Uniform Data System (UDS): Clinical Tables Part 3

Chronic Disease Management

October 26, 2023, 1:00–2:30 p.m. ET

Stacey Moody, MSW
Training and Technical Assistance Specialist, John Snow, Inc. (JSI)
Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Opening Remarks

Jonjelyn Gamble

Data and Evaluation

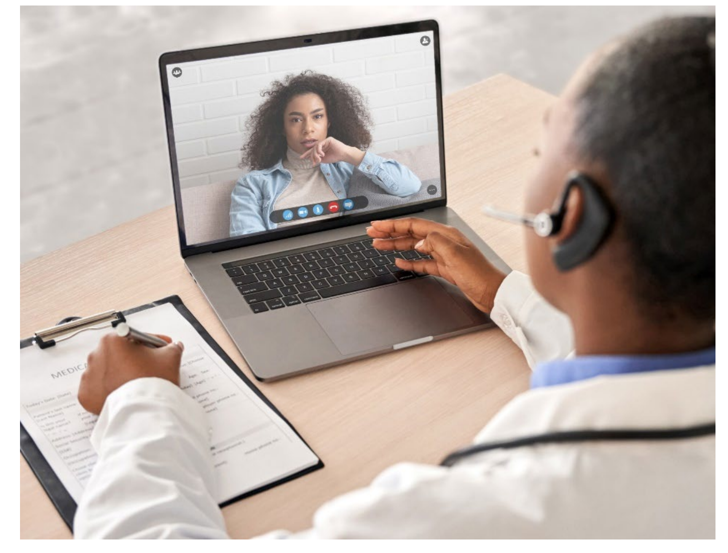
Office of Quality Improvement

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 data reporting quality improvement
- Review 2023 Uniform Data System (UDS) training resources
- Questions and answers



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.

UDS Clinical Quality Measures (CQMs)

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

CQM Reporting

UDS Terminology in Clinical Quality Reporting

Key Resources

Tables 6B and 7: CQMs

2023 Changes:

- Measure denominator eligibility now defined by electronic-specified clinical quality measure (eCQM) qualifying visit specifications.
- Measures aligned with updated eCQMs, wherever available.
    - Age “as of” for several CQMs has been revised to align with Clinical Quality Language (CQL) criteria.
    - In alignment with those updated eCQMs, several existing measures have modifications.

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

UDS CQMs

Clinical Quality Measures Deep Dive

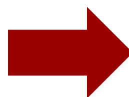
Recorded on September 21, 2023

Screening and Preventive Care Measures

Recorded on October 3, 2023

Maternal Care and Children’s Health Measures

Recorded on October 11, 2023

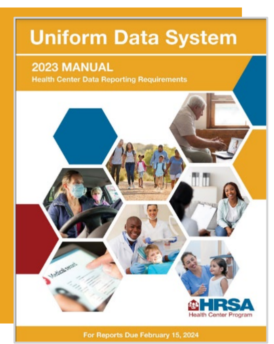


Chronic Disease Management Measures

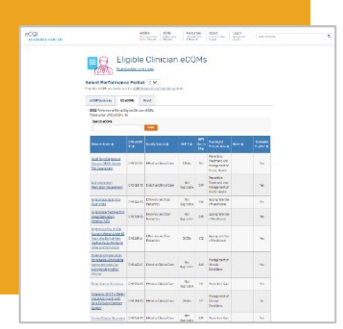
Today’s webinar

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

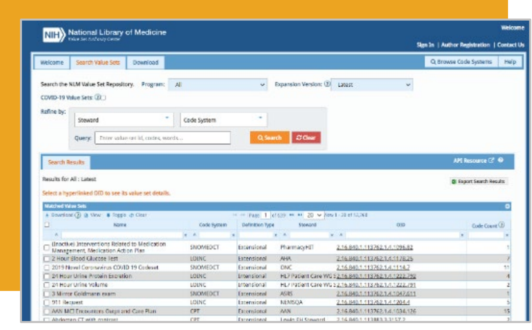
CQM Specifications



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



The manual links to the eCQI Resource Center, where measure information, specifications, data elements, and value sets are found (for those that are electronically specified).



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

Remember, HRSA is not the measure steward and therefore does not design specific measures. Measures are nationally defined.

