

## INSTRUCTIONS FOR TABLE 6B – QUALITY OF CARE MEASURES

Table 6B is included only in the Universal report. It is completed by all health centers.

This table reports data on selected quality of care measures. The quality of care measures have historically been seen in the health care community as indicators of overall community health. More recently, they have become critical elements in the implementation of the national drive to implement Electronic Health Records (EHRs). BPHC first implemented these measures in 2008 and has been updating and adding to them since then. As health centers continue to implement their EHRs, BPHC will continue to revise and expand these measures consistent with the National Quality Strategy and other national quality initiatives.

These quality of care measures are “process measures” which means that they document services which are thought to be correlated with and serve as a proxy for good long term health outcomes. We know that individuals who receive timely routine and preventive care are more likely to have improved health status. Thus, by increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, we can expect improved health status of the patient population in the future. Specifically:

- **Early entry into prenatal care:** *If women enter care in their first trimester then the probability of adverse birth outcome will be reduced.*
- **Childhood immunizations:** *If children receive their vaccinations in a timely fashion then they will be less likely to contract vaccine preventable diseases or to suffer from the sequela of these diseases.*
- **Pap tests:** *If women receive Pap tests as recommended then they can be treated earlier and will be less likely to suffer adverse outcomes from HPV and cervical cancer.*
- **Weight assessment and counseling for children and adolescents:** *If clinicians ensure that their patients’ body mass indicator (BMI) percentile is recorded, and if patients (and parents) are counseled on nutrition and physical activity (regardless of the patient’s weight) then the likelihood of obesity and its sequela will be reduced.*
- **Adult Weight screening and follow-up:** *If clinicians routinely calculate and record the BMI for their adult patients, and IF they identify patients with weight problems and develop a follow-up plan for overweight and underweight patients, then the likelihood of the debilitating sequela of serious weight problems can be reduced.*
- **Tobacco use assessment:** *If patients are routinely queried about their tobacco use (including smokeless tobacco) then providers will be able to intervene more quickly and effectively and reduce the incidence of cancer, asthma, emphysema, and other tobacco related illnesses.*
- **Tobacco use intervention:** *If tobacco users are provided with an effective mix of counseling and pharmacologic intervention then tobacco users will be more likely to quit smoking and will therefore have a lower incidence of cancer, asthma, emphysema, and other tobacco related illnesses.*
- **Pharmacologic treatment of asthmatics:** *If patients identified with persistent asthma are provided with appropriate pharmacological intervention then they will be less likely to have asthma attacks, they will require fewer emergency room visits, and be less likely to develop complications related to asthma including death.*
- **Coronary artery disease (CAD) and lipid lowering therapy:** *If clinicians ensure that patients with established coronary artery disease receive lipid lowering therapy then the likelihood of CAD related clinical events will be reduced.*
- **Ischemic Vascular Disease (IVD) and antithrombotic therapy:** *If clinicians ensure that*

patients with established ischemic vascular disease (IVD) use aspirin or another antithrombotic drug, *then* the likelihood of myocardial infarctions, and other vascular events can be reduced.

- **Colorectal cancer screening:** *If* patients 50 to 75 years old receive appropriate colorectal screening *then* early intervention is possible and premature death can be averted.

While the selected quality of care measures give a good overall description of the overall quality of primary care being provided at the center, it is clear that this is a *subset* of possible quality of care measures. The clinical quality measures described in this manual *must* be reported by all health centers. However, individual health centers may use *additional* measures, including modified versions of these measures in their grant applications, or for other internal purposes at their discretion.

## **SECTIONS A AND B: DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS**

Only health centers that provide or assume primary responsibility for some or all of a patient's prenatal care, whether or not the health center does the delivery, are required to complete Sections A and B. Health centers who do not provide prenatal care will indicate this by checking a box at the beginning of the table.

### **SECTION A: AGE OF PRENATAL CARE PATIENTS (Lines 1-6)**

Report the total number of patients who received prenatal care services *at any time during the reporting period* by age group. Be sure to include all women receiving any prenatal care during the reporting year, including the delivery of her child, regardless of when that care was initiated, including women who:

- began prenatal care during the previous reporting period and continued into this reporting period
- began care and delivered during the reporting year
- began their care in this reporting period, but will not/did not deliver until the next year.

“Total prenatal patients” includes patients who:

- receive all their perinatal care from the health center
- began prenatal care with another provider but transferred to the health center
- began prenatal care with the health center, but were transferred to another provider at some point during their prenatal care
- were provided with all their prenatal care by a health center provider, but were delivered by another provider.

To determine the appropriate age group, use the woman's age on June 30 of the reporting period. As many as half of all patients reported will usually have been reported in the prior year or will be reported in the next year. The total number of women reported in Section A on line 6 *must be equal to* the total women reported in section B – Trimester of Entry into Prenatal Care.

### **SECTION B: ENTRY INTO PRENATAL CARE MEASURE (Lines 7-9)**

**PERFORMANCE MEASURE:** The performance measure is “Proportion of prenatal care patients who entered treatment during their first trimester.” The measure itself, which is not dependent on which category of performance measurement achievement a woman might fall into, is calculated as follows:

- **Numerator:** Number of women entering prenatal care during their first trimester

(Line 7, Columns A+B)

- **Denominator:** Total number of women seen for prenatal care during the year (Line 7 + Line 8 + Line 9, Columns A+B)

#### **DETAILED INSTRUCTIONS FOR CLINICAL MEASURE:**

All patients who received prenatal care including, but not limited to, the delivery of a child during the reporting period, are reported on Lines 7 - 9. A number of criteria are used to identify how women are reported:

- The trimester is determined by the trimester of pregnancy that the woman was in *when she began prenatal care* either at one of the health center's service delivery locations or with another provider.
- A woman who begins her prenatal care with the health center is reported once and only once in Column A.
- A woman who begins her prenatal care at another provider and then transfers to the health center, is counted once and only once in Column B, and is *not* counted in Column A.
- Prenatal care is considered to have begun at the time the patient has her *first visit* with a physician or NP, PA, or CNM provider who initiates prenatal care with a complete physical exam. This visit is considered the "first visit" for UDS purposes.
- Prenatal care is *not* initiated when the patient is found to be pregnant, when she registers for care at the center, has lab tests or psycho-social or nutritional assessments done, or has a history taken. Virtually all women will be seen once or twice in the clinic before prenatal care actually begins.
- A woman is counted only once regardless of the number of trimesters during which she receives care.
- In those rare instances where a woman is in treatment for two separate perinatal courses of care in the same year, she is to be counted twice. (This can occur if a woman delivers, for example, in January and then becomes pregnant again in October.)

**FIRST TRIMESTER (Line 7)** Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be pregnant anytime through the end of the 13th week after conception<sup>2</sup>. If the woman began prenatal care during the first trimester at the health center's service delivery location, she is reported on Line 7 in Column A; if she received prenatal care from another provider during the first trimester before coming to the health center's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with health center.

**SECOND TRIMESTER (Line 8)** Includes women who received prenatal care during the reporting period whose "first visit" occurred when she was estimated to be between the start of the 14<sup>th</sup> week and the end of the 26<sup>th</sup> week after conception. If the woman began prenatal care during the second trimester at the health center's service delivery location, she is reported on

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<sup>2</sup> Obstetricians commonly count time from last reported menstrual period (LMP). Since this is two weeks earlier than conception, the first trimester would be considered up through 15 weeks post-LMP. The second trimester is through 28 weeks post-LMP. Trimester may be based on other data if LMP data are not available.

Line 8 in Column A; if she received prenatal care starting in the second trimester from another provider before coming to the health center's service delivery location, she is reported on line 8 in Column B, regardless of when she begins care with health center.

**THIRD TRIMESTER (Line 9)** Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be 27 weeks or more after conception. If the woman began prenatal care during the third trimester at the health center's service delivery location, she is reported on Line 9 in Column A; if she received prenatal care from another provider starting the third trimester before coming to the health center's service delivery location, she is reported on Line 9 in Column B, regardless of when she begins care with health center. (Note that it is highly unusual for the number in column B to be very large or larger than that in column A since it would require women to have begun care and then transferred in a very short period of time.)

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received perinatal care from the health center during the calendar year, *and is equal to the number reported on Line 6*. All prenatal women must be reported here, regardless of when they entered care (this year or last year) or when they deliver (this year or next year).

## **SECTIONS C THROUGH K: OTHER QUALITY OF CARE MEASURES**

In these sections, health centers will report on the findings of their reviews of services provided to targeted populations of current medical patients (i.e., patients who had a medical visit at least once during the reporting period). These targeted populations are:

### **SECTION C: CHILDHOOD IMMUNIZATION (Line 10)**

Children with at least one medical visit during the reporting period, who had their third birthday during the reporting period or on the following January 1, and who were first seen ever by the health center prior to their third birthday are reported on Line 10. For the purposes of this year's reporting this includes children whose date of birth is between January 2, 2010 and January 1, 2011.<sup>3</sup>

### **SECTION D: PAP TESTS (Line 11)**

Women aged 21 through 64 with at least one medical visit during the reporting period, who were first seen by the health center at some point prior to their 65<sup>th</sup> birthday are reported on Line 11. For the purposes of this year's reporting this includes women whose date of birth is between January 1, 1949 and December 31, 1989. (NOTE: This is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 in the reporting period should be included in the calculation of this measure.)

