
Validating and Reporting the 2018 UDS Clinical Measures (Version 1)



Serving Sonoma, Napa, Marin & Yolo Counties

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Purpose

The purpose of this document is to describe how to run the RCHC Bridgelt report set and Relevant report set in order to obtain the data for the UDS clinical tables (Tables 6B and 7). These instructions are based on the 2018 UDS Instructions from the Bureau of Primary Healthcare.

Summary of Content

Each UDS clinical measure has its own Relevant and Bridgelt report. Relevant Quality Measures should have “2018” in the title of the measure and may need to be activated to appear on the list. It is very important that the health center uses the latest version of the Bridgelt reports, which is documented in the RCHC Bridgelt Report Index¹. RCHC will release a new index when any reports are modified). NOTE that some reports may keep the same name (for example, CAD_LipidLower_v5) but have a new sub-version number (the CAD report is now version 5.1). The sub-version number is found in the Project Note of the report (right-click the report and choose “About” then read the Note in the window that opens). **First and foremost, the health center should compare the version numbers on the Index with the version numbers of the reports in the Toolbox and replace reports with the newest version from the Bridgelt Warehouse when necessary².**

Many of the Bridgelt reports that summarize data also have an associated validation report that are used to identify records with missing or incorrect data. The sections below describing the reports are placed in the order of appearance on the two clinical tables of the UDS report. Each section names the current Bridgelt report and version, the parameters and filters needed to obtain the correct numerator and denominator for the measure, where to find the result summary in the Excel output, and how to validate the data. Additional detail on how to run the reports can be found in the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018). A description of the eCW fields and calculations used in the report design can be found in the Technical Documentation For the Bridgelt Annual Clinical Report Set (Version 14, June 2018), which has been updated simultaneously with these Bridgelt UDS instructions . All documents can be obtained from Redwood Community Health Network (they are placed on the Peer Collaboration webpage of RCHC.net).

¹ As of the writing of these instructions, the most recent version is Bridgelt_Report_Index_July2017. However, this index is periodically updated as new versions of the reports become available

² It is recommended that outdated reports be renamed and moved to another folder within the Toolbox in case you need to use them in the future for reference or comparison.

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The Relevant Quality Measures have a standard structure and the 2018 data summary can be viewed when the measurement parameters are set to January 1, 2018 to December 31, 2018. The numerator and denominator are displayed right on the webpage (along with the number of exclusions, if applicable), and patient lists can also be viewed and downloaded for quality assurance purposes. The instructions for using the Relevant reports begin on page 25, below.

There are also three appendices at the end of this document. Appendix A contains a table comparing the 2017 to the 2018 measure definition. Appendix B contains a table that simply displays the BridgelT report name, filters and output needed for each measure. This table can be printed and used for reference. The body of the instructions below contains the detail needed to better understand the BridgelT report function and validation. Finally, Appendix C contains a list of names for the Relevant Quality Measures.

Introduction

These instructions were designed for staff at RCHC clinics who are familiar with the basic functions of BridgelT and Relevant. All reports should be run with the measurement period January 1 to December 31, 2018. Users are strongly urged to begin validating the data well-before the end of the calendar year.

Some BridgelT reports require standard set-up in eCW in order to pull the data correctly. These procedures are outlined in the document System Set-Up For the BridgelT Annual Clinical Report Set (Version 6, July 2017). RCHC periodically sends health centers an analysis of the current state of their set-up. Detailed instructions for assessing system set-up and searching for patient records that may have missing or erroneous data is found in the document Instructions for Using BridgelT Reports to Regularly Validate and Clean eCW Data (Version 5, November 2017). In many cases, the Relevant reports follow the standard data model.

Lastly, the Heckman Consulting Group has also created a set of BridgelT UDS clinical reports. In many cases, these reports pull the data differently than the standard way the RCHC clinics have agreed. If a health center runs those reports for comparison, be sure to read carefully the UDS report instructions provided by Heckman Consulting in order to understand the differences between the reports.

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Bridget Reports

TABLE 6B – QUALITY OF CARE INDICATORS

Early Entry Into Prenatal Care

Report name: UDS_Prenatal_v5

Parameters and filters: When first running the report, enter the measurement period start date (1/1/2018) and the measurement period end date (12/31/2018). Additionally, the user must also enter the UDS Age Date (6/30/2018), which is the date from which the patient's age is calculated.

The UDS report runs without the need of additional filtering in data sheet view.

Result summary: Table 6B, Section A of the UDS report requires the number of prenatal patients by age category. This is shown in the Excel output spreadsheet named "UDS Age." Table 6B, Section B requires the number of patients by trimester of entry into care and if they entered care at the grantee health center or with another provider. This is shown in the Excel output spreadsheet named "UDS Trimester." The user might need to combine rows describing the trimester of entry into care depending on the free text entered by providers for patients having a first prenatal visit with another provider.

Data validation: When a patient is first seen during the pregnancy by another provider (that is, when WithGranteeFirstVisit = "No"), the health center provider must manually enter the trimester of entry into care. Therefore, sort the trimester column (TrimesterOfEntry) and check for non-standard text values. These do not necessarily have to be corrected in the eCW patient record, but will appear in the result summary as such.

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Cervical Cancer Screening

Report name: Cervical Cancer Screening_v9

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). In the datasheet view, the user should filter for patients with one or more primary care visits (column PrimCareVisitsPeriod > 0) and patients without a hysterectomy (column Hysterectomy_Exclude not equal to "Exclude"). Also, filter for denominator patients based on gender and gender identity (Gender_Identity = "Female" or "Male-T").

Result summary: The output spreadsheet "PapHPV_Combined_Summary" can be used for reporting UDS Table 6B, Section D. The number of patients in the row "Grand Total" of the worksheet is used for the UDS report columns "TOTAL NUMBER OF FEMALE PATIENTS 23-64 YEARS OF AGE (a)" and "NUMBER CHARTS SAMPLED OR EHR TOTAL (b)" while the number in the row "Yes" (in the column Pap_HPVCombined_Status) is used for the UDS report column "NUMBER OF PATIENTS TESTED (c)."

Data validation: Validation should be done on patients who had several primary care visits during the measurement period (sort the column PrimCareVisitsPeriod in descending order) but no pap test or pap/HPV combo in the appropriate time frame (the column Pap_HPVCombined_Status = "No"). Why weren't these patients tested? You can also view the result summary by primary care provider in the output spreadsheet "PapHPV_Combined_Rendering." If you find that the report shows some patients did not get a pap but when you check their record there was a pap in the time frame, check to see if that particular pap test is included in the lab category "Pap test" (see the Bridgelt report technical document for how pap tests are identified).

