


HRSA
Health Resources & Services Administration

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

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# Opening Remarks

**Dylan Podson**

**Data and Evaluation**

**Office of Quality Improvement**

**Bureau of Primary Health Care**

**Health Resources and Services Administration**

# Agenda

- Review reporting requirements for chronic disease management measures on Tables 6B and 7
- Identify reporting strategies and tips for reporting quality improvement
- Review 2024 Uniform Data System (UDS) training resources
- Questions and answers

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# Objectives of the Webinar

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

- Understand reporting requirements for chronic disease management measures.
- Identify strategies to check data for accuracy.
- Access additional reporting support from resources and help lines.

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# UDS Clinical Quality Measure (CQM) Webinars

**Clinical Quality Measures Deep Dive**

Recorded on September 21, 2023

**Screening and Preventive Care Measures**

Recorded on October 3, 2023

**Maternal Care and Children's Health Measures**

Recorded on October 11, 2023

**Chronic Disease Management Measures**

**Today's webinar!**

Register for future UDS webinars and view past webinar recordings when available .

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# UDS Clinical Quality Measures (CQMs)

| Screening and Preventive Care | Maternal Care and Children's Health | Chronic Disease Management |
|---|---|---|
| • Cervical Cancer Screening<br>• Breast Cancer Screening<br>• Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan<br>• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention<br>• Colorectal Cancer Screening<br>• Human immunodeficiency virus (HIV) Screening<br>• Preventive Care and Screening: Screening for Depression and Follow-Up Plan | • Prenatal Care Provided by Referral Only<br>• Age of Prenatal Care Patients<br>• Early Entry into Prenatal Care<br>• HIV-Positive Pregnant Patients<br>• Deliveries Performed by Health Center's Providers<br>• Prenatal Care Patients Who Delivered During the Year<br>• Low Birth Weight<br>• Childhood Immunization Status<br>• Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents<br>• Dental Sealants for Children between 6–9 Years | • Statin Therapy for the Prevention and Treatment of Cardiovascular Disease<br>• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet<br>• HIV Linkage to Care<br>• Depression Remission at Twelve Months<br>• Controlling High Blood Pressure<br>• Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) |

# Tables 6B and 7: CQMs

## 2024 Changes:

- Measures updated to align with updated eCQMs, wherever available.
- In this alignment with those updated eCQMs, several existing measures have notable modifications.

***In addition to submitting these tables in the Electronic Handbooks (EHBs), health centers will submit de-identified patient-level report data using HL7® Fast Healthcare Interoperability Resources (FHIR)® R4 standards. Visit the UDS Modernization FAQ for more on that process.***

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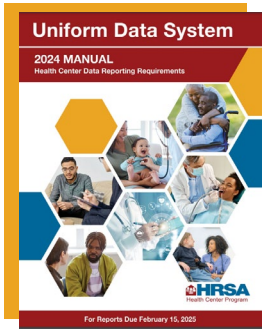
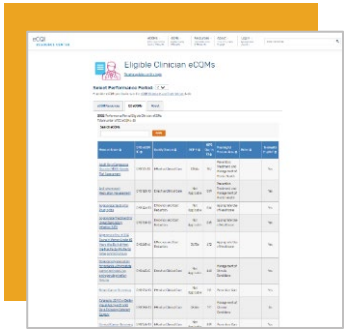
# Understanding Chronic Disease CQM Reporting on the UDS

There are key considerations and structures that must be understood in order to accurately report chronic disease measures on the UDS.

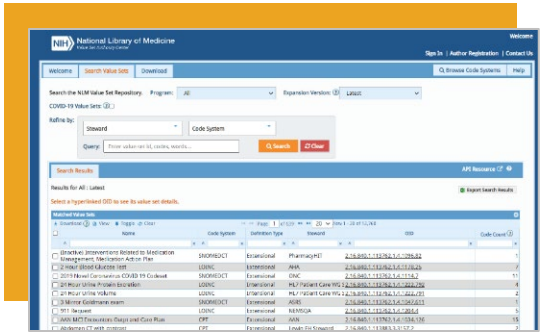
# CQM Specifications




The UDS Manual provides an overview of the UDS, covers UDS-specific considerations, and links to measure specifications.




The manual links to the Electronic Clinical Quality Improvement (eCQI) Resource Center, where measure information, specifications, data elements, and value sets are found.




The codes that make up each value set within the measure specifications are available from the Value Set Authority Center (VSAC) site.