### **SECTION E: WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS (Line 12)**

Children and adolescents aged 3 until 17 with at least one medical visit during the

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<sup>3</sup> These dates are the result of the criteria reading "before their third birthday" as opposed to the old criteria which was "by their second birthday."

reporting period, who had their third birthday during or prior to the reporting period, and who were first seen ever by the health center prior to their 17<sup>th</sup> birthday are reported on Line 12. For the purposes of this year's reporting this includes children and adolescents whose date of birth is between January 1, 1996 and December 31, 2010.

**SECTION F: ADULT WEIGHT SCREENING AND FOLLOWUP (Line 13)**

Adults age 18 or older with at least one medical visit during the reporting period and seen after their 18<sup>th</sup> birthday are reported on Line 13. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1995.

**SECTION G1: TOBACCO USE ASSESSMENT (Line 14)**

Adults age 18 or older, seen after 18<sup>th</sup> birthday, with at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 14. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1995.

**SECTION G2: TOBACCO CESSATION INTERVENTION (Line 15)**

Adults age 18 or older, seen after 18<sup>th</sup> birthday, who used tobacco products within the past 24 months, who had at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 15. For the purposes of this year's reporting this includes all tobacco using medical patients who were born on or before December 31, 1995.

**SECTION H: ASTHMA PHARMACOLOGIC THERAPY (Line 16)**

Patients age 5 through 40 with at least one medical visit during the reporting period and at least two visits ever, with a diagnosis of mild, moderate or severe persistent asthma are reported on Line 16. For the purposes of this year's reporting this includes all persistent asthmatic patients born between January 1, 1973 and December 31, 2008.

**SECTION I: CORONARY ARTERY DISEASE (CAD) AND LIPID LOWERING THERAPY (Line 17)**

Adults age 18 or older, seen after their 18<sup>th</sup> birthday, who had at least one medical visit during the reporting period, and with at least two medical visits ever, who have an active diagnosis of CAD including myocardial infarction (MI) or who have had cardiac surgery, are reported on Line 17. For the purposes of this year's reporting this includes medical patients meeting the clinical profile who were born on or before December 31, 1995.

**SECTION J: ISCHEMIC VASCULAR DISEASE (IVD) AND ASPIRIN OR OTHER ANTI-THROMBOTIC THERAPY (Line 18)**

Adults age 18 or older, seen after 18<sup>th</sup> birthday, who had at least one medical visit during the reporting period who, (1) during the current or prior year, were diagnosed with IVD **OR** (2) were discharged after coronary artery bypass surgery (CABG) or percutaneous transluminal coronary angioplasty (PTCA) or acute myocardial infarction (AMI) between January 1 and November 1 of the year prior to the measurement year are reported on Line 18. For the purposes of this year's reporting this includes all medical patients meeting the clinical profile who were born on or before December 31, 1995.

**SECTION K: COLORECTAL CANCER SCREENING (Line 19)**

Adults age 51 through 74, who had at least one medical visit during the reporting period, are reported on Line 19. For the purposes of this year's reporting this includes medical patients whose date of birth is between January 1, 1939 and December 31, 1962.

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling (methods described in Appendix C) or through the use of Electronic Health Records (EHRs) whose templates and reporting features permit the recovery of all records for 100% of the patients who fit the criteria described in this section.

For each of the populations being surveyed, rigid and specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings. (Special care must be taken since mistakes in this area may potentially portray a higher or lower quality of care than is actually the case.)

## COLUMN INSTRUCTIONS

### **COLUMN A: NUMBER OF PATIENTS IN THE "UNIVERSE"**

Enter the total number of health center patients who fit the detailed criteria described below. Note that this will no doubt include a number of patients who have not received the specific service being measured. Because these populations are *initially* defined in terms of age (or age and gender), comparisons to the numbers on Table 3A will be made. But, because *all* patients are counted on Table 3A, and only medical patients or medical patients with specific conditions are surveyed for Table 6B, and because Table 3A measures age as of June 30<sup>th</sup>, the numbers will not be equal to those which might be calculated from Table 3A.

Column A will reflect the total number of patients meeting the criteria in the agency's total patient population including all sites and all programs. Because some patients come in for a single visit or a single service (for example women's health) it is probable that their records will not meet the measurement standard. This is to be expected.

### **COLUMN B: NUMBER OF CHARTS/RECORDS SAMPLED OR EHR TOTAL**

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will either be all patients who fit the criteria (and hence the same number as the universe reported in column A) or a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population identified as the universe. Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms as this will result in over-sampling some group of patients.

If an EHR is present it may be used in lieu of a review of a sample of charts if and only if:

- The EHR *includes* every single clinic patient who meets the criteria described below for inclusion in the universe.
- The EHR *excludes* every single clinic patient who meets one or more exclusion criteria described below for exclusion from the universe.
- Every item in both the inclusion and the exclusion criteria is regularly recorded for all patients.
- The EHR has been in place long enough to be able to find the data required in prior year's activities. This means a minimum of three calendar years of full operation of the EHR (or importation of data for such a period) must be in place

before it can be used in lieu of chart audits for the childhood immunizations, Pap test, smoking and asthma measures. At least two full calendar years of operation of the EHR must be present for the adult and pediatric weight measures as well as the CAD, IVD and colorectal cancer measures.

If the EHR is to be used in lieu of the chart audit, the number in Column B will be equal to the number in Column A.

### **COLUMN C: NUMBER OF CHARTS/RECORDS MEETING THE MEASUREMENT STANDARD**

Enter the total number of records which meet the measurement standard as discussed below. The number in Column C (patients meeting the measurement standard) may never exceed the number in Column B (patient records reviewed).

### **DEFINING THE UNIVERSE: “CRITERIA” vs. “EXCLUSIONS” IN EHRs vs. CHART REVIEWS**

Because the UDS follows the structure developed for meaningful use and other systems, a condition may sometimes be listed as a criteria and sometimes as an exclusion. They should be treated as described here to either constrain the universe of an EHR report or identify charts to be replaced in a chart review process.

In the discussion which follows the concepts of “conditions” or “criteria” are at times juxtaposed with “exclusions.” This is partly because of the differing language and procedures in an EHR (or PMS) based report vs. a Chart Audit report. In an EHR or PMS review, all criteria spelled out for a measure must be able to be found in the EHR and must be in the EHR for each and every patient at the health center. To the extent that it cannot be found, it will distort the findings, and means that the EHR must not be used. If, for example, the EHR cannot differentiate between a medical patient and a dental-only patient, then the EHR cannot be used to review the immunization of two year olds because we cannot limit the universe to medical patients.

In a sample chart review process, an item listed as a “criteria” below may be used as an “exclusion.” Thus, we can ask that all three year old patients be listed but, if our sample includes someone who turns out to be a dental (only) patient, we can “exclude” that chart from the sample and replace it with another chart.

### **DETAILED INSTRUCTIONS FOR CLINICAL MEASURES**

What follows is a detailed discussion of each of the clinical measures. BPHC recognizes that some health centers may have different staff people working on each of the measures. Because of this, these pages have been designed so that the instructions for each of the measures is complete in and of itself. As a result, instructions that apply to more than one measure will nonetheless be duplicated to permit extraction of that portion of the manual.

In this section, when conditions are linked with “**AND**” it means that each of the conditions must be met independently. If some, but not all of the conditions are met, the services for that patient are considered to have failed to meet the measurement standard.

Note that some of the newer measures do not correspond directly with traditional ICD-9 or CPT codes. As a result, we have also included some CPT Category II codes (shown as CPT-II) which are specific to performance measures. These may be found in an appendix to most CPT manuals titled Category II Codes or on-line at <http://www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes-alpha-listing-clinical->

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## CHILDHOOD IMMUNIZATIONS (Line 10)

**PERFORMANCE MEASURE:** The performance measure is “Percentage of children with their 3<sup>rd</sup> birthday during the measurement year or January 1<sup>st</sup> of the following year who are fully immunized before their third birthday.” This is calculated as follows:

- **Numerator:** Number of children among those included in the denominator who were fully immunized before their 3<sup>rd</sup> birthday<sup>4</sup>. A child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate, prior to their third birthday.
- **Denominator:** Number of all children with at least one medical visit during the reporting period, who had their 3<sup>rd</sup> birthday during the reporting period or a sample of 70 of these children. For measurement year 2013, this includes all children with date of birth between January 2, 2010 and January 1, 2011. Children who were never seen by the clinic prior to their third birthday are to be excluded. There will no doubt be a number of children for whom no vaccination information is available and/or who were first seen at a point when there was simply not enough time to fully immunize them prior to their third birthday. They still must be included in the universe and thus in the denominator.

### TOTAL NUMBER OF PATIENTS WITH 3<sup>rd</sup> BIRTHDAY DURING MEASUREMENT YEAR, COLUMN (A)

Enter number of children who:

- Were born between January 2, 2010 and January 1, 2011, *and*
- Had at least one medical visit during the reporting year, including children who were seen only for the treatment of an acute or chronic condition and those who were never seen for well child care *and*
- Were seen for the first time ever prior to their third birthday. (This could have been in 2010, 2011, 2012, or 2013.)

Include all children meeting this criterion regardless of whether they came to the health center for well child services<sup>5</sup> or other medical services which include vaccinations or they came for treatment of an injury or illness. *Note that children whose only service was receipt of a vaccination, and who never received other services, are not to be counted as patients on any of the demographic tables and are not included in the universe for this table.*

Children who had a contraindication for a specific vaccine should be included in the universe. In your review, they should be counted as being “compliant” for that specific vaccine and then reviewed for the administration of the rest of the vaccines. Contraindications should be looked for as far back as possible in the patient’s history. The following may be used to identify contraindications which permit allowable vaccination-exclusions:

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<sup>4</sup> This measure, designated the “catch-up” measure *and is aligned with the Healthy People 2020 measure*, requires vaccinations *before the patient’s third birthday*. The vaccinations listed for this criteria are to be provided by the end of the 18<sup>th</sup> month. By establishing the date as the end of the 35<sup>th</sup> month there is an eighteen month grace period built into the measure.