There is another report available that displays all pap tests ordered in a chosen time frame and the essential fields in the Lab Window. The report Cervical Cancer Screen Validation_v6 should be used to find pap tests that appear to have been completed or have attached results, but all of the necessary fields have not been filled. The column MeetsSummRptCriteria will display "No" for labs that do not meet inclusion criteria. More detail is contained under the heading "Cervical Cancer Screening Lab Test Validation" in the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).

The report Cervical Cancer Exclusion_v1 displays patients with non-specific exclusion criteria. Further detail needs to be added to the medical record in order for these patients to meet the specific exclusion criteria defined by the measure. See the description of this validation report in the appendix of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).

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Setup check: Labs identified on this report are defined by lab categories. Therefore, the health center must ensure that all appropriate cervical cancer screening labs are associated with the lab category. See Appendix B of the System Set-up Document (version 6, July 2017) for more detail.

Child and Adolescent Weight Assessment and Counseling

Report name: Child_Weight_v7

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, patients are automatically filtered for having one or more primary care visits during the measurement period. The user must apply a filter to exclude patients who were pregnant any time during the measurement period (Exclusion_Pregnant not equal to “Exclude”).

Result summary: The datasheet “UDS_Summary” in the Excel output displays results that can be used for UDS reporting on Table 6B, Section E. The Grand Total on this worksheet is the denominator (Columns a and b in this section of the UDS report) and the value in the row “Met criteria” is the numerator (Column c, “NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED”).

Data validation: First, focus on those patients without a BMI percentile in the last year but with many visits. In the Bridgelt datasheet, filter for patients with no value in the column BMIPcntle_LastYear and sort descending the column PrimCareVisitsPeriod. Investigate a sample of patients with many visits but no BMI percentile.

Then, look at patients who had a BMI percentile in the past year but no counseling for nutrition or physical activity. Filter the column BMIPcntle_LastYear so it displays only “Yes” and the columns Couns_Nut_LastYear and Couns_Phys_LastYear so that they show only blanks (or in other words, not equal to “Yes”). Then sort descending the column PrimCareVisitsPeriod. Investigate why patients with many primary care visits did not receive counseling. Note: structured fields to enter counseling must have existed in eCW throughout the year for this report to be accurate.

Setup check: Ensure that there are questions in Preventive Medicine Structured Data named “Counseling for Nutrition provided” and “Counseling for Physical Activity provided.” If your health center is using Smart Forms to enter this data, make sure that the questions on the Smart Form are mapped to those questions in Preventive Medicine Structured Data. Check for other structured data elements used

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for this purpose but with non-standard text because they might not be recognized by the BridgetT report.

Adult Weight Screening and Follow-up

Report name: Adult_Weight_v9

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). The filters for patients 18 years and older with one or more primary care visits during the measurement period are automatically applied. The user must apply the filter to exclude patients who were pregnant or had Palliative Care during the measurement period (Exclusion_Preg_Palliative not equal to "Exclude")

Result summary: The output "Final_Summary" displays results that can be used for the UDS report Table 6B, Section F. The Grand Total on this worksheet is the denominator (Columns a and b in UDS table) and the value in the row "Meets documentation criteria" is the numerator (Column c, "NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE").

Data validation: First, focus on those patients without a BMI but with many visits. In the BridgetT datasheet, filter for patients with no value in the column LastBMIDate and sort descending the column PrimCareVisitsPeriod. Investigate a sample of patients with many visits but no BMI.

Second, sort the column LastBMIValue in ascending order and check the values in this column for the first few records and the last few records. Are there any extreme values that fall outside of normal possible range of BMI values?

Then, look at patients who needed a weight management follow-up plan but did not receive one. Filter the column BMICategory so it displays only "Follow up plan needed" and the column Final_Measurement_Result so it displays only "Does not meet documentation criteria." Then sort descending the column PrimCareVisitsPeriod. Investigate why patients who needed a follow-up plan and had many primary care visits did not receive a follow-up plan.

Setup check: Ensure that there is a question in Preventive Medicine Structured Data named "BMI Management Provided." If your health center is using Smart Forms to enter this data, make sure that the questions on the Smart Form are mapped to those questions in Preventive Medicine Structured

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Data. Check for other structured data elements used for this purpose but with non-standard text because they might not be recognized by the BridgeIT report.

Tobacco Use Screening and Cessation Intervention

Report name: Tobacco_v8

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018) and then use a single filter on the Data Sheet for patients with at least two primary care medical visits or at least one preventive visit in the measurement period (column Annual_Visit_Denom = "Add to annual report denominator").

Result summary: The datasheet "Tobac_Composite" in the Excel output displays results that can be used for reporting on the UDS Table 6B, Section G. The Grand Total on this worksheet is the denominator (Columns a and b in UDS table) and the value in the row "Assessed and intervened with as appropriate" is the numerator (Column c, "NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE AND PROVIDED INTERVENTION IF A TOBACCO USER").

Data validation: Examine patients without a tobacco assessment in the past two years (AnyTobacAssesm2Y = "No") but with many primary care visits in the measurement period (sort descending the column PrimCareVisitsPeriod). Investigate why a tobacco assessment was not done.

Examine patients who were tobacco users in the past two years (LastAssesmResult = "Tobacco User") but without a tobacco intervention since the last positive screen (TobaccoCessIntervAfterLastUser = "No"). Start with patients with many primary care visits in the measurement period (sort descending the column PrimCareVisitsPeriod). Investigate why a tobacco intervention was not done. Note: a cessation intervention must have been provided on the date of the last positive screen or between that date and the end of the measurement period.

Setup check: Ensure that there is a question in Social History Structured Data named "Are you a..." If your health center is using Smart Forms to enter tobacco assessment data, make sure that the questions on the Smart Form are mapped to those questions in Social History Structured Data. Check for other structured data elements used for this purpose but with non-standard text because they might not be recognized by the BridgeIT report. The report looks for responses to the tobacco assessment like "Yes" or "Current*" to determine if the patient is a tobacco user. Check for other non-standard responses.

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Ensure that there is a question in Preventive Medicine Structured Data named “Patient Counseled on the dangers of tobacco use and urged to quit.” If your health center is using Smart Forms to enter this data, make sure that the questions on the Smart Form are mapped to those questions in Preventive Medicine Structured Data. Check for other structured data elements used for this purpose but with non-standard text because they might not be recognized by the BridgIT report.

Run the BridgIT report “Clin_Medications and Med Groups”³ to see all medications and medication groups used in your system. Filter the column RxGroupName for the tobacco cessation RX Group (“Tob Cessation”) and make sure that all the medications associated with the group are correct. Then look for medications that should be but are not yet assigned to the group. Note that all appropriate medications on this list must be assigned to the tobacco medications group even if other medications with the same or similar names are already assigned.

