HRSA
Health Resources & Services Administration

Uniform Data System (UDS) Clinical Tables Part 3: Chronic Disease Management

October 6, 2021, 1:00–2:30 p.m. ET

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Vision: Healthy Communities, Healthy People

Opening Remarks

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Office of Quality Improvement

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

Working Towards UDS Patient Level Submission (UDS+) for 2023

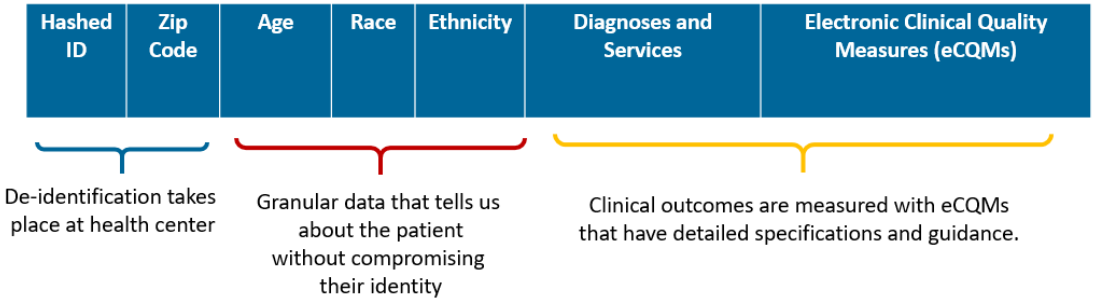
UDS+ is...

- Beginning with the 2023 UDS, BPHC will accept patient-level report data.
  - UDS Tables PBZC, 3A, 3B, 4, 6A, 6B, and 7
- HRSA plans to accept UDS+ data in two ways:
  - Manual file upload system & Fast Healthcare Interoperability Resources (FHIR)

UDS+ does not...

- Collect full copies of data directly from patients' electronic medical records.
- Collect patient identifiers.

For more information, visit: Uniform Data System (UDS) Modernization Initiative



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Agenda

- Review reporting requirements for chronic disease management measures on Tables 6B and 7
- Identify reporting strategies and tips for data reporting quality improvement
- Discuss the trends (and impact of COVID-19) on the Uniform Data System (UDS)
- Review 2021 UDS training resources
- Questions and answers

Objectives of the Webinar

By the end of this webinar, participants will be able to:

- Understand reporting requirements and the impact of telehealth on chronic disease management measures.
- Identify strategies to check data for accuracy and cross-table relationships.
- Identify recent trends in chronic disease clinical measures in UDS reporting.
- Access additional reporting support.

Acronyms

- **AMI:** acute myocardial infarction
- **CABG:** coronary artery bypass graft
- **CMS:** Centers for Medicare & Medicaid Services
- **eCQI:** Electronic Clinical Quality Improvement
- **eCQMs:** electronic-specified clinical quality measures
- **EHBs:** Electronic Handbooks
- **EHR:** electronic health record
- **ESRD:** end-stage renal disease
- **PCI:** percutaneous coronary intervention
- **PHQ:** Patient Health Questionnaire
  - PHQ-9M: PHQ modified for teens
  - PHQ-A: PHQ for adolescents

Clinical Quality Measure (CQM) Reporting

UDS Tables 6B and 7

Clinical Process and Outcome Measures

Table 6B Format

Measure Description	Describes the quantifiable indicator to be evaluated
Denominator	Patients who fit the detailed criteria described for inclusion in the measure
Numerator	Patients from in the denominator whose records meet the requirements for the specified measure
Exclusions and Exceptions	Patients not to be considered for the measure and removed from the denominator (not reported anywhere in the UDS-reported measure)
Specification Guidance	CMS measure guidance that assists with understanding and implementation of eCQMs
UDS Reporting Considerations	BPHC requirements and guidance to be applied to the measure

Reporting Format

Line	Measure Name	Denominator (a)	Number Charts Sampled or EHR Total (b)	Numerator (c)
#	Measure Description	All *eligible* patients (N)	=N, 70, or ≥80%(N)	# in (b) that meet measure requirements

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Clinical Process and Outcome Measures (*cont.*)

Table 7 Format

- Report by race and ethnicity
- High blood pressure and diabetes:
  - **Column A:** Denominator
  - **Column B:** Denominator, at least 80% of denominator, or exactly 70 patient records
  - **Column C or F:** Number of patients in Column B who meet the requirements of the numerator for the measure

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

See page 176 of the UDS Manual for Table 3B/7 crosswalk.

