

Online UDS Trainings

Module 4 – Clinical Information: Tables 6A, 6B, and 7

Slide 1 – Welcome

Welcome to Module 4 of the Bureau of Primary Health Care's 2009 Uniform Data System training. This is the fourth in a series of 9 modules which describe the reporting requirements and step-by-step instructions for completing your 2009 UDS Report.

Slide 2 - Clinical Information: Tables 6A, 6B, and 7

This module provides step-by-step instructions for completing Tables 6A, 6B and 7 which report clinical performance for evaluating quality of care. Module 5 provides a methodology for sampling medical records to complete these tables.

Slide 3 - Table 6A: Selected Diagnoses and Services Rendered

Table 6A reports the number of patients and visits for selected diagnoses and services. The list of services and diagnoses included on Table 6A is not meant to be exhaustive of all health center activity but rather includes selected services and diagnoses important to the health center patients. If the health center receives multiple 330 grants, Table 6A will be completed for the universal and for each special population grant including homeless, migrant and public housing.

Slide 4 - Table 6A: Diagnoses and Services

Lines 1-20d on Table 6A include a selected list of diagnoses. For each diagnosis the health center must report the total number of encounters with the primary diagnosis. Information to complete Table 6A is routinely obtained from claims data. Since claims data are used to complete this table, diagnoses may be underreported if they are not routinely captured as primary diagnoses. For example, grantees that dually diagnosed patients with diabetes and hypertension where diabetes is generally reported as the primary and hypertension as the secondary diagnosis will underreport patients with a diagnosis of hypertension. This is a known limitation of the table.

Lines 21 – 37 list selected services including diagnostic tests, screenings, preventive and dental services. For each service the health center must report the total number of encounters performed for that service. Once again, information to complete Table 6A is routinely obtained from claims data and because of this, services may be underreported if they are not routinely coded. For example, if the health center does not code for pap tests but rather bills a comprehensive visit, the number of pap tests may be underreported. CPT and ICD-9 codes are provided to identify services from claims data. Be sure to use CPT OR ICD-9 but not both or you will be double counting.

To complete table 6A, you are required to use billing data, but you can feel free to supplement your data with other sources if they are available.

Slide 5 - Table 6A

For each diagnosis and service, the total number of patients with that diagnosis or service is reported in column b and the corresponding visits are reported in column a. Each patient is

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counted once and only once on each line in column b although the same patient may be counted on multiple lines if they have other primary diagnoses or services which are reported on Table 6A. Please note that for a single visit only one diagnosis can be counted as there can be only one primary diagnosis. Any additional diagnoses would be secondary or tertiary. When reporting services on lines 21-26c, a single visit might result in the delivery of multiple services and this should be captured on each applicable service line.

Slide 6 - Table 6A

Visits are counted once and only once for any service code even if multiple services are given within that same code. For example, a child might come in and receive several different vaccinations, but this would count as only one visit on the vaccine line. Similarly, a patient may be counted once and only once on each line in the patient column; however, they could have multiple visits throughout the year relating to the primary diagnosis.

Slide 7 - Cross Table Issues

A quick check of the data reported in columns a and b is recommended to be sure that the reported information makes sense. If column a equals column b for all lines, this means that every patient had one and only one encounter for the diagnosis or service, which likely means that one of the columns is incorrect. Similarly, by dividing the number of visits by patients for selected services, a ratio is calculated and can be checked for reasonableness. For example, 10 pap tests per woman is not likely and suggests an error in reporting patients or encounters.

Also, if the health center completes a grant report and the universal report, no cell on the grant report can be greater than that cell on the universal. In other words, there can not be more homeless patients with a diagnosis of hypertension reported on the grant report than total patients with a diagnosis of hypertension reported on Line 11 of the universal report.

Tables 6A and 5 are also related and should be compared for reasonableness. When adding up all of the dental services listed on 6A, we would expect that the total will be larger than the dental visits reported on table 5 as it is likely that a patient might come in and receive multiple services per encounter.

Lastly, tables 6A and 7 should be compared. It's likely that the universe of patients for the clinical measure reported on table 7 will be larger than patients reported on table 6A with a hypertension or diabetes diagnoses as table 6A is limited to primary diagnoses only.

Slide 8 - Table 6B: Quality of Care Indicators

Table 6B reports quality of care measures which can be used to support quality improvement of the clinical program.

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Slide 9 - Quality of Care Indicators

Three quality of care measures are reported on Table 6B. These measures are “process measures” because they report on services provided as a proxy for long term health outcomes. They look at tests and procedures that can be provided now that we think will predict better outcomes down the road. We expect that if we do x, y will likely result. While we cannot document improvement in long term health status in one year, we can look at interim measures which are predictive of good long term outcomes. We know, for example, that a patient who receives timely routine and preventive services is more likely to have good long term health outcomes. Three process measures are reported on Table 6B, the measures include early entry into prenatal care, childhood immunizations, and pap tests. These are process measures because we know that women who enter prenatal care early are more likely to have good birth outcomes. Similarly, children who are immunized are less likely to develop vaccine preventable diseases. And women who receive a timely pap test are more likely to have a better prognosis with early treatment if cancer is detected. The following slides will discuss how each of these measures is reported.