Asthma Pharmacologic Therapy

Report name: Asthma_Pharma_v8

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, filter for patients with one or more primary care visits during the measurement period (PrimCareVisitsPeriod >0), persistent asthma (HasPersistentAsthma = “Yes”) and no exclusion criteria (Exclude_UDS does not equal “Exclude”).

Result summary: The datasheet “AsthmaMeds” in the Excel output displays results that can be used for the UDS report Table 6B, Section H. The Grand Total on this worksheet is the denominator (Columns a and b in the UDS table for this measure) and the value in the row “Yes” (for AsthmaMedWithin1Y) is the numerator (Column c, “NUMBER OF PATIENTS WITH ACCEPTABLE PLAN”).

Data validation: To validate the denominator, run the report called Asthma_Validation_v4. This report can be filtered to show all patients *without* a persistent asthma diagnosis description on the problem list, but *with* a persistent asthma diagnosis description on any assessment or claim. See the section “Asthma Problem List Validation” in the appendix of the Instructions for Using the BridgIT Annual Clinical Report Set (Version 14, June 2018), for more details.

³ Possible location: Warehouses \ Library \ Master Library \ Workbook \ UDS and CMS Clinical Setup

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Another validation of patients who might be missing a persistent asthma diagnosis can be performed directly on the data report. Filter for recent patients not recognized as having persistent asthma (PrimCareVisitsPeriod >0, HasPersistentAsthma = "No" and Exclude_UDS does not equal "Exclude") yet have been prescribed an inhaled corticosteroid or an alternative medication in the past year (AsthmaMedWithin1Y = "Yes"). Should any of these patients be clinically diagnosed with persistent asthma by a medical provider?

Setup check: Run the Bridgelt report "Clin_Medications and Med Groups"⁴ to see all medications and medication groups used in your system. Filter the column RxGroupName for the asthma RX Group ("Asthma Meds") and make sure that all the medications associated with the group are correct. Then look for medications that should be but are not yet assigned to the group. Note that all appropriate medications on this list must be assigned to the Asthma Meds group even if other medications with the same or similar names are already assigned.

Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol

Report name: CAD_LipidLower_v5

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, filter for patients with one or more primary care visits during the measurement period (PrimCareVisitsPeriod >0) and two or more visits ever (PrimCareVisitsEver > 1). Patients must also not meet the exclusion criteria (UDS_ExcludeLDL not equal to "Exclude").

Result summary: The worksheet "UDS_LL_Meds_Summary" in the Excel output summarizes the column UDS_final_result. The Grand Total on this datasheet is the denominator (Columns a and b in the UDS Table 6B, Section I) and the value in the row "Include in numerator (had medication)" is the numerator (Column c, "NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY").

Data validation: There is a validation report (CAD_Validation_v5) shows all patients with a CAD diagnosis code on the problem list, on any assessment, or on any claim. Since the data report defines patients

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with CAD by a diagnosis code on the problem list only, the validation report can be used to find patients with a CAD diagnosis code on an assessment or claim, but no diagnosis code on their problem list. These patients would otherwise be missed by the report. See the section “CAD Problem List Validation” in the appendix of the Instructions for Using the Bridgelyt Annual Clinical Report Set (Version 14, June 2018) for additional detail.

Setup check: Run the Bridgelyt report “Clin_Medications and Med Groups”⁵ to see all medications and medication groups used in your system. Filter the column RxGroupName for the lipid lowering RX Group (“UDS Lipd Meds”) and make sure that all the medications associated with the group are correct. Then look for medications that should be on the list but are not yet assigned to the group. Note that all appropriate medications on this list must be assigned to the lipid lowering meds group even if other medications with the same or similar names are already assigned.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Report name: IVD_Aspirin_v7

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, filter for patients with one or more primary care visits during the measurement period (PrimCareVisitsPeriod >0), no exclusion criteria (Exclusion_Anticoag not equal to “Exclude”), and included in the denominator (Denominator_Type = “Include: IVD code on problem list” or “Include: Myocardial Infarction with Appropriate Date” or “Include: Cardiac Surgery with Appropriate Date”). In other words, remove any patients with unknown denominator status (Denominator_Type not equal to any that begin with “Unknown: Acute MI, CABG or PCI on Problem List WITHOUT Onset Date or with old Onset Date” and not equal to “Unknown...”). See the Data Validation section below for instructions on how to deal with these “unknown” patients.

Result summary: The worksheet “UDS_Aspirin_Summary” in the Excel output summarizes the column AsprMedWithin1Y. The Grand Total on this datasheet is the denominator (Columns a and b in the UDS Table 6B, Section J) and the value in the row “Yes” is the numerator (Column c, “NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTIPLATELET THERAPY”).

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Data validation: Patients who have had an Acute Myocardial Infarction (AMI), Percutaneous Coronary Intervention (PCI) or a Coronary Artery Bypass Graft (CABG) in the past two years should be included in the denominator if they do not already have an IVD diagnosis on their Problem List. Because surgeries and cardiovascular events are often entered into various parts of the medical record without a required date, it is necessary to have a standard data-entry method so that patients can be appropriately and consistently identified. More details on data entry can be found in the IVD report section of the Technical Documentation For the Bridgelt Annual Clinical Report Set (Version 14, June 2018).

There is a validation report called IVD_CarVasSurg_Validation_v5 that displays patients who potentially might qualify for the denominator of this measure, but not enough specific information is available to include them. This report features a column "Recommended_Action" that can be used by a provider to make a change to the record if the patient actually qualifies. This action can take several forms, depending on the missing data. See the report description in the appendix of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018) for more details on how to use this report.

Setup check: Run the Bridgelt report "Clin_Medications and Med Groups"⁶ to see all medications and medication groups used in your system. Filter the column RxGroupName for the aspirin RX Group ("Aspirin Therapy") and make sure that all the medications associated with the group are correct. Then look for medications that should be on the list but are not yet assigned to the group. Note that all appropriate medications on this list must be assigned to the Aspirin Therapy Rx group even if other medications with the same or similar names are already assigned. NOTE that in 2017, the medication definition changed from "antithrombotic" to "antiplatelet." The eCW medication group name used by the report ("Aspirin Therapy") remains the same, therefore the health center must review the list of medications as described above to make sure that only the appropriate Aspirin and antiplatelet medications remain. A list of suggested antiplatelet medications appears in Appendix D of the document, System Set-Up For the Bridgelt Annual Clinical Report Set (Version 6, July 2017).

Follow the same procedure of using the Bridgelt report "Clin_Medications and Med Groups" to also check the medications in the anticoagulant medication group your health center uses for the report. Potential names include "Warfarin," "Coumadin" or "Anticoagulant."