<sup>5</sup> Health centers should add to their universe those patients whose only visits were well child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your State uses different codes for EPSDT visits, those codes should be added as well.

- **Any particular vaccine:** Allergic reaction to the vaccine or its components: ICD-9: 999.4.
- **DTaP:** Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine).
- **VZV, MMR:**
  - ❖ Immunodeficiency, including genetic (congenital) immunodeficiency syndromes ICD-9: 279.
  - ❖ HIV-infected or household contact with HIV infection ICD-9: Infection V08, symptomatic 042 or 079.53.
  - ❖ Cancer of lymphoreticular or histiocytic tissue ICD-9: 200-202.
  - ❖ Multiple myeloma ICD-9: 203. Leukemia ICD-9: 204-208.
  - ❖ Allergic reaction to neomycin.
- **IPV:** Allergic reaction to streptomycin, polymyxin B, or neomycin.
- **Hib:** None.
- **Hepatitis B:** Allergic reaction to common baker's yeast.
- **Pneumococcal conjugate:** None.

#### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column A) or a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

#### **NUMBER OF PATIENTS IMMUNIZED, COLUMN (C)**

Enter in column C the number of children from column B who have received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate prior to their 3<sup>rd</sup> birthday. In addition to those who have documentation of receiving the vaccine, count any of the following as documenting meeting the measurement standard for a given vaccine: evidence of the antigen, contraindication for the vaccine, documented history of the illnesses, or a seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all the antigens.

- **DTaP/DT:** At least four DTaP before the child's third birthday. Any vaccination administered prior to 42 days after birth cannot be counted. DT vaccine does not contain pertussis and can be used as a substitute for children who cannot tolerate pertussis vaccine.
- **IPV:** At least three polio vaccinations (IPV) with different dates of service before the child's third birthday. IPV administered prior to 42 days after birth cannot be counted.
- **MMR:** At least one measles, mumps and rubella (MMR) vaccination, with a date of service falling before the child's third birthday.
- **HIB:** Three H influenza type B (HiB) vaccinations, with different dates of service before the child's third birthday. HiB administered prior to 42 days after birth cannot be

counted.

- **Hepatitis B:** Three hepatitis B vaccinations, with different dates of service before the child's third birthday.
- **VZV (Varicella):** At least one chicken pox vaccination (VZV), with a date of service falling on or after the child's first birthday and before the child's third birthday.
- **Pneumococcal conjugate:** At least four pneumococcal conjugate vaccinations before the child's third birthday.
- The following ICD-9 and/or CPT codes are evidence of meeting the measurement standard. NOTE: Additional vaccines for these diseases – especially combination vaccines – may have been approved and their CPT codes may be added by health centers to demonstrate meeting the measurement standard. Others listed here, especially those for single diseases covered by the MMR or MMRV vaccines may no longer be manufactured. NOTE ALSO: Many State and county entities participating in the Vaccines for Children (VFC) program assign their own unique codes to some or all of these vaccines. It is the intent of this report to include all such codes as well.

**DTaP:** CPT (90698, 90700, 90701, 90720, 90721, 90723); ICD-9 (99.39)

**Diphtheria and tetanus:** CPT (90702)

**Diphtheria:** CPT (90719); ICD-9(VO2.4\*, 032\*, 99.36)

**Tetanus:** CPT (90703); ICD-9 (037\*, 99.38)

**Pertussis:** ICD-9 (033\*, 99.37)

**IPV:** CPT (90698, 90713, 90723); ICD-9 (V12.02\*, 045\*, 99.41)

**MMR:** CPT (90707, 90708, 90710); ICD-9 (055\*, 99.45)

**Measles:** CPT (90705, 90708); ICD-9 (055\*, 99.45)

**Mumps:** CPT (90704,90710); ICD-9 (072\*, 99.46)

**Rubella:** CPT (90706, 90707, 90708,90710); ICD-9 (056\*, 99.47)

**Hib:** CPT (90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748); ICD-9 (041.5\*, 038.41\*, 320.0\*, 482.2\*)

**Hepatitis B:** CPT (90723, 90740, 90744, 90747, 90748); ICD-9 (VO2.61\*, 070.2\*, 070.3\*) **VZV:** CPT (90710, 90716); ICD-9 (052\*, 053\*)

**Pneumococcal conjugate:** CPT (90669,90670)

\* Indicates evidence of disease. A patient who has evidence of the disease prior to age three is compliant for the antigen.

For immunization information obtained from the medical record, count patients as meeting the measurement standard for a given vaccine where there is evidence that the vaccine was given from (1) a chart note indicating the name of the specific antigen and the date of the immunization, or (2) a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. Immunization information may also be obtained from an immunization registry maintained by the State or other public body as long as it shows comparable information, but immunization registries generally do not update the EHR data set automatically and may require several queries to use. Registries can be used to fill in any voids in the immunization record at the health center, especially when a sample is used.

For documented history of illness or a seropositive test result, find a note indicating the date of

the event. The event must have occurred prior to the patient's third birthday and been confirmed by a clinical provider.

Notes in the newborn discharge record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator for some immunizations. This applies only to those vaccines that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of immunization agents does not constitute sufficient evidence of immunization for this measure, nor does verbal assurance from a parent or other person that a vaccine has been given.

Also, good faith efforts to get a child immunized *which fail* do not meet the measurement standard, including:

- Parental failure to bring in the patient
- Parents who refuse for religious reasons
- Parents who refuse because of beliefs about vaccines

To be counted as meeting the measurement, a child must be documented as being compliant for each and every vaccine.

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## PAP TESTS (Line 11)

**PERFORMANCE MEASURE:** The performance measure is "Percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer." (Note – this is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 should be included in the calculation of this measure.) *This measure has been changed from that used in 2012.* This is calculated as follows:

- **Numerator:** Number of female patients 24 - 64 years of age receiving one or more documented Pap tests during the measurement year or during the two years prior to the measurement year among those women included in the denominator; OR, for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, during the measurement year or during the four years prior to the measurement year. Because of the difficulty in obtaining records from third parties, it is likely that a number of women will not be able to be counted as meeting the measurement standard, even though the health center has referred the patient for services.
- **Denominator:** Number of all female patients age 24 - 64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women. For measurement year 2013, this includes patients with a date of birth between January 1, 1949 and December 31, 1989.

## TOTAL NUMBER OF FEMALE PATIENTS 24 - 64 YEARS OF AGE, COLUMN (A)

**Criteria:** Enter the number of all female patients who:

- Were born between January 1, 1949 and December 31, 1989 *and*
- Were first seen by health center prior to their 65<sup>th</sup> birthday *and*

- Had at least one medical visit in a clinical setting<sup>6</sup> during 2013.

**Exclude** women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient's history, through either administrative data or medical record review. Surgical codes for hysterectomy are: CPT (51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58551, 58552-58554, 58951, 58953-58954, 58956, 59135) and ICD-9-CM (68.4-68.8, 618.5) NOTE, however: Because very few health centers perform hysterectomies, the chance of finding these CPT codes is small. The record may, however, contain textual reference to the procedure, and should be searched for this in the event no current Pap test is identified.

If a system cannot determine exclusions from the universe, “excludable” women may be included in the universe and only later excluded from the sample, if identified. In these cases, a replacement record will be used<sup>7</sup>.

#### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column A), or a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

If a woman in the random selection is found to meet the exclusion criteria, the record is removed from the sample and another woman should be randomly selected to replace her. This can best be accomplished by selecting replacement cases at the same time that the random sample is identified.

#### **NUMBER OF PATIENTS TESTED, COLUMN (C)**

Enter the total number of female patients included in the sample, who either

- received one or more Pap tests in a three year period from 2011 through 2013 *or*
- received one or more Pap tests in a five year period from 2009 through 2013 *and* was 30 years of age or older at the time of her last Pap test *and* chose to have a Pap test and an HPV test done simultaneously.

Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. A patient is counted as having had a Pap test if a visit

<sup>6</sup> The requirement of “in a medical setting” is explicitly designed to exclude from the universe women encountered by homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit Pap tests to be conducted. Mobile clinics that are designated by the health center as approved “sites” *are* considered to be clinical settings and women seen in these clinics *are* included in the universe. This should not be construed to imply that these women do not *need* the test.

<sup>7</sup> Since the universe for this measure will generally include thousands of women, searching the charts of all non-compliant women would be problematic. If a health center chooses to use an EHR which is not configured to identify surgical procedures provided outside of the clinic they will need to accept a somewhat lower achievement rate of the measurement standard.

contains any one of the following codes or if a copy of a lab test performed by another provider is in the chart. A chart note which documents the name, date, and results from a test performed by another provider which is based on communications between the clinic and the provider is also acceptable.

The following ICD-9 and/or CPT codes are evidence of meeting the measurement standard:

CPT (88141-88155, 88164-88167, 88174-88175)

ICD-9-CM (91.46, V72.32)

Do not count as meeting the measurement standard, charts which note a referral to a third party but which do not include a copy of the lab report or a report of some form from the clinician/clinic that provided the test. Do not count as meeting the measurement standard unsubstantiated statements from patients which cannot be backed up with third party documentation. Do not count as compliant charts which note the refusal of the patient to have the test.