With these measures, it’s improvement that counts. It’s important to understand where you are at, why you’re there, and what you’re going to do about it to improve.

Slide 10 - Early Entry into Prenatal Care

Section A of Table 6B reports prenatal patients by age. This section is completed only if the health center has a prenatal program. If the health center does not provide prenatal services, you should check the box indicating that you do not have prenatal services and skip this section of the table.

For health centers with a prenatal program, you must report the age of all prenatal patients. A prenatal patient is defined as a patient who received any prenatal care during the reporting year whether they delivered during the reporting year or not. Patients who start prenatal services with the health center but transfer to another provider or fail to complete their care with the health center are still reported in this section. Similarly, patients who transfer into the practice from another provider are reported as well. Patients who only received a pregnancy test are not included.

Slide 11 - Early Entry into Prenatal Care

Section B of Table 6B reports all prenatal patients by trimester of entry. The total number of prenatal patients reported by age must equal the number reported by trimester of entry since you are describing the same patients in both Sections A and B. Again, Section B of Table 6B is only completed by health centers who have prenatal programs.

Trimester of entry is defined as the trimester that the prenatal patient had her first visit with a physician or mid-level for her pregnancy. This first visit may be with the health center or another provider. The health center should ask all patients who enter prenatal care if they have been receiving care prior to their first visit with the health center. You will need to determine

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with the patient when care began. It is not necessary to obtain documentation to confirm previous care but it is recommended that the level of care be documented in the medical record.

To complete Section B of the table, you must determine what trimester the patient first received care. That determines what row they will be reported on – First trimester on line 7, second trimester on Line 8 and third trimester on Line 9. Next, you need to record the patient in column a if the first visit was with the health center or column b if the first visit was with another provider. The sum of the six boxes – Lines 7-9 column a and b – must equal the total number of prenatal patients reported on line 6, prenatal patients by age. It's understood that as a health center you have more control over when your own existing patients begin care than you do with patients who are brand new to your center and have not come in prior to visiting for prenatal care.

Slide 12 - Childhood Immunizations

Section C reports the proportion of children aged two who are fully immunized. To complete this section of the table, you must determine the “universe” or total number of children who meet the reporting criteria. The universe is defined as all children who turned two during the reporting year who had at least one medical visit during the reporting year and were first seen prior to their second birthday. In other words, if a child is seen for the first time after they turn two, this patient should not be included in the universe. The total number of children who meet the criteria is reported in column a and represents the universe. This number is very important and must be obtained by using the defined criteria. Even if you are not able to report on the compliance rate of your entire universe, you must be able to determine the universe from which you will pull a sample.

If you have an electronic health record that has all of the information you need to electronically evaluate compliance for this measure, you can report on the universe. Otherwise you should report on a randomly selected sample of 70 patients from the universe. If the universe is less than 70 patients, you will need to report on all patients in the universe. Enter the universe or a sample of 70 patients in column b depending on your method. Report the number of patients out of column b that are that are fully vaccinated in column c.

It's important to note that column b must either equal the universe or 70. You do not get “extra credit” for using a sample size larger than 70 and must adhere to the guidelines of reporting on a sample of exactly 70 or the universe.

Slide 13 - Required Vaccines

To be fully vaccinated a child must have received a vaccine, have documented evidence of disease in the medical record, or a documented contraindication for the vaccine for ALL required vaccines. The health center does not need to have given the vaccine but must have written documentation with the date of each immunization and the immunization provider. This information can be included in the medical record or obtained from a state immunization registry. A list of required vaccines is included on the slide.

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Slide 14 - Additional Vaccine Guidance

The BPHC follows guidelines developed by the National Quality Forum which may not be the same as CDC guidance or state immunization guidelines. For purposes of the UDS reporting, the vaccines listed in the 2009 manual are required for full compliance. There is no such thing as partial compliance. If a child was not vaccinated, does not have documented evidence of disease or contraindication for the vaccine for ALL required vaccinations, they are not fully immunized. While a note in the medical record indicating that the patient received the immunization in the hospital at delivery can be counted as evidence of compliance, a note that a patient is up to date is not sufficient.

Documentation that the parent refused to have the child vaccinated or that the patient failed to return for a scheduled appointment for a vaccine does not constitute compliance.

