Introduction to Clinical Measures

For Calendar Year 2017 Uniform Data System (UDS) Reporting

November 2, 2017 from 1-2:30 PM (ET)
Objectives of this Webinar

- Understand the structure of the clinical tables
- Understand the changes to the clinical measures
- Identify ways to check data accuracy and reliability
Agenda

- Introduction to Uniform Data System (UDS) Clinical Tables
- Changes to 2017 UDS Clinical Tables
- Clinical Measures Overview
- Reminders and Strategies
- Questions
Introduction to UDS Clinical Tables and Changes for 2017
Changes to the Clinical Tables

› **Table 6A**: Updated diagnostic and service codes

› **Tables 6B and 7**: Continue to align UDS Clinical Quality Measures (CQMs) with the electronic-specified CQMs (eCQMs) used by the Centers for Medicare & Medicaid Services (CMS)

  ▪ Use **January 2017** for the 2017 reporting

  ▪ Specifications are included at the CMS [eCQI Resource Center](https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms)
## Alignment with eCQMs

<table>
<thead>
<tr>
<th>Table</th>
<th>Line</th>
<th>Description</th>
<th>eCQM</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B</td>
<td>10</td>
<td>Childhood Immunization Status</td>
<td>CMS117v5</td>
</tr>
<tr>
<td>6B</td>
<td>11</td>
<td>Cervical Cancer Screening</td>
<td>CMS124v5</td>
</tr>
<tr>
<td>6B</td>
<td>12</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>CMS155v5</td>
</tr>
<tr>
<td>6B</td>
<td>13</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>CMS69v5</td>
</tr>
<tr>
<td>6B</td>
<td>14a</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>CMS138v5</td>
</tr>
<tr>
<td>6B</td>
<td>16</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>CMS126v5</td>
</tr>
<tr>
<td>6B</td>
<td>18</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet</td>
<td>CMS164v5</td>
</tr>
<tr>
<td>6B</td>
<td>19</td>
<td>Colorectal Cancer Screening</td>
<td>CMS130v5</td>
</tr>
<tr>
<td>6B</td>
<td>21</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</td>
<td>CMS2v6</td>
</tr>
<tr>
<td>6B</td>
<td>22</td>
<td>Dental Sealants for Children between 6–9 Years</td>
<td>CMS277v0</td>
</tr>
<tr>
<td>7</td>
<td>Part B</td>
<td>Controlling High Blood Pressure</td>
<td>CMS165v5</td>
</tr>
<tr>
<td>7</td>
<td>Part C</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>CMS122v5</td>
</tr>
</tbody>
</table>

Note: Early Entry into Prenatal Care, Coronary Artery Disease, and HIV Linkage to Care on Table 6B, and Low Birthweight on Table 7 do not currently align with an eCQM.
Table 6A

Selected Diagnoses and Services Rendered
Purpose of Table 6A

- Reports visits and patients for selected diagnoses and services
- Can be used to estimate prevalence for specific diagnoses and services
- Indicates continuity of care by calculating average visits per patient by diagnosis

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Applicable ICD-10-CM Code</th>
<th>Number of Visits by Diagnosis Regardless of Primacy (a)</th>
<th>Number of Patients with Diagnosis (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selected Infectious and Parasitic Diseases</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2. Symptomatic / Asymptomatic HIV</td>
<td>B20, B97.35, O98.7-, Z21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Tuberculosis</td>
<td>A15- through A19-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Sexually transmitted infections</td>
<td>A50- through A64- (exclude A63.0), M02.3-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4a. Hepatitis B</td>
<td>B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4b. Hepatitis C</td>
<td>B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Selected Diseases of the Respiratory System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Asthma</td>
<td>J45-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Chronic obstructive pulmonary diseases</td>
<td>J40- through J44-, J47-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Excerpted from Table 6A*
Categories of Selected Diagnoses and Services

- Medical Conditions:
  - Infections and Parasitic Diseases (Lines 1-4b)
  - Diseases of the Respiratory System (Lines 5-6)
  - Other Medical Conditions (Lines 7-14a)
  - Childhood Conditions (limited to ages 0 through 17) (Lines 15-17)

- Mental Health and Substance Abuse Conditions (Lines 18-20d)

- Diagnostic Tests/Screening/Preventive Services (Lines 21-26d)

- Dental Services (Lines 27-34)
Visits Reported for Selected Diagnoses: Column A, Lines 1–20d