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## **WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS (Line 12)**

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 2<sup>8</sup> until 17 who had evidence of BMI *percentile* documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.” Note that, while this measure is titled “2 until 17,” health centers should only review the charts of children who were at least 3 years old during the measurement year. This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.
- **Denominator:** Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16<sup>th</sup> birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting year, and were seen by the health center for the first time prior to their 17<sup>th</sup> birthday **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth between January 1, 1996 and December 31, 2010.

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<sup>8</sup> This measure commonly refers to patients who are *two* years old, however the specific measurement standard criteria is that they have the required services “within one year after reaching two years . . .” This means that a patient who is two (or two and a half) years old on December 31 and has not had the required counseling still has six months to a year to meet the criteria for meeting the measurement standard, hence the use of “three years” as the criteria.

### **TOTAL NUMBER OF PATIENTS 3 through 17 YEARS OF AGE, COLUMN (A)**

**Criteria:** Enter the number of all patients who:

- Were born between January 1, 1996 and December 31, 2010 **AND**
- Were first seen ever by the health center prior to their 17<sup>th</sup> birthday **AND**
- Had at least one medical visit<sup>9</sup> in a clinical setting<sup>10</sup> during 2013.

**Exclusions:** Pregnant patients.

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population. Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

### **NUMBER OF PATIENTS WITH DOCUMENTED COUNSELING AND BMI PERCENTILE, COLUMN (C)**

Enter the total number of patients identified in column B whose 2013 record demonstrates that their BMI percentile (not just height and weight or numeric BMI score from which the BMI percentile can be calculated) was documented during the measurement year **AND** that they received counseling on nutrition during the measurement year **AND** counseling on physical activity during the measurement year.

The following ICD-9 and/or CPT codes are evidence of meeting the measurement standard:

- Codes V85.5x are for recording BMI percentile. Presence is sufficient, but not necessary.
- Codes 97802-97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary.
- ICD-9 code V65.41 is sufficient, but not necessary for physical activity counseling.

Do not count as meeting the performance measure, charts which show *only* that a well child visit was scheduled, provided or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

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## **ADULT WEIGHT SCREENING AND FOLLOW-UP (Line 13)**

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 18

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<sup>9</sup> Health centers should add to their universe those patients whose only visits were well child visits (99382, 99383, 99392, 99393) if their automated system does not include them. In addition, if your State uses different codes for EPSDT visits, those codes should be added as well.

<sup>10</sup> The requirement of “in a medical setting” is explicitly designed to exclude from the universe children and adolescents whose only visits have been in homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the health center as approved “sites” **are** considered to be clinical settings and children and adolescents seen in these clinics **are** included in the universe.

and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit **OR** within six months of the most recent visit **AND** if the most recent BMI is outside parameters, a follow-up plan is documented.
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth on or before December 31, 1995.

### **TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (A)**

**Criteria:** Enter the number of all patients who:

- Were born on or before December 31, 1995 **AND**
- Were last seen by the health center after their 18<sup>th</sup> birthday **AND**
- Had at least one medical visit in a clinical setting<sup>11</sup> during 2013.

**Exclusions:**

- Pregnant women
- Terminally ill patients (no definition is provided)

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

### **NUMBER OF PATIENTS WITH DOCUMENTED BMI AND COUNSELING IF WEIGHT IS OUTSIDE PARAMETERS, COLUMN (C)**

Enter the total number of patients identified in Column B whose 2013 record demonstrates that their BMI (not just height and weight) was documented during their last visit or within six months prior to that visit, **AND** which demonstrates that they received a follow-up plan to address their weight if they

- were under age 65 **AND** their BMI was over 25 **OR**
- were age 65 or older **AND** their BMI was over 30 **OR**
- were under age 65 **AND** their BMI was under 18.5 **OR**
- were age 65 or older **AND** their BMI was under 22

The following codes are evidence of meeting the measurement standard:

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<sup>11</sup> The requirement of “in a medical/clinical setting” is explicitly designed to exclude from the universe patients whose *only* visits have been in homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the health center as approved “sites” **are** considered to be clinical settings and patients seen in these clinics **are** included in the universe.

CPT: (CPT-II: 3008F = BMI documented) *sufficient but not necessary*  
ICD-9: V65.3 = dietary surveillance and counseling *sufficient but not necessary* for follow-up plan

Documentation in the medical record must show the actual BMI. Do not count as meeting the measurement standard, charts or templates which display *only* height and weight. The fact that an EHR is capable of calculating BMI does not replace the presence of the BMI itself.

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## TOBACCO USE ASSESSMENT (Line 14)

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 18 and older who were queried about any and all forms of tobacco use at least once within 24 months.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **OR** within 24 months of the most recent visit.
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, seen after 18<sup>th</sup> birthday, with at least one medical visit during the reporting year, and with at least *two*<sup>12</sup> medical visits ever, **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth on or before December 31, 1995.

### TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (A)

**Criteria:** Enter the number of all patients who:

- Were born on or before December 31, 1995 **AND**
- Were last seen by health center after their 18<sup>th</sup> birthday **AND**
- Had at least one medical visit during 2013 **AND**
- Had at least two medical visits ever.

**Exclusions:**

- (None)

### NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

### NUMBER OF PATIENTS QUERIED ABOUT TOBACCO USE, COLUMN (C)

Enter the total number of patients identified in Column B whose 2013 record demonstrates that

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<sup>12</sup> Two visits are specified in order to ensure that the patient has a relationship with the health center. The universe *may* be enlarged to include other patients whose relationship is demonstrated by having had a behavioral assessment, concomitant occupational therapy or concomitant mental health visits, however health centers are not expected to search for these patients.

they had been asked about their use of any and all forms of tobacco at their most recent visit or at a visit within 24 months of the last visit.

The following codes will be useful in identifying meeting the measurement standard:

CPT / ICD-9: (CPT-II codes):

- 1000F = Tobacco use assessed
- 1034F = Current tobacco smoker
- 1035F = Current smokeless tobacco user (e.g., chew, snuff)
- 99406-07 = Smoking and tobacco use cessation counseling – sufficient, but not necessary
- 305.1, 649.00-649.04 = Tobacco use disorder – sufficient, but not necessary
- 1036F = Current tobacco non-user

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## TOBACCO CESSATION INTERVENTION (Line 15)

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 18 and older who were identified as users of any and all forms of tobacco during the program year or the prior year (i.e., during 2012 or 2013) who received tobacco use intervention (cessation counseling and/or pharmacological intervention).” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received tobacco cessation counseling or smoking cessation agents during their most recent visit **OR** within 24 months of the most recent visit.
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, seen after their 18<sup>th</sup> birthday, who were identified as a tobacco user at some point during the prior twenty four months, who had at least one medical visit during the reporting period, and at least two<sup>13</sup> medical visits ever, **OR** a sample of these patients.

For measurement year 2013, this includes patients with a date of birth on or before December 31, 1995. Note that identifying tobacco users is often difficult. If this is the case, see the discussion on identifying tobacco users in Appendix C (page 64).

### TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (A)

**Criteria:** Enter the number of all patients who:

- Were born on or before December 31, 1995 **AND**
- Were last seen by health center after their 18<sup>th</sup> birthday **AND**
- Had at least one medical visit during 2013 **AND**
- Had at least two medical visits ever **AND**
- Used any form of tobacco including smoked and smokeless tobacco

**Exclusions:**

- (None)

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<sup>13</sup> Two visits are specified in order to ensure that the patient has a relationship with the health center. The universe *may* be enlarged to include other patients whose relationship is demonstrated by having had a behavioral assessment or concomitant occupational therapy or concomitant mental health visits, however health centers are not expected to search for these patients.

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

### **NUMBER OF PATIENTS WHO RECEIVED TOBACCO CESSATION INTERVENTION, COLUMN (C)**

Enter the total number of patients identified in Column B whose 2013 record demonstrates that they had, within the past 24 months,

- Received tobacco use cessation services **OR**
- Received an order for (a prescription or a recommendation to purchase) a smoking cessation medication. This medication may be a prescription or an Over the Counter (OTC) product. **OR**
- Been on (using) a smoking cessation agent.

The following codes will be useful in identifying meeting the measurement standard:  
CPT / ICD-9 (CPT-II codes):

- 1000F = Tobacco use assessed
- 1034F = Current tobacco smoker
- 305.1, 649.00-649.04 = Tobacco use disorder – sufficient, but not necessary
- 1035F = Current smokeless tobacco user (e.g., chew, snuff)
- 1036F = Current tobacco non-user (indicative of patient to be excluded from universe)
- 4000F = Tobacco use cessation intervention counseling
- 99406-07 = Smoking and tobacco use cessation counseling – sufficient, but not necessary
- 4001F = Tobacco use cessation intervention – pharmacologic therapy

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### **ASTHMA PHARMACOLOGIC THERAPY (Line 16)**

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided inhaled corticosteroid or an accepted alternative medication.
- **Denominator:** Number of patients who were 5 through 40 years of age at some point during the measurement year, who have been seen at least twice in the practice and who had at least one medical visit during the reporting year, who had an active diagnosis of persistent asthma **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth between January 1, 1973 and December 31, 2008.

## TOTAL NUMBER OF PATIENTS AGE 5 THROUGH 40, COLUMN (A)

**Criteria:** Enter the number of all patients who:

- Were born on or after January 1, 1973 and on or before December 31, 2008 **AND**
- Were last seen by health center while they were age 5 through 40 years **AND**
- Have been seen at least twice (not necessarily in the current year) **AND**
- Had at least one medical visit during 2013 **AND**
- Were diagnosed with *persistent*<sup>14</sup> asthma **OR** have persistent asthma as a current diagnosis on a chronic illness form or template.