It's recognized that there are reasons why you might not achieve complete compliance for vaccination. While reasons such as parent refusal do not constitute compliance, keeping track of them can help you to better understand your numbers and can help to inform strategy. If parental refusal is common at your health center, perhaps parent education could help to improve compliance.

Slide 15 - PAP Tests

Section D reports the proportion of women aged 24 to 64 years with at least one pap test in a three year period. To complete this section of the table, you must determine the “universe” or total number of women who meet the reporting criteria. The universe is defined as all women aged 24 to 64 years with at least one medical visit in the reporting year who were seen before age 65 and who have not had a hysterectomy. In addition, the patient must have been seen in a setting where a pap test could be performed. For example, a homeless patient who is only seen in an outreach site without appropriate facilities for a pap test are excluded from the universe. The total number of women who meet the criteria is reported in column a and represents the universe.

If you have an electronic health record that has all of the information you need to electronically evaluate compliance for this measure, you can report on the universe. This means that you must be able to identify any patient with a hysterectomy to exclude the patient from the universe. Otherwise you should report on a randomly selected sample of 70 patients from the universe. If the universe is less than 70 patients, you will need to report on all patients in the universe. Enter the universe or a sample of 70 patients in column b depending on your method.

Report the number of patients in column b that have a documented pap test in the medical record in column c. Again, it is not necessary for the health center to perform the pap test but a copy of the results must be included in the record. A note that the patient was referred or if the patient reported that they had been tested without the result is not evidence of compliance.

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Slide 16 - Handling Exclusions

As reported in the previous slide, women with a hysterectomy are excluded from the universe for this measure. If your Electronic Health Record includes this information, you can report the total number of women aged 24 to 64 who meet all eligibility criteria in columns a and b. This means that both columns a and b will exclude any women with a hysterectomy. The total in column a will equal the total reported in column b.

If your system does not permit you to electronically identify all patients who have had a hysterectomy to exclude them from the universe, you will report on a sample of 70 patients. Since you cannot identify patients with a hysterectomy, the universe reported in column a may include some patients with a hysterectomy but there is no way of knowing. You will learn how to handle the sample in Module 5.

Slide 17 - Additional Pap Test Guidance

To meet compliance of the performance measure, the medical record must include a copy of the test result or a provider note with the test date and result. It is not sufficient to have a note in the chart indicating that the patient said they had had a pap test or that the patient was referred for a pap test. Similarly, the patient is not considered in compliance with the measure if they refuse the test or fail to return for a scheduled test.

Slide 18 - Cross Table Issues

Tables 3A and 5 are interrelated with table 6B in that the universe of patients must be consistent with total patients by age on 3A and or the percentage of patients who are medical patients reported on table 5.

Tables 6B and 7 are also interrelated. Check to make sure that the number of prenatal patients reported on table 6B does not exceed or equal the number of women delivering during the reporting year on table 7.

Slide 19 - Table 7: Outcome and Disparity Measures

Table 7 reports quality of care measures which can be used to support quality improvement of the clinical program.

Slide 20 - Health Outcomes

Three quality of care measures are reported on Table 7. These measures are “intermediate outcome measures” because they report on intermediate outcomes as a proxy for long term health outcomes. While we cannot document improvement in long term health status in one year, we can look at interim outcome measures which are predictive of good long term outcomes. Three intermediate outcome measures are reported on Table 7. These measures include normal birthweight, controlled hypertension and controlled diabetes. These are intermediate outcome measures because we know that normal birthweight infants are less likely to suffer adverse health effects; patients with controlled hypertension have less cardiovascular damage, fewer

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heart attacks and less organ damage; and patients with controlled diabetes are less likely to require amputation, or to develop blindness or organ damage.

Slide 21 – Disparities

Intermediate health outcomes are reported by race and ethnicity. Large national or state sample data aggregated by race and ethnicity can be used to evaluate disparities. Health centers are cautioned against drawing conclusions about disparities based on a small sample. You will note a change in the reporting format relating to race and ethnicity from the prior year. Similarly to table 3B, patients who report their race but do not indicate that they are Latino or Hispanic are assumed to be non Hispanic and should be reported in the second section of columns.

The following slides will discuss how each of the three intermediate outcome measures is reported.

Slide 22 – Birthweight

Section A is completed by health centers with a prenatal program. If the health center does not provide prenatal services to patients, this section should be skipped.

Section A reports all prenatal patients who were included on Table 6B who delivered during the reporting year on Line 1. This includes all of your patients who may have transferred their care to another provider or were delivered by a non-health center provider. While difficult, it is expected that health centers will follow-up with all prenatal patients even those who transfer their care to another provider to complete Table 7. The total prenatal patients will likely be larger than those who delivered during the reporting year as some will deliver in the following year.

The total number of deliveries performed by health center providers is reported on Table 7 Line 2. This is deliveries that are performed by providers for whom you assume malpractice risk. If health center providers do not perform deliveries, you should report “0” deliveries on line 2. If health center providers share call with other providers and deliver non-health center patients, these patients are included on line 2.