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Tips for Clinical Measure Reporting Success

- Review the birthdates in the 2021 UDS Manual for each measure.
  - For example, some measures look at patients within a range as of the beginning of the year, while some look at age as of the last visit within the year.
- Be sure that the documentation within your health center's EHR aligns with reporting specifications.
  - For example, each measure requires certain coding, such as for diagnoses and/or procedures, so be sure those codes align with what your clinicians are using.
- Ensure there is a process for documenting results from external providers, labs, etc.
  - For example, a scanned PDF generally will not be sufficient.

Clinical Measure Reporting Success

It's essential to be familiar with the specifications for the CQMs. In part 1 of the clinical tables webinar series, accessing specifications from the eCQI Resource Center was discussed in detail. *Access that for full details!*

- Thoroughly read definitions and instructions in the 2021 UDS Manual.
- Other available guidance:
  - eCQI Resource Center
  - Telehealth Impacts on Clinical Measures
  - Clinical Measures Handout
  - eCQM Flows: Workflows for each eCQM, updated annually and downloads as a ZIP file
  - Guide for Reading eCQMs v6.0: A guide for stakeholders to understand eCQMs, including advice on how to read the various eCQM components
  - eCQM value sets: Brings you to the Value Set Authority Center (VSAC) site, where you can search value sets
  - Additional resources available on the Eligible Professional/Eligible Clinician (EP/EC) Resources page

Telehealth Impacts on 2021 UDS Clinical Measures

- Telehealth as it relates to UDS clinical measure reporting
- CMS telehealth guidance for eCQMs

Visit the Center for Connected Health Policy for important telehealth policy issues and key telehealth policy resources.

Note: Items highlighted in pink are intended to draw attention to measure components that do not permit services via telehealth or by external providers.

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	Illustrative Examples of Types of Visits	Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?	Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?	Do documented services performed by external providers (not paid for or performed by the health center) count in UDS Tables 6B and 7, Columns C or F (Numerator)?
Early Entry into Prenatal Care, no eCQM, Table 6B, Lines 7-9	• OB/GYN routine check up • Physical with primary care provider (PCP)	No. Prenatal care patients are defined based on a comprehensive in-person prenatal physical exam. Prenatal care patients established in the prior year (through a comprehensive in-person exam) and only seen through telehealth in the current year **should** be included.	Yes. Trimester of entry may be identified in this way.	Yes
Childhood Immunization Status, CMS117v9, Table 6B, Line 10	• Well-child visits for newborns • Acute pain or illness	Yes	No. Administration of immunizations are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Cervical Cancer Screening, CMS124v9, Table 6B, Line 11	• Physical with PCP • OB/GYN routine check up • Acute pain or illness • Signs or symptoms of conditions	Yes	No. Cervical cytology/HPV testing are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Breast Cancer Screening, CMS125v9, Table 6B, Line 11a	• Physical with PCP • OB/GYN routine check up • Acute pain or illness • Signs or symptoms of conditions	Yes	No. Mammograms are not acceptable in this way. These services cannot be conducted via telehealth.	Yes

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Chronic Disease Management Measures

UDS Tables 6B and 7

General Structure of Chronic Disease Management Measures

1. **Identify patients with the disease or condition.**
2. Determine whether those patients meet the other specifications for **inclusion in the measure**, meaning they don't meet any exclusions or exceptions.
3. For those included, determine whether they have **received** the specified care or service.
4. For those who have received the specified care or service, determine whether the **outcome has been documented**.