- Report the number of visits where the diagnosis was coded either as a primary diagnosis or as an additional diagnosis
  - Count each visit where the identified diagnosis is coded is counted
  - Count if patients have more than one reportable diagnosis during a visit, each is counted
Visits Reported for Selected Services: Column A, Lines 21–34

- Report the number of visits at which one or more of the selected services were provided
  - Count each visit during which the service is provided
  - Count those services provided at the health center or by an in-scope contractor paid by the health center
  - If patients have more than one reportable service during a visit, count each
  - Do not count multiple services in the same category at one visit
    - e.g., only count one visit in Column A (not two) if two vaccines are provided at a single visit
Patient Count (Services or Diagnoses): Column B

- Report the number of unduplicated patients who:
  - had a specified diagnosis or
  - who received one or more of the selected services

Services Provided by Multiple Entities

- Count services if:
  - health center provider orders and performs service
  - health center orders the test and sample collected at the health center and sent to a reference lab for processing (count regardless of who pays for service)
  - health center refers patient for service, but the health center receives results and pays for service

- Do not count if:
  - patient is referred to another provider for service or test and the health center does not pay for the service
Tips to Assess Accuracy of Table 6A Data

- Check patient counts in Column B for lines 1–20d (diagnoses) by estimating prevalence of chronic conditions and compare that to what you report for your community in your needs assessment
  - Divide the number in Column B by medical patients on Table 5
- Check Columns A and B by calculating the average number of service visits per patient for all lines
  - Compare with what your providers say is the frequency with which they see patients
  - Compare with the frequency from the prior year and check any significant changes – understand what caused them
Tables 6B and 7
Clinical Performance Measures
Types of Clinical Measures

Preventive
- Early Entry into Prenatal Care
- Low Birth Weight
- Childhood Immunization Status, CMS117v5
- Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents, CMS155v5
- Dental Sealants for Children between 6-9 Years, CMS277v0

Screenings
- Cervical Cancer Screening, CMS124v5
- Colorectal Cancer Screening, CMS130v5
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan, CMS69v5
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, CMS138v5
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan, CMS2v6

Diseases
- Use of Appropriate Medications for Asthma, CMS126v5
- Coronary Artery Disease (CAD): Lipid Therapy
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet, CMS164v5
- HIV Linkage to Care
- Controlling High Blood Pressure, CMS165v5
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), CMS122v5
# Clinical Measure Reporting Format

<table>
<thead>
<tr>
<th><strong>Measure Description</strong></th>
<th>Describes the quantifiable indicator to be evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator (Universe)</strong></td>
<td>Patients who fit the detailed criteria described for inclusion in the measure</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Patients included in the denominator whose records meet the measurement standard for the measure</td>
</tr>
<tr>
<td><strong>Exclusions/Exceptions</strong></td>
<td>Patients not to be considered for the measure or included in the denominator</td>
</tr>
<tr>
<td><strong>Specification Guidance</strong></td>
<td>CMS measure guidance that assists with understanding and implementation of eCQMs</td>
</tr>
<tr>
<td><strong>UDS Reporting Considerations</strong></td>
<td>BPHC best practices and guidance to be applied to the measure</td>
</tr>
</tbody>
</table>
Codes for measures that align with an eCQM should be identified through the [eCQI Resource Center](http://www.ecqi.org) and [United States Health Information Knowledgebase (USHIK)](http://www.ushik.gov).
Codes can be found under the ‘Data Criteria’ tab within the eCQM detail available at the USHIK website.

### Colorectal Cancer Screening

**CMS130v5**


![Data Criteria](Image)

#### Category | Data Element | Value Set
--- | --- | ---
 | 109530007, 1257210001, 191108, 1701000119104, 187757001, 269533000, 269544008, 265312008, 265611007, 351765000, 351111003, 312112002, 312113007, 312114001, 312115000, 314965007, 315058005, 363406005, 363407001, 363400006, 363409003, 363410000, 363412000, 363413005, 363414004, 363510005, 425176004, 445216003, 93689002, 93761005, 93771007, 93562009, 93980002, 94060002, 94072004, 94105000, 94179005, 94260004, 94271003, 94328009, 94509004, 94538001, 94604000, 94643001
 | (2015-09)
 | ICD9CM (2013)
 | 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.4, 154.8, 197.5
 | ICD10CM (2017)
 | C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C78.5

#### Encounter

**Encounter, Performed: Annual Wellness Visit**

2.16.840.1.113883.3.464.1003.108.12.1001 (Version: MU2 Update 2017-01-06)