Birth outcomes for all live births born to health center patients are reported on lines 3 through 5. Do not include non-health center patient birth outcomes on lines 3 -5. If a delivery results in multiple births, report all births by weight. Stillbirths are not reported. Because of twinning or multiple births, it’s unlikely that the sum of lines 3 through 5 will equal line 1.

Slide 23 - Controlled Hypertension

Section B reports the proportion of adults aged 18 to 85 with controlled hypertension. To complete this section of the table, you must determine the “universe” or total number of adult patients who meet the reporting criteria. The universe is defined as all adults aged 18 to 85 years with at least two medical visit in the reporting year and who were diagnosed prior to June 30, 2009. The reason that 2 medical visits is included in the criteria is to avoid including people who

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are visiting the area or who come in only for episodic care. The total number of adult patients with a diagnosis of hypertension who meet the criteria is reported on line 6 by race and ethnicity.

If you have an electronic health record that has all the information you need to electronically evaluate compliance for this measure, you can report on the universe. This means that you must be able to identify all patients aged 18 to 85 with a diagnosis of hypertension and two medical visits during the reporting year. Since the patient may have been diagnosed in a prior year, this means your health record must include at least 2-3 years of history. Otherwise you should report on a randomly selected sample of 70 patients from the universe. If the universe is less than 70 patients, you will need to report on all patients in the universe. Enter the universe or a sample of 70 patients on Line 7 of Section B depending on your method.

Report the number of patients on Line 8 by race and ethnicity whose most recent blood pressure was less than 140/90. If no blood pressure is documented in the chart, then the patient is considered to be out of compliance with the measure.

Slide 24 - Controlled Diabetes

Section C reports the proportion of adults aged 18 to 75 with controlled diabetes. To complete this section of the table, you must determine the “universe” or total number of adult patients who meet the reporting criteria. The universe is defined as all adults aged 18 to 75 years with at least two medical visit in the reporting year with a diagnosis of diabetes. The total number of adult patients with a diagnosis of diabetes who meet the criteria is reported on line 9 by race and ethnicity.

If you have an electronic health record that has all the information you need to electronically evaluate compliance for this measure, you can report on the universe. This means that you must be able to identify all patients aged 18 to 75 with a diagnosis of diabetes and two medical visits during the reporting year. Since the patient may have been diagnosed in a prior year, this means your health record must include at least 2-3 years of history. In addition, patients with gestational diabetes or steroid-induced diabetes are excluded from the universe and must be identified to report the universe. Otherwise you should report on a randomly selected sample of 70 patients from the universe. If the universe is less than 70 patients, you will need to report on all patients in the universe. Enter the universe or a sample of 70 patients on Line 10 of Section C depending on your method.

Report the result of the most recent HBA1c test result on Lines 11-13 by race and ethnicity. If no HBA1c test result is documented in the chart, then the patient is reported on line 13 as uncontrolled.

Slide 25 - Handling Exclusions

As stated previously, there are some patients who will be excluded from the Universe. Diabetic patients with a diagnosis of gestational diabetes or steroid-induced diabetes fall into the exclusion category. If your Electronic Health Record includes this information, you can report

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the universe on Line 9. This means that the total reported on line 9 will equal the total reported on line 10.

If your system does not permit you to electronically identify all patients who meet all criteria, you will report on a sample of 70 patients. If there are less than 70 patients in the universe, you must report on all patients. Since you cannot identify patients with a gestational diabetes or steroid-induced diabetes diagnosis, the universe reported in column a may include some patients with these diagnoses but there is no way of knowing. You will learn how to handle the sample in Module 5.

Slide 26 - Cross Table Issues

It's important to consider and review other tables when completing table 7. Tables 3A, 3B, and 5 are interrelated to table 7. Patients reported by race and Latino or Hispanic Identity reported on table 7 can not exceed total projected medical patients of the same race or ethnicity reported on table 3B. Similarly, patients reported on table 7 for each of the measures can not exceed total projected medical patients by age reported on table 3A.

Also as stated previously, you will need to compare tables 6A and 7. It is expected that patients reported on 6A with hypertension or diabetes will be less than the number reported on table 7 as 6A includes only those with a primary diagnosis.

Slide 27 - Thank You

Thank you for viewing this module. If you are interested in learning more about the UDS reporting requirements and step-by-step instructions for completing the UDS tables, please be sure to visit the other modules available online.

Slide 28 – Module 4 Quiz/Survey

Now that you've viewed module 4, let's see how much you've learned! Please take a few moments to complete a short quiz. To access the quiz, click on the link on this slide. Your participation will help to show how well you understand the content of this module, and will help us to improve our training program for next year.