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Tables 6B and 7: Chronic Disease Management Measures

UDS Table	Measure	eCQM
Table 6B, Line 17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v4
Table 6B, Line 18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v7
Table 6B, Line 20	HIV Linkage to Care	No eCQM
Table 6B, Line 21a	Depression Remission at Twelve Months	CMS159v9
Table 7, Columns 2A–2C	Controlling High Blood Pressure	CMS165v9
Table 7, Columns 3A–3F	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v9

Poll #1

Which of the chronic disease management measures do you feel *least* confident in your health center's ability to report accurately?

a) Statin Therapy
b) Ischemic Vascular Disease
c) HIV Linkage to Care
d) Depression Remission at Twelve Months
e) Controlling High Blood Pressure
f) Diabetes: HbA1c >9%

Statin Therapy for Prevention & Treatment of Cardiovascular Disease

CMS347v4

Denominator	Exclusions	Exceptions	Numerator
Patients 21 years of age or older with a medical visit during the measurement period who: • Were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), ***or*** • Have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL ***or*** were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, ***or*** Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL	• Patients who have a diagnosis of pregnancy • Patients who are breastfeeding • Patients who have a diagnosis of rhabdomyolysis	• Patients with adverse effect, allergy, or intolerance to statin medication • Patients who are receiving palliative care • Patients with active liver disease or hepatic disease or insufficiency • Patients with ESRD • Patients 40 through 75 years of age with diabetes whose most recent fasting or direct LDL-C laboratory test result was less than 70 mg/dL and who are not taking statin therapy	Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period

Statin Therapy for the Prevention & Treatment of Cardiovascular Disease

Clarifications, Tips, and Frequently Asked Questions

- Current statin therapy (including statin medication samples provided to patients) must be ordered during the measurement period.
- Intensity of statin therapy or lifestyle modification coaching is not being assessed for this measure; only prescription of any statin therapy is being assessed.
- DO NOT count other cholesterol-lowering medications as meeting the numerator criteria; only statin therapy meets the numerator criteria.
- The denominator for this measure is expansive, with three separate denominators. Ensure patients are not counted in the denominator more than once.
  - Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), they are included and further risk checks are not needed.
  - Refer to the eCQM workflow for this measure (CMS347v4) to better understand that process.

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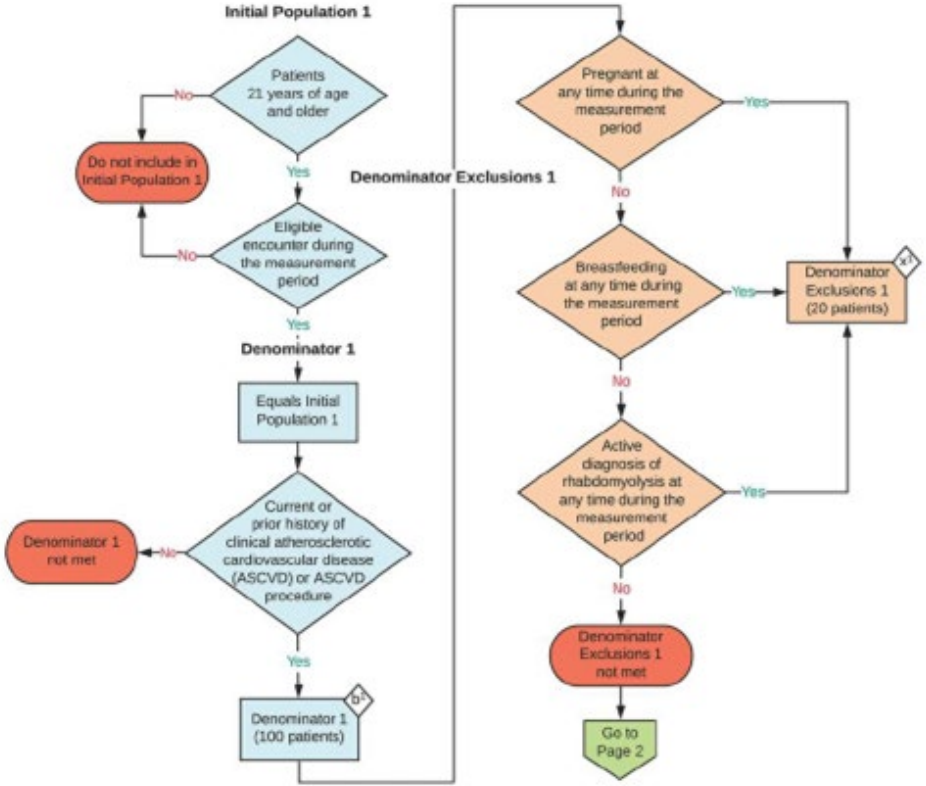
Statin Therapy for the Prevention & Treatment of Cardiovascular Disease