HCPCS (2016)

**Encounter, Performed: Face-to-Face Interaction**

2.16.840.1.113883.3.464.1003.108.12.1001 (Version: MU2 Update 2017-01-06)

SNOMEDCT (2015-09)

**Encounter, Performed: Home Healthcare Services**


CPT (2016)

**Encounter, Performed: Office Visit**

2.16.840.1.113883.3.464.1003.108.12.1001 (Version: MU2 Update 2017-01-06)

CPT (2016)
### Tables 6B and 7 Column Logic

<table>
<thead>
<tr>
<th>Information</th>
<th>Reported In</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe</td>
<td>Column A</td>
<td>Report total patients identified as part of the initial patient population</td>
</tr>
</tbody>
</table>
| Number in Review     | Column B              | Report:  
  • Universe  
  • Number greater than or equal to 80 percent of universe  
  • **Random sample** of 70 charts |
| Performance          | Column C or Column F  | Report number of records (from Column B) that meet the performance standard |
Preventive Measures

**Preventive**

- Early Entry into Prenatal Care
- Low Birth Weight
- Childhood Immunization Status, CMS117v5
- Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents, CMS155v5
- Dental Sealants for Children between 6-9 Years, CMS277v0

**Screenings**

- Cervical Cancer Screening, CMS124v5
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**Diseases**

- Use of Appropriate Medications for Asthma, CMS126v5
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- Controlling High Blood Pressure, CMS165v5
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), CMS122v5
Prenatal and Birth Outcome Measures

- Report universe of prenatal patients, women who delivered, and their birth outcomes
- No sampling permitted

<table>
<thead>
<tr>
<th>Table</th>
<th>Section</th>
<th>Description</th>
<th>eCQM</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B</td>
<td>Lines 1-6</td>
<td>Prenatal care patients by Age</td>
<td>No eCQM</td>
</tr>
<tr>
<td>6B</td>
<td>Lines 7-9</td>
<td>Early Entry into Prenatal Care</td>
<td>No eCQM</td>
</tr>
<tr>
<td>7</td>
<td>Part A</td>
<td>Low Birth Weight</td>
<td>No eCQM</td>
</tr>
</tbody>
</table>
Prenatal Patients by Age

Report all prenatal care patients served directly or who were referred for prenatal care services

<table>
<thead>
<tr>
<th>Line</th>
<th>Age</th>
<th>Number of Patients (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Prenatal Care Provided by Referral Only (Check if Yes)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Less than 15 Years</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Ages 15-19</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Ages 20-24</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ages 25-44</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Ages 45 and over</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Total Patients (Sum lines 1-5)</strong></td>
<td>22</td>
</tr>
</tbody>
</table>
Early Entry into Prenatal Care

- **Denominator**: Women seen for prenatal care during the year
  - **Exclude**: None

- **Numerator**: Women who began prenatal care during their first trimester

<table>
<thead>
<tr>
<th>Line</th>
<th>Early Entry into Prenatal Care</th>
<th>Women Having First Visit with Health Center (a)</th>
<th>Women Having First Visit with Another Provider (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>First Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Second Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Third Trimester</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Early Entry into Prenatal Care

- **Reporting Considerations:**
  - Women by trimester of entry must equal prenatal women by age as of June 30
  - Determine trimester of entry using last menstrual period
  - Only report women who transferred into your care after seeing another provider in Column B
  - Women referred out for any or all their prenatal care should be reported by trimester of entry in Column A
  - Include women who began prenatal care in 2016 and delivered in 2017

<table>
<thead>
<tr>
<th>Line</th>
<th>Early Entry into Prenatal Care</th>
<th>Women Having First Visit with Health Center (a)</th>
<th>Women Having First Visit with Another Provider (b)</th>
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<tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Third Trimester</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Women Who Delivered: Table 7 Column 1a

- **Column 1a**: Prenatal care patients who delivered during the measurement year
  - Include delivery regardless of outcome
  - Even if the delivery is of twins or triplets, or is a stillbirth, report one woman as having delivered
  - Do not include women with no documentation that delivery occurred
  - Do not include women who had a miscarriage

<table>
<thead>
<tr>
<th>Prenatal Care Patients Who Delivered During the Year (1a)</th>
<th>Live Births: &lt;1500 grams (1b)</th>
<th>Live Births: 1500–2499 grams (1c)</th>
<th>Live Births: ≥ 2500 grams (1d)</th>
</tr>
</thead>
</table>

