant universe should only include those patients who have seen you for a dental visit. If they are not your dental patient, or did not receive dental services through your contracted, paid referral, you can leave them out of the universe for this measure.

Feedback when incorrect:

Sorry, no. Your Dental Sealant universe should only include those patients who have seen you for a dental visit. If they are not your dental patient, or did not receive dental services through your contracted, paid referral, you can leave them out of the universe for this measure.

Congratulations

Congratulations! You've completed the training on Table 6B!
Thank you for taking the time today to learn about this table and for testing your knowledge. We appreciate your efforts to give us the data we need to support you in your important work.

Review

You can review any topic that we just covered by clicking on the hyperlinks in the Table of Contents on the left of your screen, but if you would like to do something else, click the **NEXT** button to see your options.

Please remember to access and download additional training resources by clicking on the RESOURCES LINK in the upper right-hand corner of your screen.

Resources

These resources allow you to access National- and State-level UDS data; and, other reporting resources such as Quick Fact Sheets, training webinars, and the in-person regional training schedule.

For ongoing questions, you can also email: UDSHelp330@BPHCDATA.NET or call the UDS Helpline toll-free at 866-UDS-HELP.