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Colorectal Cancer Screening

Report name: ColRect Cancer Screening_v7

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, filter for patients with one or more primary care visits during the measurement period (PrimCareVisitsPeriod >0) and no exclusion criteria (Exclude_Colrect_ColCancer not equal to "Exclude").

Result summary: The worksheet "Colorectal Cancer Screen Summ" in the Excel output summarizes the column Screened. The Grand Total on this datasheet is the denominator (Columns a and b in the UDS Table 6B, Section K) and the value in the row "Yes" is the numerator (Column c, "NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER"). The other rows, "Never screened" and "Old screen" are for your information only.

Data validation: There are three separate data validation reports available for this measure:

1. Colorectal Cancer FOBT Lab Test Validation (ColRect_LabTest_Validation_v3). This report displays all FOBT and FIT tests (associated with LOINC codes) ordered within a period of time that do not have results entered properly into the eCW structured data fields. See details under the heading "Colorectal Cancer FOBT Lab Test Validation" in the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).
2. Colorectal Cancer Colonoscopy and Sigmoidoscopy Image Validation (ColRect_Image_Validation_v4). The report displays all colonoscopy and sigmoidoscopy images ordered within a period of time that do not have results entered properly into the eCW structured data fields. See details under the heading "Colorectal Cancer Colonoscopy and Sigmoidoscopy Image Validation" in the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).
3. ColRect Cancer Exclusion_v1. This report displays patients with non-specific exclusion criteria. Further detail needs to be added to the medical record in order for these patients to meet the specific exclusion criteria defined by the measure. See the description of this validation report in the appendix of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).

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Setup check: Run the Bridgelt report "Clin_Lab Tests with Attributes LOINC Code Review"⁷ to view all lab names, attributes and LOINC codes used in your system. Check for any attributes showing FOBT or FIT tests not assigned to the appropriate LOINC codes (see the technical document for details).

Newly Identified HIV Cases With Timely Follow-up

Report name: HIV_Timely_Followup_v4

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). The HIV report will automatically calculate the HIV diagnosis range, which is three months prior to the measurement period start date to three months prior to the measurement period end date (for example, October 1, 2017 to September 30, 2018 for the UDS).

In the datasheet, for patients who were newly diagnosed in that period of time (HIV_diag_date_MP-3M = "First diagnosed in HIV diagnosis reporting period") and who had a visit in the past 2 years (2Years_PrimCareVisits > 1)

Result summary: The worksheet "HIV Followup 90 Days" in the Excel output summarizes the column HIV_Followup_Outcome. The Grand Total on this datasheet is the denominator (Columns a and b in the UDS Table 6B, Section L) and the value in the row "Had HIV Followup within 90 days" is the numerator (Column c, "NUMBER OF PATIENTS SEEN WITHIN 90 DAYS OF FIRST DIAGNOSIS OF HIV").

Data validation: The report looks for the newly diagnosed date in two places: structured data or the Onset date on the problem list. Therefore, it is important that all patients newly diagnosed with HIV have a date in one or the other, or they will not be picked up by the report. There is a validation report for this purpose: HIV_FirstDx_Validation_v3. The user would filter this report for patients missing the newly diagnosed date, but with the first HIV diagnosis date appearing on any the assessment, claim, or 'added to' problem list field within the correct date range. These records would then need to be audited and fixed by someone authorized to do so. See the section "Initial HIV Diagnosis Validation" of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018) for additional detail.

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Setup check: Check to see if a structured data element exists in your system named “Date of positive test” in the HPI Structured Data Category “HIV.”

Note: The HIV report can also give the number of patients diagnosed with HIV who were pregnant during the measurement period. This is useful for the measure **HIV Positive Pregnant Women**, Table 7, Top Line (Line 0). This population of patients should have had one or more primary care medical visits during the measurement period (PrimCareVisitsPeriod > 0) and also was been pregnant in that period (Pregnancy_Status = “Pregnant during measurement period”). There is no output for this measure, but the filtered data sheet will display the unduplicated number of patients.

Depression Screening and Follow-up

Report name: Depression_Screen_Followup_v8

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). In the datasheet, filter for patients without a diagnosis of depression or bipolar disorder on the problem list at the start of the measurement period (StartMP_Dx_ProbList_Exclude not equal to “Exclude”). The criteria for age (12 years and older) and one or more medical visits is automatically applied.

Result summary: The worksheet “Outcome_Summ” in the Excel output summarizes the column Reporting_Outcome. The Grand Total on this datasheet is the denominator (Columns a and b in the UDS Table 6B, Section M) and the value in the row “Appropriately screened/followed-up” is the numerator (Column c, “NUMBER OF PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE”).

Data validation: Investigate patients with many visits to the health center (sort PrimCareVisitsPeriod descending) and no exclusion criteria (StartMP_Dx_ProbList_Exclude not equal to “Exclude”) but never screened for depression (Screened_MP= “No”). Why were they not screened? Also, with the same visit and exclusion filters, look at patients with at least one positive screen (Positive_Screen_MP = “Yes”) but no follow-up (Any_Followup_SameDay = “No, did not have follow-up on the same day”). Why was there no follow-up given to the patient after they screened positive for depression?

The validation report Depress_Screen_Validation_v5 gives additional detail on individual screens during the measurement period. Whereas the annual report displays unduplicated patients and the date of the

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first positive screen plus follow-up results on that date, the validation report shows all of the screening dates in the measurement period and any associated positive screens and follow-up activities performed on the same date. For additional detail, see the section “Positive Depression Screens and Follow-up Validation Report” in the appendix of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018).

Another Bridgelt report named `Depress_Diag_Validation_v3` is used to make sure patients with depression or bipolar disorder have an appropriate diagnosis code on their Problem List. See the section “Depression Diagnosis Validation” of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018), for additional detail.

Setup check: Check the medications in the medication group “Antidepressants” by running the Bridgelt report “Clin_Medications and Med Groups”⁸. Check to see if all the required structured data elements exist in HPI Structured Data and that any associated Smart Forms are mapped to that location. See the Technical Document for more detail on how the PHQ-2 questions, PHQ-9 score, and follow-up for depression should all be entered into eCW.

Dental Sealants

Report name: `Dental_Sealants_v1`

Parameters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). The report counts the number of completed encounters with a dental provider in that period of time (column `Dental_Visits_MP`). The initial patient population displayed by the report without filters consists of patients between the ages of 6 and 9 years with at least one encounter with a dental provider in the measurement period.

This report is unlike the other clinical Bridgelt reports because it is probable that not all of the information required to evaluate the measure is actually present in eCW (and therefore not in Bridgelt). That means that health centers will need to perform a chart sample according to the procedures defined in the UDS Instruction Manual, unless there is a dental software that can be used instead. The instructions below describe how the Bridgelt report can be used in this effort.