Low Birthweight

- **Denominator**: Babies born to prenatal care patients
  - **Exclude**: Stillbirths and miscarriages

- **Numerator**: Babies born with a birth weight below normal (less than 2,500g)

<table>
<thead>
<tr>
<th>Prenatal Care Patients Who Delivered During the Year (1a)</th>
<th>Live Births: &lt;1500 grams (1b)</th>
<th>Live Births: 1500–2499 grams (1c)</th>
<th>Live Births: ≥ 2500 grams (1d)</th>
</tr>
</thead>
</table>
Child Immunization Status, CMS117v5

- **Denominator**: Children who turn 2 during the measurement period and had a medical visit during 2017
  - **Exclude**: None

- **Numerator**: Children who by their second birthday:
  - were fully immunized
  - had documented history of having had one of the vaccine-preventable illnesses
  - had a seropositive test result for one of the illnesses
  - or had an allergic reaction to the a specific vaccine
Required Vaccinations

- ALL of the following vaccines are required:
  - 4 diphtheria, tetanus, and acellular pertussis (DTP/DTaP)
  - 3 polio (IPV)
  - 1 measles, mumps, rubella (MMR)
  - 3 H influenza type B (Hib)
  - 3 hepatitis B (Hep B)
  - 1 chicken pox VZV (Varicella)
  - 4 pneumococcal conjugate (PCV)
  - 1 hepatitis A (Hep A)
  - 2 or 3 rotavirus (RV)
  - 2 influenza (flu) vaccines

- Reporting Considerations: Unsuccessful efforts to immunize a child do not meet the measurement standard
  - Religious or personal objections do not meet the measurement standard
Denominator: Patients age 3 through 17 who had at least one medical visit during the measurement period
  - Exclude: Patients who were pregnant during 2017

Numerator: Children and adolescents who, during the measurement period had all of the following:
  - BMI percentile recorded
  - Counseling for nutrition
  - Counseling for physical activity

Reporting Considerations:
  - Report all medical visits (not just primary care provider or obstetrician/gynecologist; include nurse practitioner and physician’s assistant visits as medical visits)
  - Report as a single numerator
Dental Sealants for Children Age 6-9, CMS277v0

- **Denominator**: Children 6 through 9 years with an oral assessment or comprehensive or periodic oral evaluation dental visit in the measurement period and are at moderate to high risk of caries
  - **Exclude**: Children for whom all first permanent molars are non-sealable

- **Numerator**: Children who received a sealant on a permanent first molar during the measurement period

- **Reporting Considerations**:
  - Include dental visits with your health center or provided through a paid referral
  - Although draft eCQM reflects age 5-9 years of age, use age 6-9
Screenings

Preventive

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Diseases

- Use of Appropriate Medications for Asthma, CMS126v5
- CAD: Lipid Therapy
- IVD: Use of Aspirin or Another Antiplatelet, CMS164v5
- HIV Linkage to Care
- Controlling High Blood Pressure, CMS165v5
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), CMS122v5
Cervical Cancer Screening, CMS124v5

- **Denominator:** Women 23 through 64 years of age with a medical visit during 2017
  - **Exclude:** Women who had a hysterectomy and have no residual cervix
- **Numerator:** Women with one or more screenings for cervical cancer. Appropriate screenings are:
  - Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test
  - Cervical cytology + human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test
- **Reporting Considerations:**
  - Count tests performed outside of the health center if the record contains the date of test, who performed it, and results
  - Patients who refuse the test are not considered compliant
Colorectal Cancer Screening, CMS130v5

**Denominator:** Patients 50 through 75 years of age with a medical visit in 2017

- **Exclude:** Patients with a diagnosis of colorectal cancer or a history of total colectomy

**Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings include:

- Fecal occult blood test (FOBT), including fecal immunochemical test (FIT), during 2017
- Flexible sigmoidoscopy during 2017 or the prior 4 years
- Colonoscopy during 2017 or the prior 9 years

**Reporting Considerations:**

- If test is performed outside the health center, the chart must contain a copy of test results or correspondence that shows results
- FOBT (including FIT) test kits can be mailed to patients during the year, but receipt, processing, and documentation of the test sample is required
Adult BMI Screening and Follow-Up Plan, CMS69v5

- **Denominator**: Patients 18 years or older on date of the visit with at least one medical visit during 2017
  - **Exclude**: Patients who:
    - Are pregnant
    - Are receiving palliative care
    - Refuse measurement of height and/or weight or follow-up
    - Have a documented medical reason