eCQM Workflow

eCQM Workflow shows the process for three separate initial populations: the denominator, exclusions, and numerator for each.



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

CMS164v7

Denominator	Exclusions	Exceptions	Numerator
Patients 18 years of age and older with a medical visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement period **or** who had a diagnosis of IVD overlapping the measurement period	Patients who: • Had documentation of use of anticoagulant medications overlapping the measurement period • Were in hospice care during the measurement period	None	Patients who had an active medication of aspirin or another antiplatelet during the measurement period

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

Clarifications, Tips, and Frequently Asked Questions

- Allergies to medication are **not an exclusion** for this measure, so patients with allergies are *not* excluded from the denominator.
- This eCQM has not been updated by the measure steward (it is still version 7, as opposed to most others which are now version 9). Version 7, which is the same as prior year, should continue to be used for 2021 reporting.
- SNOMEDCT and ICD-10 codes are available for determining if a patient has IVD; be sure to review those in this Value Set: 2.16.840.1.113883.3.464.1003.104.12.1003. These should be used to determine if a patient has IVD; do not use just any reference to IVD in any encounter, be it a lab order, radiology visit, or secondary diagnosis that was later refuted with further testing.

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HIV Linkage to Care

No eCQM

Denominator	Exclusions	Exceptions	Numerator
Patients first diagnosed with HIV by the health center between December 1 of the prior year through November 30 of the current measurement period and who had at least one medical visit during the measurement period or prior year.	None	None	Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers and: • Had a medical visit with your health center provider who initiated treatment for HIV, or • Had a documented visit with a referral resource who initiated treatment for HIV.

HIV Linkage to Care

Clarifications, Tips, and Frequently Asked Questions

- Only include patients who are diagnosed with HIV for the first time *ever* at the health center within the specified timeframe.
- The “clock starts” for linkage to care when the diagnosis is made or the onset date, typically when the confirmatory test is done. Check your EHR vendor guidance for exactly where/how this needs to be captured in your system.
- Successful linkage to care is either a visit with the health center for HIV care or a completed referral for HIV care within 30 days of initial diagnosis. The visit may *not* be a visit where only a confirmatory test is done or only education is provided, however it is *not* necessarily required that the patient start antiretroviral therapy (ART) medication.

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Depression Remission at Twelve Months