Remember, the Health Resources and Services Administration (HRSA) is not the measure steward and therefore does not design specific measures. Measures are nationally defined.

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# UDS Clinical Quality Measure Reporting Acronyms and Definitions

## General Acronyms and Definitions

- **CMS:** Centers for Medicare & Medicaid Services
- **eCQI:** Electronic Clinical Quality Improvement
- **eCQMs:** Electronic-specified Clinical Quality Measures
- **EHBs:** Electronic Handbooks
- **EHR:** Electronic Health Record
- **Countable Visit:** A visit that meets UDS requirements and is therefore reported on Table 5 of the current year UDS report.
- **Qualifying Encounter:** A visit that meets the specified qualifying visit criteria for a given eCQM; these vary by eCQM.
- **Provider:** Exercises independent professional judgment in the provision of services rendered to the patient within the scope of project, assumes primary responsibility for assessing and/or treating the patient for the care provided at the visit, and documents services in the patient's health record. See Appendix A of the 2024 UDS Manual.

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# Components of Clinical Quality Measures

| Denominator | Numerator | Exclusions and Exceptions |
| --- | --- | --- |
| • Identifies the group of patients that the measure is assessing for numerator compliance.<br>• Equal to the initial population identified in the eCQM specifications less those who meet exclusion criteria.<br>• Reported in Column A. | • Measures whether the service, event, or outcome criteria were met.<br>• Each patient in the denominator is assessed to determine whether they meet the numerator.<br>• Reported in Column C. | • **EXCLUSIONS:** Patients who meet exclusion criteria are not to be considered for the measure. They are removed from the denominator *before* determining if numerator criteria are met.<br>• **EXCEPTIONS:** Patients who *do* meet denominator criteria but *do not* meet numerator criteria ***and*** do meet any of the exception criteria are therefore removed from the denominator and not included in numerator. |

# Denominators: Qualifying Encounters

**Clinical measure guidance for the UDS specifies that in order to be included in any given CQM denominator, patients must have:**

- A **countable UDS visit** during the calendar year reported on Table 5, **and**

- A **visit that meets the qualifying encounter definitions** for that particular eCQM's measure criteria and specifications.
- Each measure defines its own qualifying encounters in its specifications.

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# Understanding Eligible Visits for CQMs

- Accessing and Reading Electronic Clinical Quality Measures (eCQMs) for UDS
- Accessing Value Set Codes for Clinical Quality Measures

**Does this mean that *all* patients with UDS countable visits are now included in the denominator for CQMs?**

No! It means that those patients who meet the measure specifications are included in each measure's denominator. For some measures, this is *a lot* of visit types; while some others are fairly narrow. Each measure steward identifies the denominator for the measures that they develop.

**Does this mean we need to be doing pap tests or colorectal cancer screenings for our dental patients or case management patients?**

Dental visit codes are not specified as qualifying encounters for the cervical cancer screening or colorectal cancer screening measures. If the patient had other visits, they *could* be eligible. The qualifying encounters are specified for each measure which can be reviewed in the eCQI Resource Center.

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# General Flow of Chronic Disease Management Measures

1. The group of patients with at least one countable UDS visit during the calendar year *and* a qualifying encounter visit (as defined by the measure steward for the selected eCQM) during the calendar year is identified.
2. That group of patients is then assessed against exclusions specified in the measure. If they meet an exclusion, they are removed from the denominator.
3. Those patients in the denominator are then assessed for whether their record meets the numerator specifications, such as whether there is documentation that they received the specific care or service or achieved the needed outcome.
4. Those patients whose record does align with the numerator specifications are reported as the numerator (Column C).
5. Those whose record does not meet the measure specifications are assessed against exceptions; if the record does contain an exception, then the patient is removed from the denominator (and not included in the numerator, of course). After that, the denominator is complete and ready to report.

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# Understanding Columns of Table 6B

- Health centers report the full denominator for the CQM in **Column A**.
  - Note: Don't be misled by the heading title! This is where the health center will report the denominator *as defined by the measure specifications,* not all patients in this age range.
- **Column B** must equal Column A *or* be 80% or more of Column A. In Column B:
  - Report all patients who meet the specifications (same as Column A), **or**
  - In those limited cases where a health center doesn't have access to the full set of data needed to assess numerator compliance with a number equal to or greater than 80% of Column A.
    - Health centers are not permitted to use chart sampling for reporting CQMs. If your health center does not use a certified EHR, contact UDS Support to discuss options.
- **Column C** is the number of patients in the denominator, from Column B, who meet the numerator requirements.