### Exclusions:

- Allergic reaction to asthma medications
- Individuals with a diagnosis of asthma who are discovered, upon review, to have intermittent mild asthma, not persistent asthma.

## NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

## NUMBER OF PATIENTS WITH PERSISTENT ASTHMA WITH PHARMACOLOGIC TREATMENT DOCUMENTED, COLUMN (C)

Enter the total number of patients identified in Column B whose 2013 record demonstrates that they had

- Received a prescription for or were using an inhaled corticosteroid **OR**
- Received a prescription for or were using an acceptable pharmacological agent, specifically: inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines

The following codes will be useful in identifying universe and meeting the measurement standard:

CPT / ICD-9 (CPT-II codes):

- 493.x = Asthma
- 1038F = Persistent asthma (mild, moderate or severe)
- 1039F = Intermittent asthma (indicative of patient to be excluded from universe)
- 4015F = Persistent asthma, appropriate pharmacologic treatment prescribed

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<sup>14</sup> It is the clear intent that the universe be limited to patients with *persistent* asthma and, specifically, that patients with mild intermittent asthma, for which no daily medication is needed, be excluded from the universe. But, while there are CPT Category II codes that differentiate between these conditions, there are no traditional ICD-9 codes which do so. Accordingly, a diagnosis of "asthma" (ICD-9 493.x) is permitted as an alternative criteria *or* as an initial screening methodology. Since the universe for this measure may include hundreds of patients, the task of searching the charts of all non-compliant patients may be problematic. If a health center chooses to use an EHR for this task which is not configured to exclude intermittent asthma they will need to accept reporting a lower achievement rate of the measurement standard.)

Do not count as compliant patients who are receiving a form of treatment other than pharmacologic treatment or whose only pharmacologic treatment is a short-acting bronchodilator for symptomatic relief.

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## **CORONARY ARTERY DISEASE (CAD): DRUG THERAPY FOR LOWERING LDL CHOLESTEROL (Line 17)**

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided or were taking lipid lowering medications.
- **Denominator:** Number of patients who were seen during the measurement year after their 18<sup>th</sup> birthday, who had at least one medical visit during the reporting year, with at least two medical visits ever, and who had an active diagnosis of coronary artery disease (CAD) including any diagnosis for myocardial infarction (MI) or who had had cardiac surgery in the past – **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth on or before December 31, 1995.

### **TOTAL NUMBER OF PATIENTS AGE 18 AND OLDER WITH CAD DIAGNOSIS, COLUMN (A)**

**Criteria:** Enter the number of all patients who:

- Were born on or before December 31, 1995 **AND**
- Were last seen by health center after their 18<sup>th</sup> birthday **AND**
- Had at least one medical visit during 2013 **AND**
- Had at least two medical visits ever **AND**
- Have an active diagnosis of coronary artery disease (CAD) **OR** were diagnosed as having had a myocardial infarction (MI) **OR** have had cardiac surgery<sup>15</sup>.

#### **Exclusions:**

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

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

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<sup>15</sup> A large number of surgical CPT codes relating to the *performance* of a CABG or PTCA are included in the specifications for cardiac surgery, however these may be difficult to find. Health centers should utilize EHR reporting capabilities to identify patients with a history of pertinent cardiac surgeries.

### **NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY. COLUMN (C)**

Enter the total number of patients identified in Column B whose 2013 record demonstrates that they had

- Received a prescription for or were using a lipid lowering therapy.

The following codes will be useful in identifying the universe:

CPT / ICD-9 (CPT-II codes):

- CAD = 410.xx, 411.xx, 412.xx, 413.xx, 414.0x, 414.8, 414.9,
- History of surgeries = V45.81, V45.82

Do not count as compliant patients who are receiving a form of treatment other than pharmacologic treatment. Persons involved in therapeutic lifestyle changes and/or control of non-lipid risk factors *without* concomitant pharmaceutical treatment have not met the measurement standard.

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### **ISCHEMIC VASCULAR DISEASE (IVD): USE OF ASPIRIN OR ANOTHER ANTI-THROMBOTIC: (Line 18)**

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1, 2012 to November 1, 2012 **OR** who had a diagnosis of ischemic vascular disease during 2013 who had documentation of use of aspirin or another antithrombotic.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed or used.
- **Denominator:** Number of patients who were aged 18 and older at some point during the measurement year, who had at least one medical visit during the reporting year, who had an active diagnosis of ischemic vascular disease (IVD) during the current or prior year **OR** had been discharged after AMI or CABG or PTCA between January 1, 2012 and November 1, 2012 – **OR** a sample of these patients. For measurement year 2013, this includes patients with a date of birth before December 31, 1995.

### **TOTAL NUMBER OF PATIENTS AGE 18 AND OLDER WITH IVD DIAGNOSIS, COLUMN (A)**

**Criteria:** Enter the number of all patients who:

- Were born on or before December 31, 1995 **AND**
- Were last seen by the health center while they were 18 years of age or older **AND**
- Had at least one medical visit during 2013 **AND**
- Had an active diagnosis of ischemic vascular disease (IVD) during 2012 or 2013 **OR** had been discharged after AMI or CABG or PTCA between January 1, 2012 and November 1, 2012.

### **Exclusions:**

- None

## NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

## NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTI-THROMBOTIC USE, COLUMN (C)

Enter the total number of patients identified in Column B whose 2013 medical record demonstrates that they had

- Received a prescription for, were given, or were using Aspirin or another antithrombotic drug.

The following codes will be useful in identifying the universe:

### CPT / ICD-9 (CPT-II codes):

- ICD-9 = 411.xx, 413.xx, 414.0x, 414.8, 414.9, 429.2, 433.0, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.8, 445.81, V45.81, V45.82
- CPT = 33510 – 33536

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## COLORECTAL CANCER SCREENING: (Line 19)

**PERFORMANCE MEASURE:** The performance measure is “Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer.” This is calculated as follows:

- **Numerator:** Number of patients aged 51 through 74 with appropriate screening for colorectal cancer.
- **Denominator:** Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year<sup>16</sup>. (NOTE: Though age 50 to 75 is in the title of this measure, the detail calls for persons to be screened within a year of turning 50 and prior to reaching age 75.) For measurement year 2013, this includes patients whose date of birth is between January 1, 1939 and December 31, 1962.

Documented colonoscopy conducted during the measurement year or the previous 9 years or flexible sigmoidoscopy conducted during the measurement year or the previous 4 years meet the measurement standard criteria. Though codes are shown for colonoscopy and flexible sigmoidoscopy it is possible that these CPT codes may not be found in the health center’s EHR or other computerized system. It *is* possible that the procedures were performed elsewhere, but

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<sup>16</sup> The CMS Meaningful Use criteria for this measure includes persons seen at any point within the last two years, however, for the purposes of reporting in UDS Table 6B, medical patients must have had one medical visit during the current measurement year.

confirmation of this is required by having in the chart either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results of the test. Fecal occult blood test (FOBT), including the fecal immunochemical test (FIT), can also be used to document meeting the measurement standard and, because of its much lower cost and ease of administration, is much more likely to be found for health center patients. Because the FOBT is to be conducted annually, it is required that there be evidence of a test during the measurement year. Thus, a patient who had an FOBT in November of 2012 (for example) would still need one in 2013, even if the patient did not present in the clinic after June of 2013. Test kits can be mailed to patients during the year, but receipt and processing of the test sample is required. Evidence of mailing is not, in and of itself, sufficient.

#### **TOTAL NUMBER OF PATIENTS AGE 51 through 74, COLUMN (A)**

**Criteria:** Enter the number of all patients who:

- Were born between January 1, 1939 and December 31, 1962 **AND**
- Had at least one medical visit during 2013

**Exclusions:**

- Patients who have or who have had colorectal cancer

#### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (B)**

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column A) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

#### **NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER, COLUMN (C)**

Enter the total number of patients identified in Column B whose 2013 record demonstrates that they had

- a colonoscopy after January 1, 2004 **OR**
- a flexible sigmoidoscopy after January 1, 2009 **OR**
- a fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test during the measurement year

The following codes will be useful in identifying meeting the measurement standard:

CPT / ICD-9 (CPT-II codes):

- ICD-9 = 45.22 - 45.25, 45.42 - 45.43, V76.51
- CPT = 45330 - 45345, 44388 - 44397, 45355 - 45392, 82270, 82274

## QUESTIONS AND ANSWERS FOR TABLE 6B

**1. Are there any changes to the table this year?**

Yes, The childhood immunization measure was changed to the “catch-up” schedule and reflects the Healthy People 2020 Childhood Immunization goals, permitting reporting as meeting the measurement standard, children who were immunized prior to their third birthday. In addition, three of the vaccines required by CDC (Hep-A, flu, and rotavirus) were deleted from the measure definition. Also, Pap test measurement standard definition was expanded to reflect current USPSTF guidelines to include women who were 30 years or older at the time of their last Pap test and elected to have an HPV test done at the same time. For these women, evidence of a Pap test in the measurement year or the prior four years is required.

**2. A child came in only once in 2013 for an injury and never returned for well child care. If her record is selected for the immunization measure sample do we have to consider her chart to not have met the measurement standard?**

Yes. Once a patient enters a health center’s system of medical care, the center is expected to be responsible for providing all needed preventive health care and/or document that they have received it.