⁸ Possible location: Warehouses \ Library \ Master Library \ Workbook \ UDS and CMS Clinical Setup

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Chart Audit: The filtering of the Bridgelt report depends on the use of the specified CDT codes on claims. To be included in the denominator of the report, the patient must have the following CDT codes:

1. Oral assessment, comprehensive evaluation or periodic oral evaluation (CDT: D0120, D0145, D0150, D0180, or D0191). If at least one of these codes is present on a claim in the year prior to the end of the measurement period, the column Had_OralEval will display “Yes.”
2. Caries risk assessment of moderate or high risk (CDT: D0602 or D0603). If at least one of these codes is present on a claim in the year prior to the end of the measurement period, the column Risk_Carries will display “Moderate to high risk.”

If your health center is consistently using both of these sets of codes, the filters for these columns can be set to “Yes” and then the chart sampling procedure will only need to determine if the patient has exclusion criteria (i.e., all first permanent molars are non-sealable). However, from a quick investigation, many health centers are using only the oral evaluation codes.

The chart audit is used to obtain the numbers for columns (a), (b) and (c) of Table 6B, line 22 on the UDS report. The first stage of the audit is the Denominator Determination, which is used to calculate column (a) and obtain the sample of 70 records that can be used for the second stage. Certain columns on the Bridgelt can be used to accept or exclude a record from the denominator, but other information must come from the patient’s actual dental record. The second stage of the audit is the Numerator Determination. In this stage, the dental record is checked to see if the patient received a sealant on a permanent first molar tooth.

Denominator Determination. When the Bridgelt report is run for the Measurement Period of 1/1/2018 to 12/31/2018, the initial patients displayed are between the ages of 6 and 9 years and have at least one encounter with a dental provider in the measurement period. Sort the list by the column Random_Number in ascending order (this column displays a random number between 1 and 1000) and begin checking the patients beginning with the first (top) record. When inspecting records, you must keep a count of two things: the number of records inspected and the number of records included in the denominator. The Denominator Determination stage stops when you reach 70 records included in the denominator.

To include the patient in the denominator, all three of the following conditions must be met. Otherwise exclude the patient from the denominator. The information needed to evaluate these conditions can come from Bridgelt or the dental record.

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1. The patient had at least one oral assessment, comprehensive evaluation or periodic oral evaluation in the measurement year. Information can come from Bridgelt (column Had_OralEval = "Yes") or the dental record.
2. The patient had a caries risk assessment of moderate or high risk. Information can come from Bridgelt (column Risk_Carries = "Moderate to high risk") or the dental record.
3. The patient does not have all non-sealable first permanent molars (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing). Information comes the dental record.

Once you have 70 records included in the denominator, stop the Denominator Determination stage. You will need to make an estimate for Line 22, column (a). First, divide 70 by the number of records you had to review to find the 70. Second, multiply this ratio by the total number of patients between the ages of 6 and 9 years who have at least one encounter with a dental provider in the measurement period (this is the initial population displayed by the Bridgelt report). Line 22, column (b) is equal to 70.

Refer to the section named "Identifying Dental Sealants Universe Where Codes and Caries Risk Level Are Unavailable" in Appendix C of the 2018 UDS Instructions (page 181) for more details.

Numerator Determination. Take the 70 records and determine if these patients are included in the numerator⁹. These patients must have received a sealant on a permanent first molar tooth. The column Had_Dental_Sealant will display "Had sealant on any tooth" if the CDT code "D1351" appeared on any claim in the year prior to the measurement period end date. However, note that this code is used for the application of any dental sealants, not just those for permanent first molar teeth. Therefore, this code is present only for guidance, and the last date a sealant was applied appears in the column Last_Dental_Sealant. The dental record will need to be inspected for denominator patients in cases where this code appears or not. Of the 70 denominator records, enter the number of patients who met the numerator criterion in Line 22, column (c).

⁹ Even though the denominator and numerator determinations are separate in these instructions, to save time, you can look for the numerator criterion at the same time as looking at the denominator criteria for the records that are included in the denominator.

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TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Birth Weight From Deliveries

Report name: UDS_Deliveries_v4

Parameters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018).

Result summary and filters: There are three result summaries for Table 7, Section A. They are:

1. “UDS deliv by grantee prov” for Line 2 (note: results displayed by race and ethnicity, but only the grand total is reported on the UDS)
2. “UDS Patients Delivered” for Column 1a
3. “UDS birth weights” for Columns 1b – 1d

The filters needed for each measure and the data sheets that summarize the data are explained in the section “Birth Weight From Deliveries” of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018). NOTE: data validation must occur before using the results (see next section).

Data validation: A separate document titled “Technical Documentation for the Bridgelt Annual Clinical Report Set” (Version 14, June 2018) discusses the columns of the report in relation to the data entry fields in eCW. The data report was designed to initially display as many potential patients as possible, then allow filtering once records with missing or non-standard data are cleaned.

Even though the report contains result output worksheets that summarize the data, users might decide to copy the data to an Excel spreadsheet in their own files and correct and/or update the fields there. Some health centers do not allow records to be altered or completed once they are ‘locked.’

The procedure for validating the data is more complex than for the other UDS reports, and this is detailed in the section “Birth Weight From Deliveries” of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018). In brief, users need to follow-up with patients who should have delivered during the year but had no documented delivery or other outcome, and also to check for missing or non-standard birth weight entries.

Because of the potential for missing or non-standard data, it is strongly recommended that health centers begin their data validation efforts early and incorporate them into monthly practice.

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Setup Check: Use the Bridgelt report “Clin_OB Discharge Tab”¹⁰ to review the items recorded on OB Discharge Tab. Refer to the RCHC manuals System Set-Up For the Bridgelt Annual Clinical Report Set (Version 14, June 2018) and the Technical Documentation For the Bridgelt Annual Clinical Report Set (Version 14, June 2018) for more detailed descriptions of the items that the data report is picking up in eCW.

Blood Pressure Control Among Patients With Hypertension

Report name: Hypertension_v8

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). The ‘diagnosed prior’ date is automatically determined to be 6/30/2018 based on this measurement period. When viewing the datasheet, filter for patients with one or more primary care visits (PrimCareVisitsPeriod > 0), first diagnosed with general hypertension prior to six months before the end of the Measurement Period (EssHTN_DiagnosisBeforePriorDate = “Yes”) and not meeting any exclusion criteria (Exclusion_HTN not equal to “Exclude”).

Result summary: This measure is reported by race and ethnicity categories on Table 7, Section B. The output spreadsheet named “BP UDS Race Ethnicity” displays the race and ethnicity categories the health center uses in the rows and the UDS blood pressure categories in the columns. Note that the race and ethnicity categories might need to be organized and/or summarized to fit the required UDS categories, depending on how the health center enters data into these fields.