- **Numerator**: A documented BMI during their visit or during the 6 months prior to the current visit and
  - When BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the six months prior to the current visit
    - *Normal parameters*: greater than or equal to 18.5 and less than 25 kg/m²

- **Reporting Considerations**: Record or template must show the actual BMI. Display of height/weight only is insufficient.
Tobacco Use: Screening and Cessation Intervention, CMS138v5

- **Denominator**: Patients 18 years and older seen for at least 2 medical visits or at least 1 preventive medical visit during 2017
  - **Exclude**: Patients with documentation of medical reason(s) for not screening for tobacco use

- **Numerator**: Patients screened for tobacco use at least once within 24 months before the end of 2017
  - **And** who received tobacco cessation intervention if identified as a tobacco user

- **Reporting Considerations**:
  - Patients should be asked about all forms of tobacco use
  - Cessation interventions include:
    - Received cessation counseling services, or
    - Received an order for a tobacco use cessation medication, or
    - Are on (using) a tobacco use cessation agent
Screening for Depression and Follow-Up Plan, CMS2v6

- **Denominator**: Patients aged 12 years and older with at least one medical visit during 2017
  - **Exclude**: Patients:
    - With an active diagnosis for depression or bipolar disorder
    - Who refuse to participate
    - Who are in urgent or emergent situations
    - Whose functional capacity or motivation to improve may impact the accuracy of results

- **Numerator**: Patients who:
  - Were screened for depression on the date of the visit using an age-appropriate standardized tool and
  - If screened positive for depression, have a follow-up plan documented on the date of the positive screen

- **Reporting Considerations**: None
Diseases

Preventive
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- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), CMS122v5
Denominator: Patients age 5 through 64 years with persistent asthma who had a medical visit during 2017

- Exclude: Patients with an active diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, cystic fibrosis, or acute respiratory failure

Numerator: Patients who were ordered at least one prescription for a preferred therapy during 2017

Reporting Considerations:
- Do not include patients with mild or intermittent asthma
- Preferred therapy includes: inhaled corticosteroids or other acceptable pharmacological agents
Coronary Artery Disease (CAD): Lipid Therapy

 Universe: Patients 18 years and older with an active diagnosis of CAD or having either been diagnosed as having had a myocardial infarction (MI) or having had cardiac surgery in the past, with a medical visit during 2017 and at least two medical visits ever

 Exclude:
  • Patients whose last low-density lipoprotein (LDL) test during the measurement year was less than 130 mg/dL
  • Patients with an allergy to, a history of adverse outcomes from, or intolerance to LDL lowering medications

 Numerator: Patients who received a prescription for or were provided or were taking lipid-lowering medications in 2017

 Reporting Considerations: Do not include in the numerator:
  • Patients for whom no LDL was recorded
  • Patients who received a form of treatment other than pharmacologic treatment
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet, CMS164v5

- **Denominator**: Patients 18 years and older with a medical visit during 2017 who had an acute MI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) during the 12 months prior to 2017 or who had an active diagnosis of IVD during 2017
  - **Exclude**: Patients who had documentation of use of anticoagulant medications at some point in 2017

- **Numerator**: Patients who use aspirin or another antiplatelet during 2017

- **Reporting Considerations**: Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug
HIV Linkage to Care

- **Denominator**: Patients first diagnosed with HIV by the health center between October 1, 2016 and September 30, 2017 who had at least one medical visit during 2016 or 2017
  - **Exclude**: None

- **Numerator**: People newly diagnosed with HIV by your health center that received treatment within 90 days of diagnosis

- **Reporting Considerations**:
  - Treatment must be initiated within 90 days of diagnosis
  - Treatment may be by reporting entity or a referral source, but must be actual treatment, not completion of referral
  - Identification of patients crosses years and may include 2016 patients
Controlling High Blood Pressure, CMS165v5

- **Denominator**: Patients 18 through 85 years who had a diagnosis of essential hypertension within first 6 months of 2017 or any time prior with a medical visit during 2017
  - **Exclude**:
    - Patients with evidence of end-stage renal disease, dialysis, or renal transplant before or during 2017
    - Patients with a diagnosis of pregnancy during 2017

- **Numerator**: Patients whose blood pressure (BP) at the most recent visit is adequately controlled (less than 140/90 mmHg)

- **Reporting Considerations**: Include only people diagnosed with hypertension on or before June 30, 2017
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), CMS122v5