**3. What if a woman we treat for hypertension and diabetes goes to an ObGyn in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not do Pap tests?**

Once the patient has been seen in your clinic, you are responsible for providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to document Pap tests by contacting providers of Pap tests directly in order to obtain documentation by FAX, or by requesting that health center patients mail a copy of their test history, or through other appropriate means. The woman would be considered to be a part of your universe if she received any medical visit(s) in 2013. If there is no copy of the results of her Pap test included in her chart, she would be considered having not met the measurement standard.

**4. If we pull a chart for a woman who we sent to the health department for her Pap test, but the results are not posted, can we call the health department, get the results, post them, and then count the chart as having met the measurement standard?**

The health center should obtain a copy of her test result to include in the patient’s record for future care. However, the chart still has not met the measurement standard for the reporting year (although the record may now be valid for successive years depending on when the test was performed).

**5. If we inform a parent of the importance of immunizations but they refuse to have their child immunized may we count the chart as having met the measurement standard if the refusal is documented?**

No. A child is fully immunized if and only if there is documentation the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, and history of illness for all required vaccines.

**6. Are parents required to bring to the health center documentation of childhood immunizations received from outside the health center?**

Parents are encouraged to provide documentation of immunizations that their children

receive elsewhere, but other mechanisms of obtaining this information are also acceptable. Health centers are encouraged to document childhood immunizations by contacting providers of immunizations directly in order to obtain documentation by FAX, or by requesting health center patients to mail a copy of their immunization history, or by finding the child in a State or county immunization registry or through other appropriate means. Health center patients should not be requested to return to the center merely to provide immunization documentation.

**7. Some of the immunization details are different than those used by CDC in the CASA or CO-CASA reviews of our clinic. May we use these CDC standards to report on the UDS?**

No. HRSA is now using one of the Healthy People 2020 standards to evaluate provision of vaccines to children. Using a different set of standards will distort the data. Because data are being compared to Table 3A data, such misalignment may be detected in which case health centers will be asked to resample their data. A center *may* use a different set of standards for its own internal Quality Assurance program, or to meet the CMS Meaningful Use criteria, but these may not be substituted for the BPHC measure definitions for the UDS reporting on Table 6B.

**8. We want to use these reviews to compare our sites and our providers to one another. As a result we would like to use a larger universe. Is there any problem with this?**

Yes. First, all health centers using a sample must use 70 charts. This facilitates the development of state, national, and other roll-up reports. Second, and perhaps more important, any change in the sample size as described would bias the sample and provide distortions in the data set. A health center *may* draw a larger random sample and use only the first 70 for the UDS, but the larger sample must be a random sample of the entire organization – it may not oversample specific sites or providers to facilitate internal QI activities.

**9. What happens if the CPT or ICD-9 codes change again?**

The codes are reviewed annually by the UDS Support Center staff. If you think that there is a CPT or ICD-9 code for a measure which is not being reflected in the list, contact the UDS Support Center. They will review the code with the BPHC and will incorporate approved changes to codes into the manual of future reporting.

**10. Is the Pap test review for women starting at age 21 or at age 24?**

For this measure you will look only at women who were 24 years or older (up to age 65) at some point in 2013. You will *not* look at any women who were 21, 22, or 23 years old at the end of 2013. Because the measure asks about Pap tests *administered* in 2013 *or* in 2012 *or* in 2011, it is possible that a 24 year old woman would have been 21 in 2011. If she received a Pap test in that year she would be considered to have met the measurement standard. We are looking only at women who are 24 through 64, but their qualifying test may have been received when they were 21 through 64. Health centers should take care to review charts *only* for women who were 24 through 64 in 2013 and should *not* select any charts for women who were younger.

**11. When the listing of CPT codes says “sufficient, but not necessary” what does this mean?**

The codes are generally for activities which, if undertaken, make it obvious that the criteria was met. But there are other ways to meet the criteria as well. For example, the code may be for “tobacco use disorder.” If a provider codes this, it is clear that they have evaluated

the patient for tobacco use and its presence in the chart is sufficient to document the evaluation. But this code is not necessary. The patient could have been evaluated for tobacco use without this diagnosis ever being made.

**12. Does “counseling for nutrition and . . . physical activity” have specific content that must be provided? Does it need to be provided if the child is well within the “normal” range?**

No, the counseling has no specific required content. It is tailored by the clinician given the patient’s BMI percentile. But, yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for *all* children and adolescents. Starting children and adolescents off right is important in efforts to improve long-term health outcomes and quality of life.

**13. I have a patient who turned 2 in November of 2012. Should she be included in the Child and Adolescent weight measure? Does this measure start at age 2 or age 3?**

No – do not include the child. The measure looks at children who were two, but allows the measurement to be recorded up to one year after her second birthday. Since she still has ten months for her BMI percentile to be charted and for her parents to receive counseling, she would not be included in the universe. For this measure you will look only at children and adolescents who were 3 years or older (until age 17 – one year after 16<sup>th</sup> birthday) at some point in 2013. You will *not* look at any child or adolescent who had not yet turned 3 or who was over 17 years old at the end of 2013. For children who are 3, the documentation for weight assessment and counseling may have been when they were 2.

**14. For adult patients, our protocol calls for a weight to be measured at every visit, but for height to be measured “at least once every two years.” Is this acceptable?**

BMI is calculated from current height and weight. Inasmuch as height in adults does not normally change more than a quarter of an inch in a two year period it is reasonable to follow such a protocol if it has been approved by your clinical staff.

**15. The measure says that there must be effective intervention for tobacco users. Are there specific interventions that must be used in order to consider them effective?**

No. This is at the discretion of the clinician and should be consistent with their assessment of the patient’s level of tobacco use. As long as the clinician documents that they intervened and this intervention is consistent with the health center’s own protocols, the treatment has met the measurement standard for this measure.

**16. If our provider documents that they felt maintaining a dust free environment and a diet low in allergens coupled with a “rescue inhaler” is adequate to treat a persistent asthmatic, can we consider this patients treatment to have met the measurement standard?**

No. For persistent asthma one of the listed pharmacologic interventions is required. Rescue inhalers are not contraindicated, but they are not sufficient to meet the requirement of a pharmacologic intervention.

## TABLE 6B – QUALITY OF CARE MEASURES

(No prenatal care provided? Check here: )

SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS				
1	LESS THAN 15 YEARS			
2	AGES 15-19			
3	AGES 20-24			
4	AGES 25-44			
5	AGES 45 AND OVER			
6	TOTAL PATIENTS (SUM LINES 1 – 5)			
SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE				
TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR		Women Having First Visit with Health Center ( a )	Women Having First Visit with Another Provider ( b )	
7	First Trimester			
8	Second Trimester			
9	Third Trimester			
SECTION C – CHILDHOOD IMMUNIZATION				
CHILDHOOD IMMUNIZATION		TOTAL NUMBER OF PATIENTS WITH 3 <sup>RD</sup> BIRTHDAY DURING MEASUREMENT YEAR ( a )	NUMBER CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS IMMUNIZED ( c )
10	MEASURE: Children who have received age appropriate vaccines prior to their 3 <sup>rd</sup> birthday during measurement year (on or prior to December 31)			
SECTION D – CERVICAL CANCER SCREENING				
PAP TESTS		TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE ( a )	NUMBER CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS TESTED ( c )
11	MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

SECTION E – WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS				
CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING		TOTAL PATIENTS AGED 3 – 17 ON DECEMBER 31 (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12	MEASURE: Children and adolescents aged 3 until 17 during measurement year (on or prior to 31 December) with a BMI percentile, <b>and</b> counseling on nutrition and physical activity documented for the current year			
SECTION F – ADULT WEIGHT SCREENING AND FOLLOW-UP				
ADULT WEIGHT SCREENING AND FOLLOW-UP		TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	MEASURE: Patients aged 18 and older with (1) BMI charted <b>and</b> (2) follow-up plan documented <b>if</b> patients are overweight or underweight			
SECTION G1 – TOBACCO USE ASSESSMENT				
TOBACCO ASSESSMENT		TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE (c)
14	MEASURE: Patients queried about tobacco use one or more times in the measurement year or prior year			
SECTION G2 – TOBACCO CESSATION INTERVENTION				
TOBACCO CESSATION INTERVENTION		TOTAL PATIENTS USING TOBACCO (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ADVISED TO QUIT (c)
15	MEASURE: Tobacco users aged 18 or older who have received cessation advice or medication			
SECTION H – ASTHMA PHARMACOLOGICAL THERAPY				
ASTHMA TREATMENT PLAN		TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16	MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

SECTION I – CORONARY ARTERY DISEASE (CAD): LIPID THERAPY				
LIPID THERAPY		TOTAL PATIENTS AGED 18 AND OLDER WITH CAD DIAGNOSIS ( a )	NUMBER CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY ( c )
17	MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy			
SECTION J – ISCHEMIC VASCULAR DISEASE (IVD): ASPIRIN OR ANTITHROMBOTIC THERAPY				
ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY		TOTAL PATIENTS 18 AND OLDER WITH IVD DIAGNOSIS OR AMI, CABG, OR PTCA PROCEDURE ( a )	CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY ( c )
18	MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy			
SECTION K – COLORECTAL CANCER SCREENING				
COLORECTAL CANCER SCREENING		TOTAL PATIENTS 51 THROUGH 74 YEARS OF AGE ( a )	CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER ( c )
19	MEASURE: Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer			

## INSTRUCTIONS FOR TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

This table reports data on health status measures for birthweight, diabetes and hypertension by race and Hispanic/Latino ethnicity. All health centers submit Table 7. This table is submitted only in the Universal report.