| Line | Example: Childhood Immunization Status | Total Patients with 2nd Birthday (a) | Number of Records Reviewed (b) | Number of Patients Immunized (c) |
|---|---|---|---|---|
| 10 | MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday | 250 | 250 | 139 |

| Line | Example: Childhood Immunization Status | Total Patients with 2nd Birthday (a) | Number of Records Reviewed (b) | Number of Patients Immunized (c) |
|---|---|---|---|---|
| 10 | MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday | 250 | 215 | 139 |

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# Understanding Columns of Table 7

**Although Table 7 is much more complex overall, it follows the same structure as Table 6B.**

- Health centers report the full denominator for the CQM in **Column A**.
  - Column 2A: Denominator for Controlling High Blood Pressure CQM
  - Column 3A: Denominator for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) CQM
- **Column B** is number of records reviewed. In Columns B, 2B, and 3B on Table 7:
  - Report all patients who meet the specifications (same number as the denominator in Column A), **or**
  - In those limited instances where a health center doesn't have access to the full set of data needed to assess numerator compliance with a number equal to or greater than 80% of Column A.
    - Health centers are *not* permitted to use chart sampling for reporting CQMs.
- **Column C** is the number of patients in the denominator, from Column B, who meet the numerator requirements.

**Table 7 is *also* reported by Race and Ethnicity.**

While Table 6B presents these three columns in a single row, Table 7 displays the same three columns across multiple rows, organized by race and ethnicity sections.

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# Example
## Table 7 Format

Each section, indicated by the heading here, is a **single ethnicity**, with all corresponding race options listed beneath it.

Each patient included in Columns 2a, 2b, and 2c as appropriate is reported by their **ethnicity** (section) and **race** (row).
Must align with Table 3B!

| Line | Race and Ethnicity | Total Patients 18 through 84 Years of Age with Hypertension (2a) | Number of Records Reviewed (2b) | Patients with Hypertension Controlled (2c) |
|---|---|---|---|---|
| | **Mexican, Mexican American, Chicano/a** | | | |
| 1a1m | Asian Indian | | | |
| 1a2m | Chinese | | | |
| 1a3m | Filipino | | | |
| 1a4m | Japanese | | | |
| 1a5m | Korean | | | |
| 1a6m | Vietnamese | | | |
| 1a7m | Other Asian | | | |
| 1b1m | Native Hawaiian | | | |
| 1b2m | Other Pacific Islander | | | |
| 1b3m | Guamanian or Chamorro | | | |
| 1b4m | Samoan | | | |
| 1cm | Black/African American | | | |
| 1dm | American Indian/Alaska Native | | | |
| 1em | White | | | |
| 1fm | More than One Race | | | |
| 1gm | Unreported/Chose Not to Disclose Race | | | |
| | *Subtotal Mexican, Mexican American, Chicano/a* | | | |
| | **Puerto Rican** | | | |
| 1a1p | Asian Indian | | | |
| 1a2p | Chinese | | | |
| 1a3p | Filipino | | | |
| 1a4p | Japanese | | | |
| 1a5p | Korean | | | |
| 1a6p | Vietnamese | | | |
| 1a7p | Other Asian | | | |
| 1b1p | Native Hawaiian | | | |
| 1b2p | Other Pacific Islander | | | |

***See page 198 of the UDS Manual for Table 3B/7 crosswalk.***

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# Understanding Age and Birthdates

## Tables 6B and 7 Measures

- Each measure specifies **age of patients included in the denominator** and, sometimes, age when receiving a given service or screening.
- The age may be as of the beginning of the year, as of the time of the visit, or as of the end of the year, **depending on the measure specifications**.
- For these and all measures, it's critically important to **refer to the birthdates listed in the manual and/or the Clinical Quality Language (CQL) in the specifications for the eCQM**, rather than trying to interpret from the name or description of the measure.

### EXAMPLES

**Diabetes: HbA1c Poor Control (CMS122v12) Initial population assessed:** Patients 18 through **75 years of age by the end of the measurement period** with diabetes with a qualifying encounter and a countable UDS visit during the measurement period (*meaning age 75 as of Dec. 31, 2024*)

**Depression Remission at Twelve Months (CMS159v12) Initial population assessed:** Patients aged 12 years and older **at the start of the measurement period** with a diagnosis of major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event between November 1, 2022, through October 31, 2023, as specified in the measure criteria, and a countable UDS visit in the year.