The worksheet “BP UDS Race Ethnicity” in the Excel output summarizes the column LastBPStatus_UDS_ACO. The column “Grand Total” on the worksheet is the denominator (Columns 2a and 2b in the UDS Table 7, Section B) and the values in the column “Controlled” are the numerator (Column 2c, “Patients with HTN Controlled”).

Data validation: First, look for blood pressure values that contain non-standard values by comparing text in “LastBPValuePeriod” to “BPSys” and “BPDias.” If the report does not understand the values before or after the “/” in the column “LastBPValuePeriod” it will leave “BPSys” and “BPDias” blank. Therefore look for rows where there is a BP recorded (LastBPValuePeriod is not blank) but there is not a systolic or diastolic value (use a filter for when “BPSys” is blank, and then use another for when “BPDias” is blank).

¹⁰ Possible location: Warehouses \ Library \ Master Library \ Workbook \ UDS and CMS Clinical Setup

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Next, look for patients who have lots of visits in the measurement period but no blood pressure reading or no recent reading. Filter for patients without a recent blood pressure (LastBPDatePeriod is null or not within the last year, or LastBPStatus_Detailed = “No result” or “Not measured in past year”) and sort the entire list by primary care visits (the column PrimaryCareVisitsPeriod in descending order). Are there patients who do not have a blood pressure even though they were seen many times and it is routine to get a blood pressure during a primary care visit?

Appendix A of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018) contains a description of a report that can be used to ensure that all patients with hypertension have a hypertension diagnosis code on their problem list (see the heading “Hypertension Problem List Validation”).

Setup check: Run the Bridgelt report “Clin_Vitals Keys used”¹¹ to see all vitals used in your system. The report pulls only those vitals with a name beginning with “*BP*” (where “*” can be any text or no text). Make sure that there are no other commonly used blood pressure vital names.

Blood Sugar and Other Measures Among Patients With Diabetes

Report name: Diabetes_v8

Parameters and filters: Upon running the report, enter the measurement period (i.e., 1/1/2018 to 12/31/2018). When viewing the datasheet, filter for patients with one or more primary care visits (PrimCareVisitsPeriod > 0) in the measurement period.

Result summary: This measure is reported by race and ethnicity categories on Table 7, Section C. The output spreadsheet named “A1c UDS Race Ethnicity” displays the race and ethnicity categories the health center uses in the rows and the UDS HbA1c categories in the columns. Note that the race and ethnicity categories might need to be organized and/or summarized to fit the required UDS categories, depending on how the health center enters data into these fields.

The worksheet “A1c UDS Race Ethnicity” in the Excel output summarizes the column LastA1CStatus_UDS. The column “Grand Total” on the worksheet is the denominator (Columns 3a and

¹¹ Possible location: Warehouses \ Library \ Master Library \ Workbook \ UDS and CMS Clinical Setup

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3b in the UDS Table 7, Section C). The values in the output column “Patients with HbA1c >9% Or No Test During Year” are placed in the column “Patients with HbA1c >9% Or No Test During Year (3f)” of the UDS table.

Data validation: First, look for HbA1c values that contain non-standard text or values by sorting the last lab value (LastA1CResult) in ascending order and inspect the non-blank cells near the top and bottom of the column. Are there non-standard results that did not translate to the A1c status column (LastA1CStatus_UDS)? Were there results out of the normal test range, for example an A1c with a value of 75?

Next, look for patients who have lots of visits in the measurement period but no A1c test or no recent test. Filter for patients without a recent A1c result (LastA1CResult is null or not within the last year) and sort the entire list by primary care visits (the column PrimaryCareVisitsPeriod in descending order). What happened to these patients? Why weren’t they tested?

See the section “Diabetes Problem List Validation” in the Appendix of the Instructions for Using the Bridgelt Annual Clinical Report Set (Version 14, June 2018) for a description of a report that can be used to ensure that all patients with diabetes have a diabetic diagnosis code on their problem list. There is another validation report that focuses on HbA1c lab results that may not be completely entered into structured data in the same appendix (see the section “Diabetes Lab Test Validation”).

Setup check: Run the Bridgelt report "Clin_Lab Tests with Attributes LOINC Code Review"¹² to view all lab names, attributes and LOINC codes used in your system. Check for any attributes showing A1c tests not assigned to the appropriate LOINC codes (see the technical document for details).

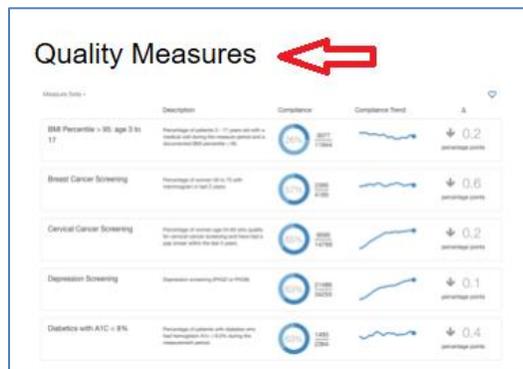
¹² Possible location: Warehouses \ Library \ Master Library \ Workbook \ UDS and CMS Clinical Setup

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Relevant Reports

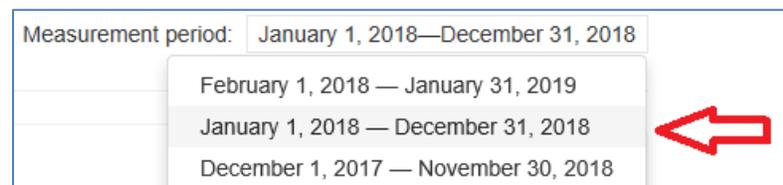
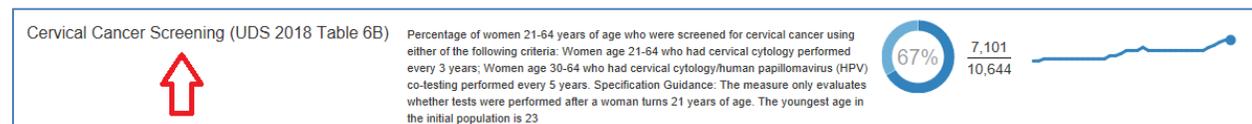
First Method: Quality Measures Section

Relevant Quality Measures display a summary of the UDS data in year-long periods of time. If the measurement period is set to January to December, then the UDS annual data can be viewed. Appendix C contains a list of the standard Quality Measure names for the UDS clinical measures in Tables 6B and 7.



To obtain the UDS data, go to the Quality Measures section of Relevant.

Click on the measure you are interested in.