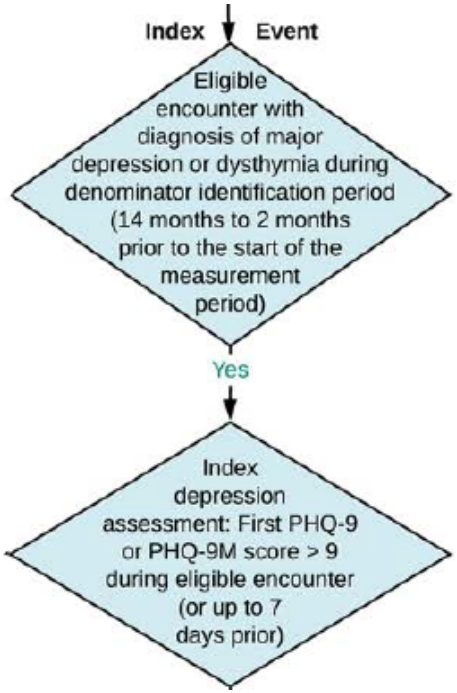
CMS159v9

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score **greater than 9** during the index event between November 1, 2019, through October 31, 2020, and at least one medical visit during the measurement period.	Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder Patients who: • Died • Received hospice or palliative care services • Were permanent nursing home residents	None	Patients who achieved remission at 12 months as demonstrated by the most recent 12-month (+/- 60 days) PHQ-9 or PHQ-9M score of **less than 5**

Depression Remission at Twelve Months

Clarifications, Tips, and Frequently Asked Questions

- Patients may be screened using PHQ-9 or PHQ-9M up to 7 days prior to the office visit, including the day of the visit.
- For this measure, the **PHQ-9 must be used**. The depression screening measure (which is a separate screening measure) does not specify a required tool, but this measure does.
- If **multiple PHQ-9 scores** are captured within the 60-day window (12 months from the index event +/- 60 days), use most recent score.
- If **no PHQ-9 is completed** within the window 12 months from the index event +/- 60 days, then the patient does not meet the measurement standard and is not included in the numerator.



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Controlling High Blood Pressure

CMS165v9

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 84 years of age who had a diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period with a medical visit during the measurement period	• Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period • Patients with a diagnosis of pregnancy during the measurement period • Patients who were in hospice care during the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 consecutive days during the measurement period • Patients aged 66 and older with advanced illness and frailty	None	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period

This measure and all Table 7 measures are reported by race and ethnicity.

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Controlling High Blood Pressure

Clarifications, Tips, and Frequently Asked Questions

- Include patients who have an active diagnosis of hypertension (typically meaning diagnosis of hypertension on the problem list) even if their medical visits during the year were unrelated to the diagnosis.
- Remote patient monitoring is permissible if the data is transmitted directly from the patient's device or if the provider sees and records blood pressure taken by a patient's remote device in the patient health record.
- Only the last blood pressure reading taken and recorded in the reporting year (Calendar Year 2021) is used to determine if the specified measure requirements are met.
- Blood pressure readings taken at any visit type at the health center can be counted toward the Controlling High Blood Pressure measure compliance. So for example, blood pressure readings done at a dental visit could count so long as the result is from the most recent visit.
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

CMS122v9

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 74 years of age with diabetes with a medical visit during the measurement period	• Patients who were in hospice care during the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 consecutive days during the measurement period • Patients aged 66 or older with advanced illness and frailty	None	Patients whose most recent HbA1c level performed during the measurement period was greater than 9.0 percent or patients who had no HbA1c test conducted during the measurement period

This measure and all Table 7 measures are reported by race and ethnicity.

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Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

Clarifications, Tips, and Frequently Asked Questions

- Only include patients with an active diagnosis of Type 1 or Type 2 diabetes in the denominator of this measure.
  - Patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) are NOT in the denominator.
- If a patient who is included in the denominator does not have an HbA1c in their chart in the year (whether they did not have a test or the result is missing), then the patient is reported as 9% or no test in the year (Column 3F).
- Lower is better for this measure.

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Chronic Disease Management Measures: Tips

Tips for Quality Improvement and Success

Poll #2

Have you focused quality improvement activities on any of these measures in the past? Check all that apply.