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# Understanding National Specifications for Clinical Quality Measures

Most clinical quality measures are nationally specified, meaning their requirements are set at the national level by measure stewards. Therefore, understanding the measure specifications is critical for accurate workflow and documentation, which drive reporting and outcomes.

# Chronic Disease Management Measure
# Acronyms and Definitions

## Chronic Disease Related Acronyms

- **AMI: A**cute Myocardial Infarction
- **ASCVD:** Atherosclerotic Cardiovascular Disease
- **CABG:** Coronary Artery Bypass Graft
- **ESRD:** End-Stage Renal Disease
- **HbA1c:** Hemoglobin A1c
- **LDL-C:** Low-Density Lipoprotein Cholesterol
- **PCI:** Percutaneous Coronary Intervention
- **PHQ:** Patient Health Questionnaire
  - PHQ-9M: PHQ modified for teens
  - PHQ-A: PHQ for adolescents

# 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 | CMS347v7 |
| Table 6B, Line 18 | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet | No longer electronically specified, follow most recent specifications: CMS164v7 |
| Table 6B, Line 20 | HIV Linkage to Care | No eCQM |
| Table 6B, Line 21a | Depression Remission at Twelve Months | CMS159v12 |
| Table 7, Columns 2A–2C | Controlling High Blood Pressure | CMS165v12 |
| Table 7, Columns 3A–3F | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | CMS122v12 |

# Chronic disease measures differ in some key ways from other measures on Table 6B and 7.

## More Complex Denominator Definitions

- These measures have more complex and specific criteria for determining the denominator (the patient population to be evaluated). For example, the Statin Therapy measure includes patients at high risk of cardiovascular events, defined by specific diagnoses or results, which must be identified using defined criteria.
- In contrast, other measures, such as those for preventive screenings (e.g., cervical cancer screening), often have broader and simpler age-based or visit-based denominator definitions.

## Numerator Often Relies on Results

- The numerator for these chronic disease measures typically involves more specific clinical actions, such as prescribing a particular medication (e.g., statin therapy) or achieving specific clinical outcomes (e.g., controlling high blood pressure).
- Other clinical quality measures might focus on whether a screening was performed, which can be simpler to document.

# Structure of this Section

We'll review each of the chronic disease measures in three sections:

1. Review of the measure components: denominator, exclusions, exceptions, and numerator
2. Discussion of notable changes to the measure for this year, if there are any
3. Clarifications and answers to frequently asked questions

# Table 6B: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v7)

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 and meet ***any*** of the following criteria:<br>1. Previously diagnosed with ***or*** currently have a diagnosis of clinical ASCVD, including an ASCVD procedure.<br>2. Aged 20 to 75 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia.<br>3. Aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes.<br>4. Aged 40 to 75 at the beginning of the measurement period with a 10-year ASCVD risk score (i.e., 2013 American College of Cardiology (ACC)/American Heart Association (AHA) ASCVD Risk Estimator or the ACC Risk Estimator Plus) of >= 20 percent during the measurement period. | • Patients who are breastfeeding at any time during the measurement period.<br>• Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period. | • Patients with statin-associated muscle symptoms or an allergy to statin medication.<br>• Patients who are receiving palliative or hospice care.<br>• Patients with active liver disease or hepatic disease or insufficiency.<br>• Patients with end-stage renal disease (ESRD).<br>• Patients with documentation of a medical reason for not being prescribed statin therapy. | Patients who are actively using or who received an order (prescription) for statin therapy at any time during the measurement period |

It's important to refer to the specifications and value sets for all the needed details: CMS347v7

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# Changes to the Measure for 2024

## Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v7)

- Patients **who were previously diagnosed with** or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD)– previously, the measure required an active diagnosis.
- In addition to the other risk groups in the denominator, the following group has been added: Patients 40 through 75 years of age with a 10-year ASCVD risk score >= 20 percent
  - Related to this additional group, the measure clarifies:
    - There is no LDL-C result required.
    - The 10-year ASCVD risk assessment options: The 10-year ASCVD risk score is calculated using the Pooled Cohort Equations: 1) the 2013 ACC/AHA ASCVD Risk Estimator (maps to Logical Observation Identifiers Names and Codes [LOINC] Code 79423-0) *or* 2) the ACC Risk Estimator Plus (maps to LOINC Code 99055-6). If your EHR does not have either of these risk calculators, we recommend that you use the online versions.
    - The 10-year ASCVD risk score (quantitative result, i.e., result.value, "%") must be documented in a structure field.
    - The 10-year ASCVD risk assessment must be performed during the measurement period.