These measures are “intermediate outcome measures” which means that they document measurable outcomes of clinical intervention as a surrogate for good long term health outcomes. Increasing the proportion of patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. Specifically:

- Low Birthweight: *If there are fewer low birthweight children born, then there will be fewer children who suffer the multiple negative sequela of low birthweight, such as delayed or diminished intellectual and/or physical development.*
- Controlled Hypertension: *If there is less uncontrolled hypertension, then there will be less cardiovascular damage, fewer heart attacks, less organ damage later in life.*
- Controlled Diabetes: *If there is less uncontrolled diabetes then there will be fewer amputations, less blindness, less organ damage later in life.*

Table 7 also reports health outcomes by race and Hispanic/Latino ethnicity to provide information on the extent to which health centers help to reduce health disparities. Race and Hispanic/Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. *Note that using race and ethnicity data from the chart which is inconsistent with that in the registration data may result in errors in reporting that must be corrected.* Health centers who report on a sample of patients – and even those who report on their entire universe of patients – are cautioned against using their data to evaluate disparities in their own systems given small sample sizes. On a national level, however, reported data provides results which HRSA can use to help evaluate overall disparities for all BPHC-funded programs.

### **HIV POSITIVE PREGNANT WOMEN, TOP LINE**

All health centers are to report the total number of HIV positive pregnant women served by the health center on Line “0” *regardless of whether or not they provide prenatal care services.*

### **DELIVERIES PERFORMED BY HEALTH CENTER PROVIDER (Line 2)**

Report the total number of deliveries *performed by health center clinicians* during the reporting period on line 2. (This line is not reported by the race or Hispanic/Latino ethnicity of the women delivered.) On this line ONLY, the health center is to include deliveries of women who were *not* part of the health center’s prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor’s patients when the health center provider participates in a call group and is on call at the time of delivery; emergency deliveries when the health center provider is on-call for the emergency room; and deliveries of “undoctored” patients who are assigned to the provider as a requirement for privileging at a hospital. Include as “health center clinicians” any clinician who is paid by the health center while doing the delivery, regardless of the method of compensation. Do *not* include deliveries where a clinic provider bills separately, receives, and retains payment for the delivery.

## **DELIVERIES AND LOW BIRTH WEIGHT MEASURE BY RACE AND HISPANIC / LATINO ETHNICITY, SECTION A (Columns 1a – 1d)**

Only health centers that provide, or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the health center does the delivery, are required to complete Section A. All health center prenatal care patients who delivered during the reporting period, and all children born to them, are reported in Columns 1a – 1d.

### **PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Column 1a)**

Report the total number of women who were enrolled in the health center's prenatal care program at any point during their most recent pregnancy who delivered during the reporting year. Health centers are responsible for reporting on these women even if the delivery was done by another provider. Health centers are also required to follow up on women who are referred out, and to track and report their deliveries and birth outcomes. Include all women who had deliveries, regardless of the outcome, but do not include deliveries where you have no documentation that the delivery occurred (for example, for women who may have moved out of the area and/or who were lost to follow-up). This column collects data on "patients who delivered." Even if the delivery is of twins or triplets, the health center is still to report only *one* delivery.

### **BIRTHWEIGHT OF INFANTS BORN TO PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Columns 1b – 1d)**

**PERFORMANCE MEASURE:** The performance measure is "Proportion of patients born to health center patients whose birthweight was *below* normal (less than 2500 grams). Note that this is the only "negative" measure in the UDS. For this, the *higher* the number of infants born with below normal birthweight, the *worse* the performance on the measure. While data are provided for each racial and ethnicity category, the performance measure looks only at the totals. The measure itself, which is not dependent on which category of failure to meet the measurement standard an infant falls in, is calculated as follows:

- **Numerator:** Number of children born with a birthweight of under 2500 grams (Line i, columns 1b + 1c)
- **Denominator:** Number of children born (Line i, Columns 1b + 1c + 1d)

Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period, according to the appropriate birthweight group. (Do not report still-births or miscarriages.) These columns collect data on "infants born." If the delivery is of twins or triplets, the health center will report the birthweight of the two or three children.

**NOTE:** Health centers must report birthweights for live children of **all** women who were in their prenatal care program and who delivered during the reporting period. *Data are reported regardless of whether the health center did the delivery themselves, referred the delivery to another provider, or the woman transferred to another provider on her own. Followup is required.*

The number of deliveries reported in Column 1a will normally not be the same as the total number of infants reported in Columns 1b – 1d because of multiple births and still births.

- **VERY LOW BIRTHWEIGHT (Column 1b)** – Report the total number of live children whose weight at birth was less than 1500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.
- **LOW BIRTHWEIGHT (Column 1c)** – Report the total number of live children whose weight at birth was 1500 grams through 2499 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.
- **NORMAL BIRTHWEIGHT (Column 1d)** – Report the total number of live children whose weight at birth was equal to or greater than 2500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

## **HYPERTENSION BY RACE AND HISPANIC / LATINO ETHNICITY, SECTION B (Columns 2a – 2c)**

In this section, health centers report on findings from their reviews of current hypertensive patients, i.e., patients who had at least two medical visits during the reporting period who have been diagnosed as hypertensive at some point while they were a patient at the health center.

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates or search parameters permit the recovery of 100% of the records of the patients which fit the sampling profile.

Very specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings.

Section B of Table 7 reports on all health center adult patients, 18 to 85 years of age, who have been diagnosed as hypertensive at any time before June 30 of the measurement year and who have been seen in the health center for medical visits at least *twice* during the reporting year. (The diagnosis may have first been made in a year prior to the measurement year or at the last visit of the year or at any time in between.)

**PERFORMANCE MEASURE:** The performance measure is “Proportion of patients born between January 1, 1929 and December 31, 1995 with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading.” (NOTE: Many health centers use a different measure for their quality assurance process for their diabetic or dialysis patients. This may well be appropriate, but for the purposes of UDS reporting, the 140/90 measure must be used.) This is calculated as follows:

- **Numerator:** Number of patients in the denominator whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg.
- **Denominator:** All patients 18 to 85 years of age as of December 31 of the measurement year:
  - with a diagnosis of hypertension (HTN) **AND**,
  - who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year **AND**,
  - who have been seen for medical visits at least twice during the reporting year

- **OR** a statistically valid sample of 70 of these patients.

### **TOTAL PATIENTS AGED 18 TO 85 WITH HYPERTENSION, COLUMN 2a**

**Criteria:** Enter the total number of patients by race and Hispanic/Latino ethnicity who meet all of the following criteria:

- Were born between January 1, 1929 and December 31, 1995 **AND**,
- Have been seen at least twice during the reporting year for *any reportable* medical visit **AND**,
- Have been diagnosed with hypertension (HTN) before June 30 of the measurement year as evidenced by an ICD-9 code of 401.xx - 405.xx. It does not matter if hypertension was treated during the measurement year or is currently being treated. The notation of hypertension may appear during or prior to 2013.

Blood pressure readings (BP) that are **self-reported** by the patient such as when a patient calls in a blood pressure from home are generally not eligible unless a clinical management decision is made using that reading. If the patient is equipped with reliable technology and the provider is confident that the reading is reliable such that the provider is recording the automated BP reading and making prescription change or other decisions based on those readings, the health center can use the measurement.

**Exclusions:** Pregnant patients, patients with end state renal disease (ESRD).

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN 2b**

Enter the total number of hypertensive health center patients by race and Hispanic/Latino ethnicity (Column 2a) included in the universe for whom data have been reviewed. This will ***either*** be all patients who fit the criteria ***or*** a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire universe identified in Column 2a. Larger samples will not be accepted. Health centers ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. The sampling method is described in Appendix C. If an EHR is present it may be used in lieu of a chart review of a sample of charts if and only if:

- The EHR includes every single clinic patient between the ages of 18 and 85 with diagnosed hypertension, regardless of whether or not they were specifically treated for hypertension.
- Blood pressure is regularly recorded in the EHR for all patients
- The EHR has been in place throughout the reporting year, and ideally for at least three years.

If the EHR is to be used, the number in Column 2b will be equal to the number in Column 2a. NOTE: Health centers who have I2I-Track, PC-DEMS, PECS, or other disease tracking systems may use them to report the universe **ONLY IF** it can be limited to a calendar year report and **only** if it includes all required data elements, i.e., it includes data for the required time frame for *all* hypertensive patients from *all* service sites.

### **PATIENTS WITH CONTROLLED BLOOD PRESSURE, COLUMN 2c**

Hypertensive patients born between January 1, 1929 and December 31, 1995 whose charts have been reviewed (those identified in Column 2b) whose systolic blood pressure measurement was less than 140 mm Hg *and* whose diastolic blood pressure was less than 90

mm Hg at the time of their last measurement in 2013 are reported in Column 2c by race and Hispanic/Latino ethnicity. (Patients who have not had their blood pressure tested during the reporting year will be considered to have failed the performance measure. They are counted in columns 2a and 2b, but not in column 2c.)

### IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS

1. Comparisons are made between the universe reported on Table 7, Column 2a, and the data reported on Table 3B. Under no circumstances may a health center report more hypertensive Hispanic/Latinos or more hypertensive patients of any given race in Column 2a than are reported for that race or for the Hispanic/Latino ethnic group on Table 3B.
2. Under most circumstances persons with no reported race **and** no reported ethnicity (Row h) will be relatively small. Use Row h only if, when you ask a patient their race and whether or not they are Hispanic/Latino, they refuse to answer *both* questions. *Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.*

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### DIABETES BY RACE AND HISPANIC/LATINO ETHNICITY, SECTION C (Columns 3a – 3f)

In this section, health centers report on findings from their reviews of current diabetic patients (i.e., patients who had at least two medical visits during the reporting period and who have been diagnosed as diabetic at some point while they were a patient at the health center.)