- ❑ Statin Therapy
- ❑ Ischemic Vascular Disease
- ❑ HIV Linkage to Care
- ❑ Depression Remission at Twelve Months
- ❑ Controlling High Blood Pressure
- ❑ Diabetes: HbA1c >9%

Recent Trends in Chronic Disease Management

	2018	2019	2020	2019 - 2020		2018 - 2020	
				Change	%	Change	%
Quality of Care Indicators/Health Outcomes							
Chronic Disease Management							
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	-	70.09%	71.92%	1.83%	2.61%	-	-
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	80.86%	80.78%	78.80%	-1.98%	-2.45%	-2.06%	-2.55%
HIV Linkage to Care[1]	85.55%	87.21%	81.41%	-5.81%	-6.66%	-4.14%	-4.84%
Controlling High Blood Pressure (Hypertensive Patients with Blood Pressure < 140/90)	63.26%	64.62%	57.98%	-6.64%	-10.27%	-5.27%	-8.34%
Diabetes: Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year	32.79%	31.95%	35.60%	3.65%	11.42%	2.81%	8.59%

★ Remember that for the diabetes measure, lower rate is better, so an increase means more patients have uncontrolled diabetes.

Unfortunately, between 2018 and 2020, all chronic disease management measures have gone in the opposite direction than desired.

The statin measure improved from 2019-2020!

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Chronic Disease Comparisons for Health Centers

	Health Center	Healthy People 2020 Goals[4]	Healthy People 2030 Goals[6]	Averages						
				CT	National	Urban	Size	Sites[1]	Special population Agricultural Workers[2]	Special population Homeless[3]
							20,000-49,999	11-15	Below 25%	Below 25%
				n = 16	n = 1375	n = 797	n = 300	n = 180	n = 1345	n = 1294
QUALITY OF CARE INDICATORS/HEALTH OUTCOMES*										
Chronic Disease Management										
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*	77.83%	-	-	77.22%	71.92%	71.97%	72.87%	72.71%	72.05%	71.93%
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet*	83.33%	-	-	82.39%	78.80%	78.95%	79.10%	79.68%	78.81%	78.79%
HIV Linkage to Care*	100%	85.50%	95.00%	84.85%	81.41%	81.92%	82.19%	74.14%	81.39%	81.45%
Controlling High Blood Pressure*	58.63%	61.20%	60.80%	56.33%	57.98%	56.38%	57.91%	57.23%	57.98%	58.06%
Diabetes: Hemoglobin A1c Poor Control*	37.00%	16.20%	11.60%	36.48%	35.60%	36.66%	35.48%	36.27%	35.44%	35.53%

- Health center performance comparison report shown, left.
- The first column shows the individual health center's (e.g., your own) rate on each measure.
- The next two columns show Healthy People 2020 and Healthy People 2030 goals, and the subsequent columns show the average from among health centers with similar characteristics.

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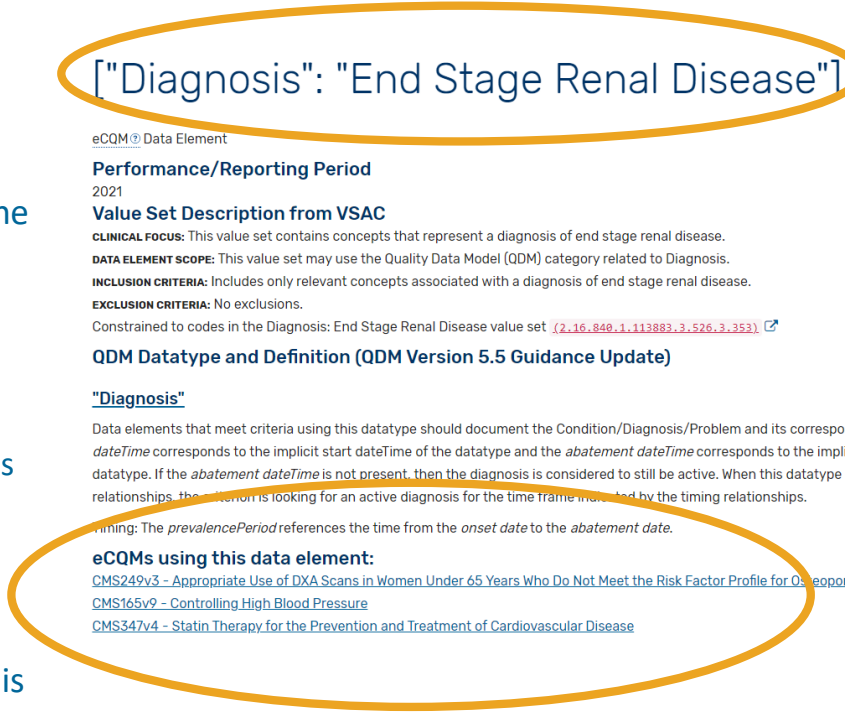
Tips for Success with Chronic Disease Management Measures