# Clarifications, Tips, and Frequently Asked Questions

## Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

1. Current statin therapy must be documented in the patient's current medication list or ordered during the measurement period.

2. Intensity of statin therapy or lifestyle modification coaching is *not* being assessed for this measure; lifestyle modification does not meet the numerator specifications.

3. *Do not* count **other** cholesterol-lowering medications as meeting the numerator.

4. Although a telehealth-only visit may qualify a patient for the denominator, a telephone-only visit *will not* qualify for inclusion in the denominator.

5. The denominator for this measure is expansive, with **four** separate denominator criteria.
   *It is important to understand that patients are not included in the denominator more than once. Once a patient meets one set of denominator criteria, they are included and further risk checks are not needed.*

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# Table 6B: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet CMS164v7

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 **and** are 18 years of age and older 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:<br>• Had documentation of use of anticoagulant medications overlapping the measurement period<br>• Were in hospice care during the measurement period | None | Patients who had an active medication of aspirin or another antiplatelet during the measurement period |

Note that this measure is no longer electronically specified; health centers should continue to follow the guidance and details of CMS164v7

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# Clarifications, Tips, and Frequently Asked Questions

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

1. Allergies to medication are not an exclusion for this measure, so patients with allergies are not excluded from the denominator.

2. This measure has not been updated by the measure steward. Version 7 continues to be used for 2024 reporting.

3. SNOMED CT and ICD-10 codes are available for determining whether a patient has IVD; be sure to review those in the value set.

   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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# Table 6B:
# Depression Remission at Twelve Months (CMS159v12)

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 **and** are 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, 2022, and October 31, 2023. | Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder<br><br>Patients who:<br>• Died<br>• Received hospice or palliative care services<br>• 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 |

It's important to refer to the specifications and value sets for all the needed details: CMS159v12

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# Changes to the Measure for 2024

Depression Remission at Twelve Months (CMS159v12)

The Depression Remission measure **no longer excludes** permanent nursing home residents from the denominator.

The other exclusions remain.

# Clarifications, Tips, and Frequently Asked Questions

## Depression Remission at Twelve Months (CMS159v12)

For this measure, the **PHQ-9 or PHQ-9M must be used**. The depression screening measure (which is a separate eCQM) does not specify a required tool, but this measure does.

1

Patients may be screened using the PHQ-9 or PHQ-9M **up to 7 days prior to the office visit or on the day of the visit**.

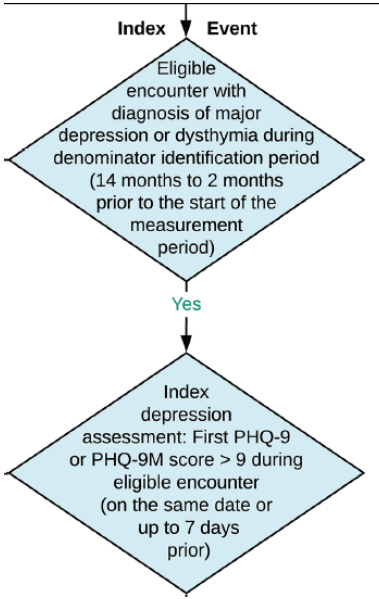
2

If **multiple PHQ-9 scores** are captured within the 60-day window (12 months from the index event +/- 60 days), use the most recent score.

3

If **no PHQ-9 is completed within the 120-day window** (12 months from the index event +/- 60 days), then the patient does not meet the numerator requirements.

4

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# Table 6B:
# HIV Linkage to Care

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 ***and* were first ever diagnosed with HIV *by the health center*** between December 1, 2023, and November 30, 2024. | None | None | Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by the health center (and are included in the denominator) and:<br>• Had a medical visit with your health center provider who initiated treatment for HIV, **or**<br>• Had a documented visit with a referral resource who initiated treatment for HIV. |

# Clarifications, Tips, and Frequently Asked Questions

## HIV Linkage to Care

1. Only include patients who are diagnosed with HIV for **the first time ever *at the health center*** within the specified timeframe.

2. The clock starts for linkage to care when the diagnosis is made or on 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.

3. 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. A visit where a confirmatory test is done or only education is provided does *not* meet the linkage to care requirement. However, it is not required that the patient start antiretroviral therapy (ART) medication at the visit.

4. Relevant CPT and ICD codes to help identify patients for the Table 6B HIV Linkage to Care measure can be found at **HIV Linkage to Care and Pre-exposure Prophylaxis (PrEP) Codes**.