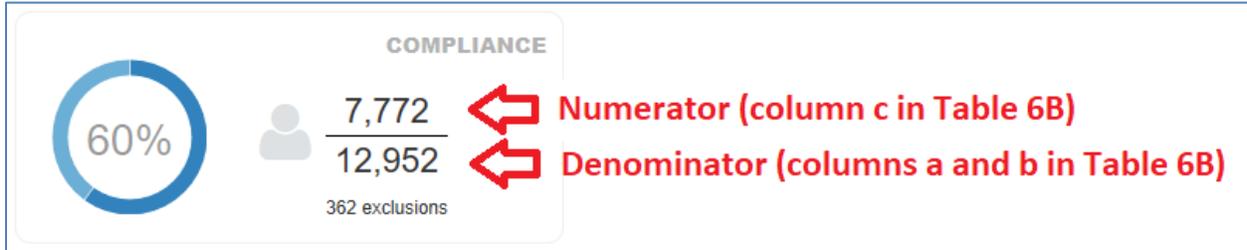


Choose the appropriate UDS measurement period from the drop-down list in the upper-right corner of the webpage.

Then, look for the Compliance graph and equation on the left-side of the webpage.

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The Compliance equation contains the results for the Table 6b section you are examining. Results for Table 7 (and for Section A of Table 6B) require additional detail. See the second method below.

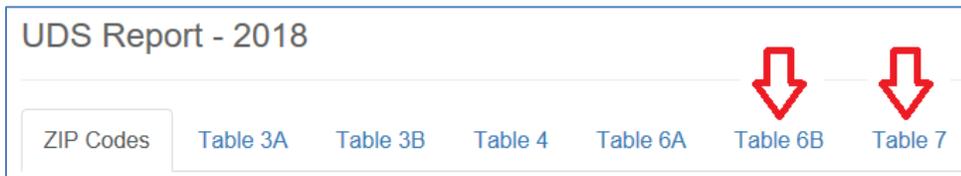


Second Method: UDS Report Tables Section

Go to the UDS tables section of Relevant. The address should be similar to this:

https://<your health center>.relevant.healthcare/uds_table_zip_codes_reports

Click on the link to Table 6B or Table 7



The tables automatically display the UDS measurement period and corresponding UDS columns.

Section D — Cervical Cancer Screening					
Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number of Charts Sampled or EHR total (b)	Number of Patients Tested (c)	Percentage of Patients Tested (d)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	12,952	12,952	7,772	60%

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Appendix A: Comparison of 2017 and 2018 UDS Measures

The table below compares the 2017 definition of the measure to the 2018 definition for those measures that changed. The specific changes are emphasized in italic font.

Measure Name	2017 UDS Definitions (From 2016 BPHC Instruction Manual)		2018 UDS Definitions (From 2017 BPHC Instruction Manual)	
	Denominator	Numerator	Denominator	Numerator
Adult Weight Screening and Follow-up	<ul style="list-style-type: none"> • 18 years or older during the reporting year and ever seen after 18th birthday • Had at least one medical visit during the reporting period • Exclusion: pregnant or had palliative care during the reporting period 	<ul style="list-style-type: none"> • Had a BMI documented at last visit in the reporting period <i>or within 6 months of the last visit</i> • When the most recent BMI is outside “normal” parameters, a follow-up plan is documented at that visit <i>or within 6 months of that visit</i> • Definition of normal parameters for all ages (18 years and older): BMI => 18.5 and < 25 kg/m² 	<ul style="list-style-type: none"> • 18 years or older during the reporting year and ever seen after 18th birthday • Had at least one medical visit during the reporting period • Exclusion: pregnant or had palliative care during the reporting period 	<ul style="list-style-type: none"> • Had a BMI documented at last visit in the reporting period <i>or within 12 months of the last visit</i> • When the most recent BMI is outside “normal” parameters, a follow-up plan is documented at that visit <i>or within 12 months of that visit</i> • Definition of normal parameters for all ages (18 years and older): BMI => 18.5 and < 25 kg/m²
Tobacco Use Screening and Cessation Intervention	<ul style="list-style-type: none"> • 18 years or older during the reporting year and ever seen after 18th birthday • Had at least two medical visits or at least one preventive visit during the reporting period 	<ul style="list-style-type: none"> • Had a tobacco assessment documented <i>within two years of the last visit</i> • If the patient was a tobacco user in the two-year screening period, the patient had at least one of the following <i>within two years prior to the last visit</i>: <ul style="list-style-type: none"> - Tobacco use cessation counseling - Smoking cessation agents (active medication or order) 	<ul style="list-style-type: none"> • 18 years or older during the reporting year and ever seen after 18th birthday • Had at least two medical visits or at least one preventive visit during the reporting period 	<ul style="list-style-type: none"> • Had a tobacco assessment documented <i>within two years of the end of the reporting period</i> • If the patient was a tobacco user in the two-year screening period, the patient had at least one of the following <i>on or after the last positive screen date</i>: <ul style="list-style-type: none"> - Tobacco use cessation counseling - Smoking cessation agents (active medication or order)

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Measure Name	2017 UDS Definitions (From 2016 BPHC Instruction Manual)		2018 UDS Definitions (From 2017 BPHC Instruction Manual)	
	Denominator	Numerator	Denominator	Numerator
Colorectal Cancer Screening	<ul style="list-style-type: none"> Between 50 and 75 years during the reporting period Had at least one medical encounter during the reporting period Exclusions: had colorectal cancer or total colectomy 	Had at least one of the following: <ul style="list-style-type: none"> FOBT or FIT in the past year Sigmoidoscopy in the past 5 years Colonoscopy in the past 10 years 	<ul style="list-style-type: none"> Between 50 and 75 years during the reporting period Had at least one medical encounter during the reporting period Exclusions: had colorectal cancer or total colectomy 	Had at least one of the following: <ul style="list-style-type: none"> FOBT in the past year FIT-DNA in the past 3 years Sigmoidoscopy in the past 5 years CT colonography in the past 5 years Colonoscopy in the past 10 years
Screening for Clinical Depression and Follow-Up Plan	<ul style="list-style-type: none"> 12 years or older at beginning of the reporting period Had at least one medical encounter during the reporting period Exclusions: patients with an active diagnosis for Depression or Bipolar Disorder 	<ul style="list-style-type: none"> Patients who were screened for clinical depression in the past year using an age appropriate standardized tool If the screen was positive, a follow-up plan was documented on the same date as the positive screen The PHQ-9 is considered a “secondary screen for depression” and therefore not directly counted as follow-up. If the PHQ-9 indicates depression, further follow-up is needed. 	<ul style="list-style-type: none"> 12 years of age or older at beginning of the reporting period Had at least one medical encounter during the reporting period Exclusions: patients with an active diagnosis for Depression or Bipolar Disorder 	<ul style="list-style-type: none"> Patients who were screened for clinical depression in the past year using an age appropriate standardized tool If the screen was positive, a follow-up plan was documented on the same date as the positive screen. The PHQ-9 is considered “further evaluation for depression” and therefore counted as follow-up

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Appendix B: Filters and Output Sheets

All reports should be run for the measurement period, which is the calendar year for the UDS report (1/1/2018 to 12/31/2018).