- **Review underlying data regularly, to be sure documentation aligns with requirements and is being picked up appropriately by the EHR.**
  - Ensure **onset or diagnosis date** for any given disease or condition is documented accurately (e.g., not defaulting to visit date unless that is correct).
  - Ensure that the **problem list is reviewed and updated regularly** to be sure only appropriate patients who have an *active* diagnosis are included where required.
- **Review health IT setup, rules, and data to be sure that data is collected in a way that supports reporting.**
  - For example, is the PHQ-9 regularly administered to assess and document if remission has been achieved? Does it only allow numeric entry in order to support accurate scoring?
  - Are favorites set up so that clinicians can easily make the choice (e.g., select the codes) that meets the specified measure requirements or that apply the appropriate exclusion?

Tips for Success with Chronic Disease Management Measures (*cont.*)

- **Become familiar with common exceptions and/or exclusions that exist for the measure and be sure those are documented.**
  - Many exceptions are common across more than one measure. Improving documentation for these exceptions and/or exclusions helps improve reporting more than one measure. For example:
    - End-stage renal disease (ESRD).
    - Patients aged 66 and older with advanced illness and frailty.
    - Palliative care.
    - Hospice care.
  - You can see which measures a given data element is used in when clicking on that data element in the eCQI Resource Center.



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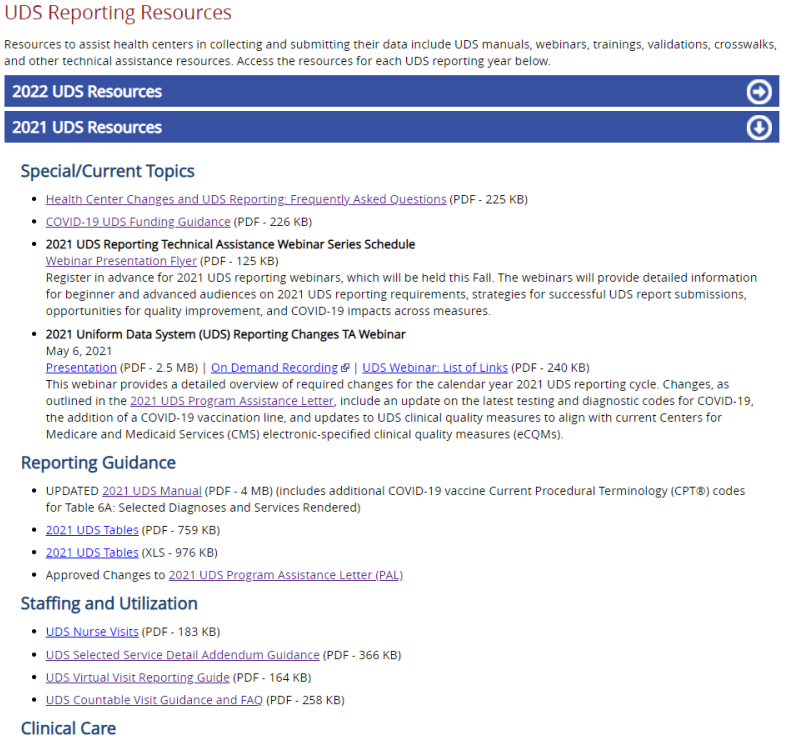
Resources, Questions, and Answers

BPHC UDS Reporting Resources

- **Now Available: UDS Reporting Resources on the BPHC site**
- Resources now regrouped by topic to better align with UDS tables:
  - Special/Current Topics
  - Reporting Guidance
  - Staffing and Utilization
  - Clinical Care
  - Financials
  - Additional Reporting Topics
  - UDS Data



UDS Reporting Resources

Resources to assist health centers in collecting and submitting their data include UDS manuals, webinars, trainings, validations, crosswalks, and other technical assistance resources. Access the resources for each UDS reporting year below.