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# Table 7:
# Controlling High Blood Pressure (CMS165v12)

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 **and** are aged 18–85 years by the end of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period | Patients who fit any of the following in the measurement year:<br>• End stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.<br>• Hospice care for any part of the measurement period.<br>• 66 and older living long term in a nursing home<br>• 66–80 with an indication of frailty who also meet advanced illness criteria<br>• 81 and older with an indication of frailty.<br>• Receiving palliative care for any part of the measurement period. | None | Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period |

**This measure and all Table 7 measures are reported by race and ethnicity.**
It's important to refer to the specifications and value sets for all the needed details: CMS165v12

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# Changes to the Measure for 2024

## Controlling High Blood Pressure (CMS165v12)

Controlling High Blood Pressure measure guidance language changed from “remote monitoring device” to “automated blood pressure monitor or device.”

The measure now reads: *In reference to the numerator element, only blood pressure readings performed by a clinician or* ***an automated blood pressure monitor or device*** *are acceptable for numerator compliance with this measure.*

This distinction was made to clarify that any remote device needs to be automated/digital—meaning that a patient’s blood pressure being taken manually and reported to the provider does **not** meet the measure.

# Controlling High Blood Pressure

## Clarifications, Tips, and Frequently Asked Questions

1. Include patients who have an active diagnosis of hypertension (typically meaning diagnosis on the problem list), even if their medical visits during the year were unrelated to the diagnosis.

2. Use the last day that blood pressure reading was taken and recorded in 2024 to determine whether the specified measure requirements are met.

3. Blood pressure readings taken at any type of visit at the health center count toward measure compliance. For example, blood pressure readings done at a dental visit count if that result is from the most recent visit.

4. 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.

5. Only blood pressure readings performed by a clinician or an automated blood pressure monitor are acceptable for the numerator.

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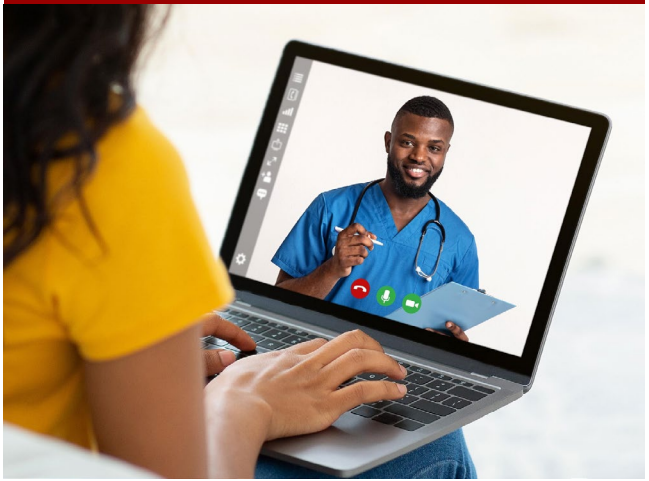
# Automated Blood Pressure Monitor

**What is acceptable in terms of automated monitoring devices and readings?**



- Valid readings may be transmitted directly by the device to the clinician, conveyed to the clinician by the patient, or read from the device by the clinician during an in-person/virtual encounter.
- The measure **allows** patient-reported data using most methods of digital collection/reporting and **prohibits** patient-reported data taken with non-automated/digital devices, such as with a manual blood pressure cuff and stethoscope.
- This cannot be audio-only (clinician must see the reading).
- There is **not** a list of valid remote monitoring devices for this measure.
- It is up to the clinician to determine that the reading came from an automated device **and** is clinically valid before documenting it in the patient's record.

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# Table 7:
# Diabetes: HbA1c Poor Control (> 9%) CMS122v12

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients who have a countable UDS visit on Table 5 **and** aged 18–75 years with diabetes who had hemoglobin A1c > 9.0% during the measurement period | • Patients who were in hospice care for any part of the measurement period<br>• Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period<br>• Patients aged 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior<br>• Patients who received palliative care for any part of the measurement period | None | Patients whose most recent HbA1c level performed during the measurement period was greater than 9.0%, or was missing, or was not performed during the measurement period |

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

It's important to refer to the specifications and value sets for all the needed details: CMS122v12

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

## Clarifications, Tips, and Frequently Asked Questions

1. 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 (Uncontrolled, in Column 3F).

2. Even if the treatment of the patient's diabetes has been referred to a non–health center provider, the health center is expected to have the current lab test results in its records.

3. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

4. Lower score (or percentage) on this measure indicates better quality outcome. That means this measure is the inverse of other measures.

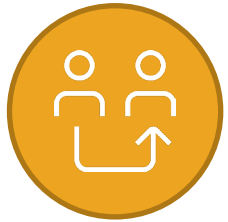
# Chronic Disease Management Measures: Tips

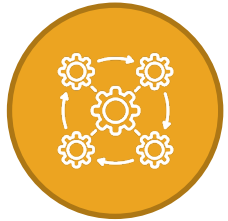
## Tips for Quality Improvement and Success

# Tips for Success with Chronic Disease Measures

**Review underlying workflows and documentation regularly, to monitor for alignment across measure specifications, EHR setup, and clinical workflow.**

- 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 patients who have an *active* diagnosis are included, where required.
- Ensure information and tools are available to **document and code appropriately**.
  - Are favorites or shortcuts 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?
- Ensure **workflows support meeting measure requirements**.
  - For example, if the PHQ-2 is administered at each visit, then patients in the depression remission measure may not be receiving the PHQ-9 they need in order to meet the numerator.
  - If blood pressure is taken in dental or other visits, is there a plan for what to do if the patient's reading is high (e.g., retake, follow up with medical)?





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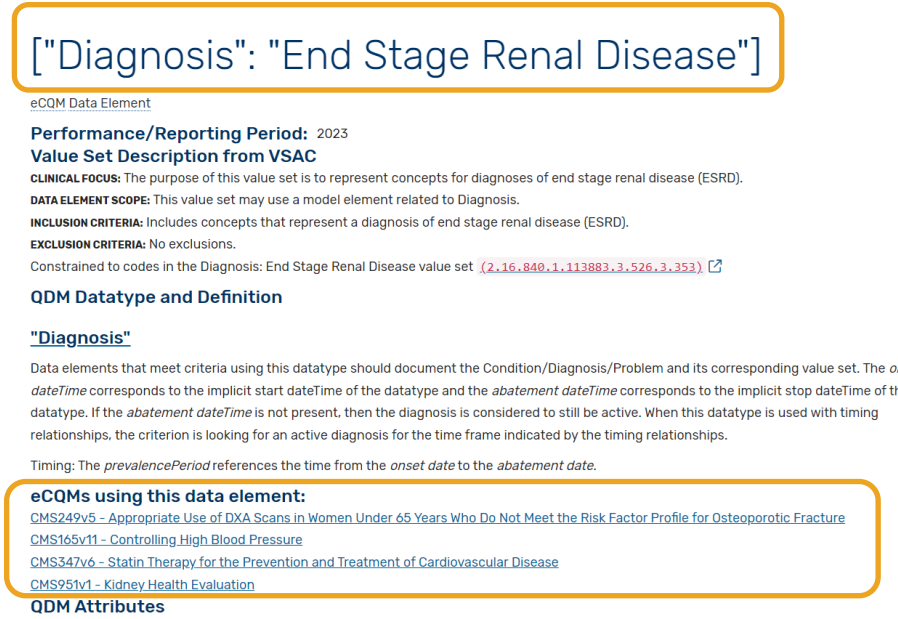
# Tips for Success with Chronic Disease Measures (*cont.*)

**Become familiar with common exceptions and exclusions and be sure those are documented in your system when applicable.**

- Many exceptions and exclusions are common across more than one measure.
- Improving documentation for these helps improve reporting for more than one measure. For example:
  - End Stage Renal Disease
  - 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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# UDS Reporting Webinar Series

## The webinar series includes:

- **UDS Changes Technical Assistance Webinar**
- **UDS Basics:** Orientation to Terms and Resources
- **Clinical Quality Measures Deep Dive**
- **UDS Clinical Tables Part 1:** Screening and Preventive Care Measures
- **UDS Clinical Tables Part 2:** Maternal Care and Children's Health Measures
- **UDS Clinical Tables Part 3:** Chronic Disease Management Measures ***-- Today!***
- **Reporting UDS Financial and Operational Tables**
- **Successful Submission Strategies**

**All webinars are archived on the Health Resources and Services Administration (HRSA) website; watch them anytime!**

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# UDS Data Modernization and UDS Patient Level Data (UDS+)

Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

# Why are we modernizing UDS?

- Leverage developments in health information technology (health IT) over the last decade that allow us to advance health equity efforts while reducing reporting burden
- Standardize data collection using FHIR resources to automate and reduce the technical burden for health centers
- Improve the fidelity and integrity of data and enable more robust analyses to improve equitable access to high quality, cost-effective care for our patients
- Drive quality improvement for vulnerable and historically underserved population groups
- Allow HRSA to better administer the Health Center Program and better serve its patients