Measure	Report Name	Filters on data sheet	Output sheet
TABLE 6B – QUALITY OF CARE INDICATORS			
Early Entry Into Prenatal Care	UDS_Prenatal_v5	No additional filters	<ul style="list-style-type: none"> • UDS Age • UDS Trimester
Cervical Cancer Screening	Cervical Cancer Screening_v9	<ul style="list-style-type: none"> • PrimCareVisitsPeriod > 0 • Hysterectomy_Exclude <u>not</u> equal to "Exclude" • Gender_Identity = "Female" or "Male-T" (in other words, <u>exclude</u> "Female-T" from Gender_Identity) 	PapHPV_Combined_Summary
Child and Adolescent Weight Assessment and Counseling	Child_Weight_v7	Exclusion_Pregnant <u>not</u> equal to "Exclude"	UDS_Summary
Adult Weight Screening and Follow-up	Adult_Weight_v9	Exclusion_Preg_Pallative <u>not</u> equal to "Exclude"	Final_Summary
Tobacco Use Screening and Cessation Intervention	Tobacco_v8	Annual_Visit_Denom = "Add to annual report denominator"	Tobac_Composite
Asthma Pharmacologic Therapy	Asthma_Pharma_v8	<ul style="list-style-type: none"> • PrimCareVisitsPeriod >0 • HasPersistentAsthma = "Yes" • Exclude_UDS does <u>not</u> equal "Exclude" 	AsthmaMeds
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol	CAD_LipidLower_v5	<ul style="list-style-type: none"> • PrimCareVisitsPeriod >0 • PrimCareVisitsEver > 1 • UDS_ExcludeLDL <u>not</u> equal to "Exclude" 	UDS_LL_Meds_Summary

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Measure	Report Name	Filters on data sheet	Output sheet
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	IVD_Aspirin_v7	<ul style="list-style-type: none"> PrimCareVisitsPeriod >0 Denominator_Type = "Include: IVD code on problem list" –OR– "Include: Acute MI, CABG or PCI on Problem List with Onset Date" (filter for both options, if both are available) Exclusion_Anticoag <u>not</u> equal to "Exclude" 	UDS_Aspirin_Summary
Colorectal Cancer Screening	ColRect Cancer Screening_v7	<ul style="list-style-type: none"> PrimCareVisitsPeriod >0 Exclude_Colrect_ColCancer <u>not</u> equal to "Exclude" 	Colorectal Cancer Screen Summ
Newly Identified HIV Cases With Timely Follow-up	HIV_Timely_Followup_v4	<ul style="list-style-type: none"> HIV_diag_date_MP-3M = "First diagnosed in HIV diagnosis reporting period" 2Years_PrimCareVisits > 1 	HIV Followup 90 Days
Depression Screening and Follow-up	Depression_Screen_Followup_v8	StartMP_Dx_ProbList_Exclude <u>not</u> equal to "Exclude"	Outcome_Summ
Dental Sealants	Dental_Sealants_v1	This report is used to help with the chart audit, and is not used to summarize patients	
TABLE 7 – HEALTH OUTCOMES AND DISPARITIES			
Birth Weight From Deliveries	UDS_Deliveries_v4	No additional filters (but note that some patient data validation should occur before summarizing)	<ul style="list-style-type: none"> UDS deliv by grantee prov UDS Patients delivered UDS birth weights
Blood Pressure Control Among Patients With Hypertension	Hypertension_v8	<ul style="list-style-type: none"> PrimCareVisitsPeriod > 0 EssHTN_DiagnosisBefore PriorDate = "Yes" Exclusion_HTN <u>not</u> equal to "Exclude" 	BP UDS Race Ethnicity
Blood Sugar Control Among Patients With Diabetes	Diabetes_v8	<ul style="list-style-type: none"> PrimCareVisitsPeriod > 0 	A1c UDS Race Ethnicity

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Appendix C: Relevant UDS Quality Measures

All Quality Measures should be displayed for the appropriate measurement period, which is the calendar year for the UDS report (1/1/2018 to 12/31/2018). Note that the default date range displayed may not be this range.

Measure	Report Name
TABLE 6B – QUALITY OF CARE INDICATORS	
Early Entry Into Prenatal Care	Early Entry into Prenatal Care First Trimester (UDS 2018 Table 6B) NOTE: Use the UDS Tables section of Relevant for the detailed table.
Childhood Immunization Status	Childhood Immunization Status (UDS 2018 Table 6B) Note: eCW might not have complete immunization information for each patient
Cervical Cancer Screening	Cervical Cancer Screening (UDS 2018 Table 6B)
Child and Adolescent Weight Assessment and Counseling	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (UDS 2018 Table 6B)
Adult Weight Screening and Follow-up	Preventive Care and Screening: Body Mass Index (BMI) Screening And Follow-Up Plan (UDS 2018 Table 6B)
Tobacco Use Screening and Cessation Intervention	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (UDS 2018 Table 6B)
Asthma Pharmacologic Therapy	Use of Appropriate Medications for Asthma (UDS 2018 Table 6B)
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol	Coronary Artery Disease (CAD): Lipid Therapy (UDS 2018 Table 6B)
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (UDS 2018 Table 6B)
Colorectal Cancer Screening	Colorectal Cancer Screening (UDS 2018 Table 6B)
Newly Identified HIV Cases With Timely Follow-up	HIV Linkage to Care (UDS 2018 Table 6B)
Depression Screening and Follow-up	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (UDS 2018 Table 6B)
Dental Sealants	Dental Sealants for Children between 6-9 Years (UDS 2018 Table 6B)
TABLE 7 – HEALTH OUTCOMES AND DISPARITIES	
Birth Weight From Deliveries	Birth Weight: Normal (UDS 2018 Table 7, inverted) NOTE: Use the UDS Tables section of Relevant for the detailed table.

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Measure	Report Name
Blood Pressure Control Among Patients With Hypertension	Controlling High Blood Pressure (UDS 2018 Table 7) NOTE: Use the UDS Tables section of Relevant for the detailed table.
Blood Sugar Control Among Patients With Diabetes	Diabetes: Hemoglobin A1c Control ($\leq 9\%$) (UDS 2018 Table 7, inverted) NOTE: The Quality Measure is inverted. NOTE: Use the UDS Tables section of Relevant for the detailed table.