2022 UDS Resources

2021 UDS Resources

Special/Current Topics

- Health Center Changes and UDS Reporting: Frequently Asked Questions (PDF - 225 KB)
- COVID-19 UDS Funding Guidance (PDF - 226 KB)
- **2021 UDS Reporting Technical Assistance Webinar Series Schedule**
  Webinar Presentation Flyer (PDF - 125 KB)
  Register in advance for 2021 UDS reporting webinars, which will be held this Fall. The webinars will provide detailed information for beginner and advanced audiences on 2021 UDS reporting requirements, strategies for successful UDS report submissions, opportunities for quality improvement, and COVID-19 impacts across measures.
- **2021 Uniform Data System (UDS) Reporting Changes TA Webinar**
  May 6, 2021
  Presentation (PDF - 2.5 MB) | On Demand Recording | UDS Webinar: List of Links (PDF - 240 KB)
  This webinar provides a detailed overview of required changes for the calendar year 2021 UDS reporting cycle. Changes, as outlined in the 2021 UDS Program Assistance Letter, include an update on the latest testing and diagnostic codes for COVID-19, the addition of a COVID-19 vaccination line, and updates to UDS clinical quality measures to align with current Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs).

Reporting Guidance

- UPDATED 2021 UDS Manual (PDF - 4 MB) (includes additional COVID-19 vaccine Current Procedural Terminology (CPT®) codes for Table 6A: Selected Diagnoses and Services Rendered)
- 2021 UDS Tables (PDF - 759 KB)
- 2021 UDS Tables (XLS - 976 KB)
- Approved Changes to 2021 UDS Program Assistance Letter (PAL)

Staffing and Utilization

- UDS Nurse Visits (PDF - 183 KB)
- UDS Selected Service Detail Addendum Guidance (PDF - 366 KB)
- UDS Virtual Visit Reporting Guide (PDF - 164 KB)
- UDS Countable Visit Guidance and FAQ (PDF - 258 KB)

Clinical Care

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Available Assistance

- Technical assistance materials, including local trainings, are available online:
  - HRSA Health Center Program website and UDS training website
- UDS Support Center for assistance with UDS reporting questions:
  - udshelp330@bphcdata.net
  - 866-UDS-HELP (866-837-4357)
- Health Center Program support for questions about the Health Center Program

- EHBs support
  - UDS Report and Preliminary Reporting Environment access (in EHBs)
  - EHBs system issues: 877-464-4772, Option 1
  - EHBs account access and roles: 877-464-4772, Option 3
- National Training and Technical Assistance Partners (NTTAPs)

Resources for Clinical Measures

- eCQI Resource Center
- National Quality Forum
- Healthy People 2030
- Adjusted Quartile Ranking
- Health Information Technology, Evaluation, and Quality Center (HITEQ)
- Million Hearts
- U.S. Preventive Services Task Force
- CDC National Center for Health Statistics State Facts
- Quality Payment Program
- Healthcare Effectiveness Data and Information Set (HEDIS)

Upcoming Webinars

- Upcoming Webinars
  - Reporting UDS Financial and Operational Tables (10/14/21, 1:00–2:30 p.m. ET)
  - Successful Submission Strategies (10/20/21, 1:00–2:30 p.m. ET)
- Past webinar presentations are archived on HRSA's UDS Resources page:
  - Counting Visits in the UDS
  - UDS Clinical Tables Part 1: Screening and Preventive Care Measures
  - UDS Clinical Tables Part 2: Maternal Care and Children's Health

Thank You!

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