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates or search parameters permit the recovery of 100% of the records of the patients which fit the sampling profile.

Very specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings.

This section of Table 7 reports on all health center patients 18 to 75 who have been diagnosed as diabetic at some point during their time as a patient at the health center.

**PERFORMANCE MEASURE:** The performance measure is “Proportion of adult patients born between January 1, 1939 and December 31, 1995 with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year.” Health centers report results in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%. The measure itself, which is not dependent on which category of failure to meet the measurement standard a patient falls in, is calculated as follows:

- **Numerator:** Number of adult patients whose most recent hemoglobin A1c level during the measurement year is  $\leq 9\%$  among those patients included in the denominator.
- **Denominator:** Number of adult patients aged 18 to 75 as of December 31 of the measurement year
  - with a diagnosis of Type I or II diabetes **AND**,
  - who have been seen in the clinic for medical visits at least *twice* during the

- reporting year **AND**,
  - do not meet any of the exclusion criteria
- OR** a statistically valid sample of 70 of these patients

### **TOTAL PATIENTS AGED 18 TO 75 WITH TYPE I OR II DIABETES, COLUMN 3a**

**Criteria:** Enter the number of adult patients by race and Hispanic/Latino ethnicity who meet the following criteria:

- Were born between January 1, 1939 and December 31, 1995 **AND**,
- Have been seen at least *twice* for medical care during the reporting year, **AND**,
- Have a diagnosis of diabetes. It does not matter if diabetes was treated or is currently being treated or when the diagnosis was made. The notation of diabetes may appear during or prior to the 2013 measurement year. To confirm the diagnosis of diabetes, one of the following must be found in the medical record:
  - ICD-9-CM Codes 250.xx, or 648.0, or
  - diabetic patients may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics / antihyperglycemics).

Note that unlike the hypertension measure, the diabetes measure calls for reporting on all diabetic patients regardless of when they were first diagnosed. It specifically *does not make use of* the June 30 date used to identify hypertensive patients.

#### **Exclusions:**

Exclude any patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year.<sup>17</sup> Note that patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0 or 251.8) reported during the measurement year are *not* to be included.

### **NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN 3b**

Enter the total number of diabetic health center patients by race and Hispanic/Latino ethnicity included in the universe (Column 3a) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column 3a) or a scientifically drawn sample of 70 patients (using the methodology described in Appendix C) from all patients who fit the criteria. If a sample is to be used it **must** be a sample of 70 and **must** be drawn from the entire patient population who fit the criteria (the universe reported in Column 3a). Larger samples will not be accepted. Health centers **may not** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. If an EHR is present it may be used in lieu of a chart review of a sample of charts if and only if:

- the EHR includes every diabetic patient,
- every item in the criteria is regularly recorded for all patients, and,
- the EHR has been in place throughout the performance year, and ideally for at least three years to permit identification of all diabetic patients.

If the EHR is to be used in lieu of the chart audit, the number in Column 3b will be equal to the number in Column 3a.

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<sup>17</sup> If a search is made for pharmaceuticals that are used to treat diabetes, a person with these various conditions might be identified in error – hence this exclusion. If no search is done for pharmacy identification of patients, this can be ignored.

### REPORTED HEMOGLOBIN A1c LEVELS, COLUMNS 3c through 3f

For this report, the last hemoglobin A1c (HbA1c) level taken in the measurement year as documented through laboratory data or medical record review, is reported. **If there is no record of an HbA1c level being obtained during the measurement year, the chart will be reported in Column 3f: “greater than 9.0% or no test during the year.”** Patients with no test during the measurement year are included as non-compliant along with those who have poor HbA1c control. Note that even if the treatment of the patient’s diabetes has been referred to a non-health center provider, the health center is expected to have the current lab test results in its records.

- **Patients with HbA1c < 7% (Column 3c):** Number of patients included in Column 3b whose most recent HbA1c was less than 7%.
- **Patients with 7% ≤ HbA1c < 8% (Column 3d):** Number of patients included in Column 3b whose most recent HbA1c was greater than or equal to 7%, but less than 8%.
- **Patients with 8% ≤ HbA1c ≤ 9% (Column 3e):** Number of patients included in Column 3b whose most recent HbA1c was greater than or equal to 8% and less than or equal to 9%.
- **Patients with HbA1c > 9% or No Test During Year (Column 3f):** Number of patients included in Column 3b whose most recent HbA1c was greater than 9% **and** patients who did not receive an HbA1c test during the reporting year or whose test result is missing.

Note that the combined total of Columns 3c through 3f must equal the number of charts sampled or EHR total reported in Column 3b.

### IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS:

1. Comparisons are made between the universe reported on Table 7, Column 3a and the data reported on Table 3B. Under no circumstances may a health center report more diabetic Hispanic/Latinos or more patients from any given race reported in Column 3a than are reported for that race or for the Hispanic/Latino ethnic group on Table 3B.
2. Under most circumstances persons with no reported race **and** no reported ethnicity (Row h) will be relatively small. Use Row h only if, when you asked a patient their race and whether or not they are Hispanic/Latino, they refused to answer both questions. *Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.*

## QUESTIONS AND ANSWERS FOR TABLE 7

**1. Are there any changes to the table this year?**

No, but look-alikes are now required to complete this table's race and ethnicity detail.

**2. When would we use Row h: Unreported/Refused to Report race and ethnicity?**

Row h will be used infrequently. It is to be used only in those instances where a patient refuses to provide their race and refuses to state whether or not they are Hispanic/Latino. Patients who provide a race, but do not answer affirmatively to a question about Hispanic/Latino ethnicity are to be classified as Non-Hispanic/Latino and reported on the appropriate race line, Line 2a – 2g. Patients who indicate they are Hispanic/Latino but do not provide a race are reported on line 1g.

**3. Data are requested by race and Hispanic/Latino ethnicity. How are these to be coded?**

Race and Hispanic/Latino ethnicity are coded on this table in the exact same manner that is used for coding on Table 3B. Refer to instructions for Table 3B for further information. Note that if the race and/or ethnicity in the patient's medical chart is different than that reported in the registration process it will result in errors. Care should be taken to ensure that the same information is recorded in both data sources.

**4. Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**

Patients are encouraged to provide documentation of HbA1c tests received elsewhere, but this is not required. Health centers are encouraged to document HbA1c tests by contacting providers of tests directly in order to obtain documentation by FAX, or by requesting health center patients to mail a copy of test results, or through other appropriate means. Health center patients should not be requested to return to the center merely to provide test documentation, however failure to document results means that the patient must be reported as not meeting the measurement standard.

**5. We want to use these reviews to compare our sites and our providers to one another. As a result, we would like to use a larger universe. Is there any problem with this?**

Yes. First, all health centers using a sample **must use 70 random charts**. This facilitates the development of state, national, and other roll-up reports. Second, and perhaps more important, any change in the sample size as described would bias the sample and provide distortions in the data set. A health center *may* draw a larger random sample and use only the first 70 for the UDS, but the larger sample must be a random sample of the entire organization – it may not oversample specific sites or providers to facilitate internal QI activities.

Reporting Period: January 1, 2013 through December 31, 2013

**TABLE 7 – HEALTH OUTCOMES AND DISPARITIES**  
**Section A: Deliveries and Birth Weight by Race and Hispanic/Latino Ethnicity**

Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: =>2500 grams (1d)
0	HIV Positive Pregnant Women				
2	Deliveries Performed by Health Center's Providers				
<b>Hispanic/Latino</b>					
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	<i>Subtotal Hispanic/Latino</i>				
<b>Non-Hispanic/Latino</b>					
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	<i>Subtotal Non-Hispanic/Latino</i>				
<b>Unreported/Refused to Report Ethnicity</b>					
h	Unreported/Refused to Report Race and Ethnicity				
i	<b>Total</b>				

**TABLE 7 – HEALTH OUTCOMES AND DISPARITIES**  
**Section B: Hypertension by Race and Hispanic/Latino Ethnicity**

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
<b>Hispanic/Latino</b>				
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	<i>Subtotal Hispanic/Latino</i>			
<b>Non-Hispanic/Latino</b>				
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	<i>Subtotal Non-Hispanic/Latino</i>			
<b>Unreported/Refused to Report Ethnicity</b>				
h	Unreported/Refused to Report Race and Ethnicity			
<b>i</b>	<b>Total</b>			

**TABLE 7 – HEALTH OUTCOMES AND DISPARITIES**

Section C: Diabetes by Race and Hispanic/Latino Ethnicity

#	Race and Ethnicity	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%≤ Hba1c <8% (3d)	Patients with 8%≤ Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)
<b>Hispanic/Latino</b>							
1a	Asian						
1b1	Native Hawaiian						
1b2	Other Pacific Islander						
1c	Black/African American						
1d	American Indian/Alaska Native						
1e	White						
1f	More than One Race						
1g	Unreported/Refused to Report Race						
	<i>Subtotal Hispanic/Latino</i>						
<b>Non-Hispanic/Latino</b>							
2a	Asian						
2b1	Native Hawaiian						
2b2	Other Pacific Islander						
2c	Black/African American						
2d	American Indian/Alaska Native						
2e	White						
2f	More than One Race						
2g	Unreported/Refused to Report Race						
	<i>Subtotal Non-Hispanic/Latino</i>						
<b>Unreported/Refused to Report Ethnicity</b>							
h	Unreported/Refused to Report Race and Ethnicity						
i	<b>Total</b>						