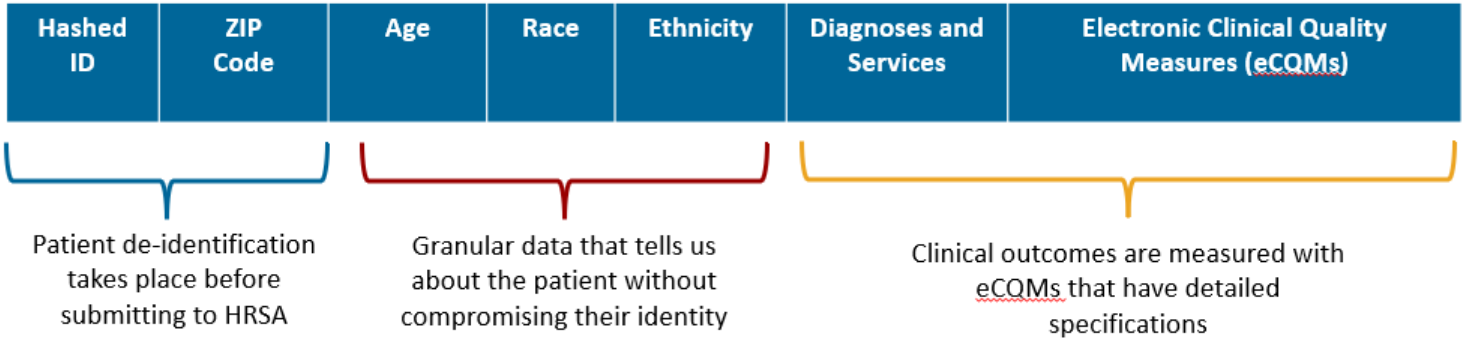
# UDS Patient Level Submission (UDS+)

UDS+ is...

- De-identified patient level data
- Applicable to UDS Tables Patients by ZIP Code, 3A, 3B, 4, 6A, 6B, and 7
- Submitted via FHIR

UDS+ is not...

- Full copies of data directly from patients' electronic medical records




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

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# UDS+ 2024 Reporting Year: Submission Requirements

**2024 UDS+ Submissions Due by April 30, 2025**

1. Submit data for your ***medical*** patients.

2. Submit ***all*** the demographic tables data:
   - **Table:** Patients by ZIP Code
   - **Table 3A:** Patients by Age and by Sex Assigned at Birth
   - **Table 3B:** Demographic Characteristics
   - **Table 4:** Selected Patient Characteristics

   *(Managed Care Utilization lines are NOT required for UDS+ CY 2024 reporting)*

3. Submit ***one eCQM*** from the measures listed below:
   - **Table 6B:** Quality of Care Measures
     - Breast Cancer Screening
     - Cervical Cancer Screening
     - Colorectal Cancer Screening
   - **Table 7:** Health Outcomes and Disparities
     - **Controlling High Blood Pressure***
     - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

   ** Recommended measure*

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# 2024 Calendar Year: UDS & UDS+ Reporting

All health centers are **required** to submit **aggregated** UDS data by **February 15, 2025**.

- Submit aggregated UDS data through EHBs, using the traditional submission method.
- Include all UDS tables and appendices.
- This will be the official submission of record.

All health centers will be required to submit a minimum amount of **patient-level data (UDS+) by April 30, 2025**.

- Submit UDS+ data via FHIR.
- Include, at a minimum, only demographic data and one eCQM for medical patients.
- UDS+ submission supports system capacity building and progress toward full implementation.

**EHBs will remain the submission of record.**

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# How can health centers prepare for UDS+?

## UDS TEST COOPERATIVE

Join the UTC for continued UDS+ updates and resources.

## HL7® FHIR®

Review:

- HL7.org
- HL7® FHIR® resources page
- UDS+ FHIR Implementation Guide (IG)

## ENGAGEMENT

Visit the UDS Modernization Initiative webpage for up-to-date UDS+ information.

Encourage your health IT vendors to join the UTC and participate in UDS+ testing before 2025.

Submit questions through the BPHC Contact Form by selecting **Uniform Data System (UDS)** > **UDS Modernization** > **Patient-Level Submission (UDS+).**

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# Questions and Answers

# Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net ***or*** Health Center Program Support

**1-866-837-4357**

bphc.hrsa.gov

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