- **Denominator**: Patients 18 through 75 years with diabetes who had a medical visit in 2017
  - **Exclude**: Patients with a diagnosis of secondary diabetes due to another condition

- **Numerator**: Patients whose most recent HbA1c level performed during 2017 is greater than 9.0 percent or who had no test conducted in 2017

- **Reporting Considerations**: Report most recent HbA1c levels of patients, as follows:
  - HbA1c <8% (Column 3d1)
  - HbA1c >9% or No Test During the Year (Column 3f)
  - The sum of these two columns will not equal the total in Column 3b
Reminders and Strategies
When to Report: Important Dates

- **September 11**: Performance Data Collection Environment (PDCE) available
- **January 1**: UDS Report available in the Electronic Handbooks (EHB)
- **February 15**: UDS Report due date
- **February 15 - March 31**: Review period
  - Work with your assigned UDS reviewer
- **March 31**: All corrected submissions must be finalized
  - No further changes made after this date
Strategies for Successful Reporting

- Read the UDS Manual
- Work as a team: Tables are interrelated
- Adhere to definitions and instructions: Read the 2017 UDS Manual, eCQMs, fact sheets, PDCE, and other resources and apply definitions
- Check your data before submitting
  - Check data trends and relationships across tables, refer to issues raised by last year’s reviewer, and compare data to benchmarks
  - Address edits in EHB by correcting or providing meaningful explanations that demonstrate your understanding
    - “The number is correct” or “The vendor confirms accuracy” are not sufficient
  - Report on time, but do not submit incomplete reports
- Work with your reviewer to resolve reporting issues
Available Assistance

- Technical assistance materials are available online:
  - BPHC HRSA Website
  - UDS Training Website
  - Modernization Project Website
- Year-round telephone and email support line for UDS reporting questions and use of UDS data: 866-837-4357 or EHB Support
  - HRSA Call Center for EHB account access and roles: 877-464-4772
  - BPHC Helpline for EHB system issues: 877-974-2742
- Performance data collection environment to analyze data (in EHB)
  - EHB Access
- ONC Issue Tracking System (OITS) JIRA project eCQM Issue Tracker
  - [OITS Account sign up](#)
  - Post questions in the [eCQM Issue Tracker](#) at [https://oncprojecttracking.healthit.gov/support/projects/CQM](https://oncprojecttracking.healthit.gov/support/projects/CQM)
- Technical support from your UDS reviewer during the review period (only)
- [Primary Care Associations](#) or National Cooperative Agreements
Resources for Clinical Measures

- eCQI Resource Center
  - [https://ecqi.healthit.gov/ep](https://ecqi.healthit.gov/ep)

- Clinical Quality Measures

- United States Health Information Knowledgebase (USHIK)

- National Quality Forum

- Healthy People 2020

- Adjusted Quartile Ranking
  - [https://bphc.hrsa.gov/datareporting/reporting/ranking.html](https://bphc.hrsa.gov/datareporting/reporting/ranking.html)

- Million Hearts Hypertension Control Change Package

- U.S. Preventive Services Task Force
  - [https://www.uspreventiveservicestaskforce.org](https://www.uspreventiveservicestaskforce.org)

- CDC National Center for Health Statistics State Facts
  - [http://www.cdc.gov/nchs/fastats/map_page.htm](http://www.cdc.gov/nchs/fastats/map_page.htm)

- Health Center Quality Improvement Awards
  - [https://bphc.hrsa.gov/programopportunities/fundingopportunities/quality/index.html](https://bphc.hrsa.gov/programopportunities/fundingopportunities/quality/index.html)

- Quality Payment Program

- Healthcare Effectiveness Data and Information Set
  - [http://www.ncqa.org/hedis-quality-measurement/hedis-measures](http://www.ncqa.org/hedis-quality-measurement/hedis-measures)
Webinars

- **Upcoming Webinars**
  - Using UDS Data and Reports for Program Evaluation and Quality (11/16/2017)
  - UDS for Bureau of Health Workforce Grantees (11/17/2017)

- **Past Webinars**
  - Preparing for and Understanding Your UDS Submission (10/24/2017)
  - Webinars will be archived on [HRSA’s BPHC Health Center Program website](http://www.hrsa.gov/)

Webinars will be archived on HRSA’s BPHC Health Center Program website.
Questions?
Thank you!

Thank you for attending this webinar and for all of your hard work to provide comprehensive and accurate data to BPHC!

Ongoing questions can be addressed to UDSHelp330@BPHCDATA.NET
866-UDS-HELP