Components of Clinical Measures

Denominator	Numerator	Exclusions and Exceptions
• Identifies the group of patients that the measure is looking at to determine compliance. • Equal to the initial population identified in the CQM.	• Measures whether the service, event, or outcome requirements were met. • Each patient in the denominator is assessed to determine if they meet the numerator.	• **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. • **EXCEPTIONS:** Patients who do meet denominator criteria but do not meet numerator criteria and meet any of the exception criteria are removed from the denominator.

Birthdate Updates to Tables 6B and 7 Measures

- Age “as of” for several CQMs has been updated to reflect age as of the end of the measurement period (instead of beginning), in alignment with CQL:
    - Controlling High Blood Pressure *(Table 7)*
    - Diabetes: Hemoglobin A1c (HbA1c) Poor Control *(Table 7)*
- For these measures, a patient must be the age specified as of December 31.
- For these and all measures, it’s critically important to refer to the birthdates listed in the manual and/or the CQL in the specifications for the eCQM, rather than trying to interpret from the name or description of the measure.

EXAMPLE:

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (CMS122v11)

Description: Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Initial population assessed: Patients 18 through 75 years of age by the end of the measurement period with diabetes with an eligible countable visit during the measurement period (*meaning age 75 as of Dec. 31, 2023*)

Change to Tables 6B and 7 Reporting Criteria

UDS-Specific Medical Visit Requirement Has Been Removed

Beginning with 2023 reporting, patients **with qualifying visits, as defined by the measure steward for each selected measure**, are to be considered for the denominator:

2022 UDS Guidance	NEW 2023 UDS Guidance
Include and evaluate patients for the denominator who had **at least one medical visit** during the measurement period as specified in the measure (dental visits are used for the dental sealant measure), even though some eCQMs may specify a broader range of service codes.	Include and evaluate patients for the denominator who had **at least one eligible countable visit (as defined by the measure steward for the selected eCQM)** during the measurement period as specified in the measure.

Now, in order to be eligible for clinical measure denominator reporting on the UDS:

- The person must be a health center patient on the UDS (meaning, included in the demographic tables, have a countable visit *anywhere on Table 5*) **AND**
- Have a visit (or visits) that meet the individual eCQM's specified qualifying encounters.

CQM Eligibility Is Now Defined by eCQM Specifications.

In the specifications for **each measure**, the initial population and denominator are defined, and the qualifying visits for that measure are defined therein. Remember, these specifications are **defined by the measure steward**, not by HRSA.

Qualifying visits for each measure are defined by value sets.

A value set is a list of specific values, terms, and their codes, used to describe clinical and administrative concepts in quality measures. These include CPT, ICD-10, SNOMED, LOINC, and RxNorm.

For example, the value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001) is used as part of qualifying visit definition for many measures:

- CMS122v11 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0 percent)
- CMS165v11 - Controlling High Blood Pressure

Other value sets are also specified in the qualifying encounters for each measure. It's not just this one, and it's *not the same for all measures*!

Clinical Process and Outcome Measures

Table 6B Format

Denominator (a)	Number of Records Reviewed *[Denominator]* (b)	Number of Charts/Records Meeting the Numerator Criteria *[Numerator]* (c)
Number of patients who fit the detailed criteria described for inclusion in the measure	A number equal to or greater than 80% of Column A (patients who fit the criteria)	Number of records from Column B that meet the numerator criteria for the measure

Table 7: Additional Race and Ethnicity Categories

Race and ethnicity categories on Table 7 have been updated to align with Table 3B.

Chronic disease management measures on Table 7 are now reported with more granular race and ethnicity categories.

- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

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)
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black/African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban			
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			
1b4a	Samoan			
1ca	Black/African American			

Clinical Process and Outcome Measures

Table 7 Format

- Report by race and ethnicity.
- High blood pressure and diabetes:
  - **Column A:** Denominator
  - **Column B:** Total number of records reviewed or at least 80% of denominator
  - **Column C or F:** Number of patients from 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 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 197 of the UDS Manual for Table 3B/7 crosswalk.

Tips for Clinical Measure Reporting Success

- Review the birthdates in the 2023 UDS Manual for each measure.
- Make sure the documentation in your health center's electronic health record (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.

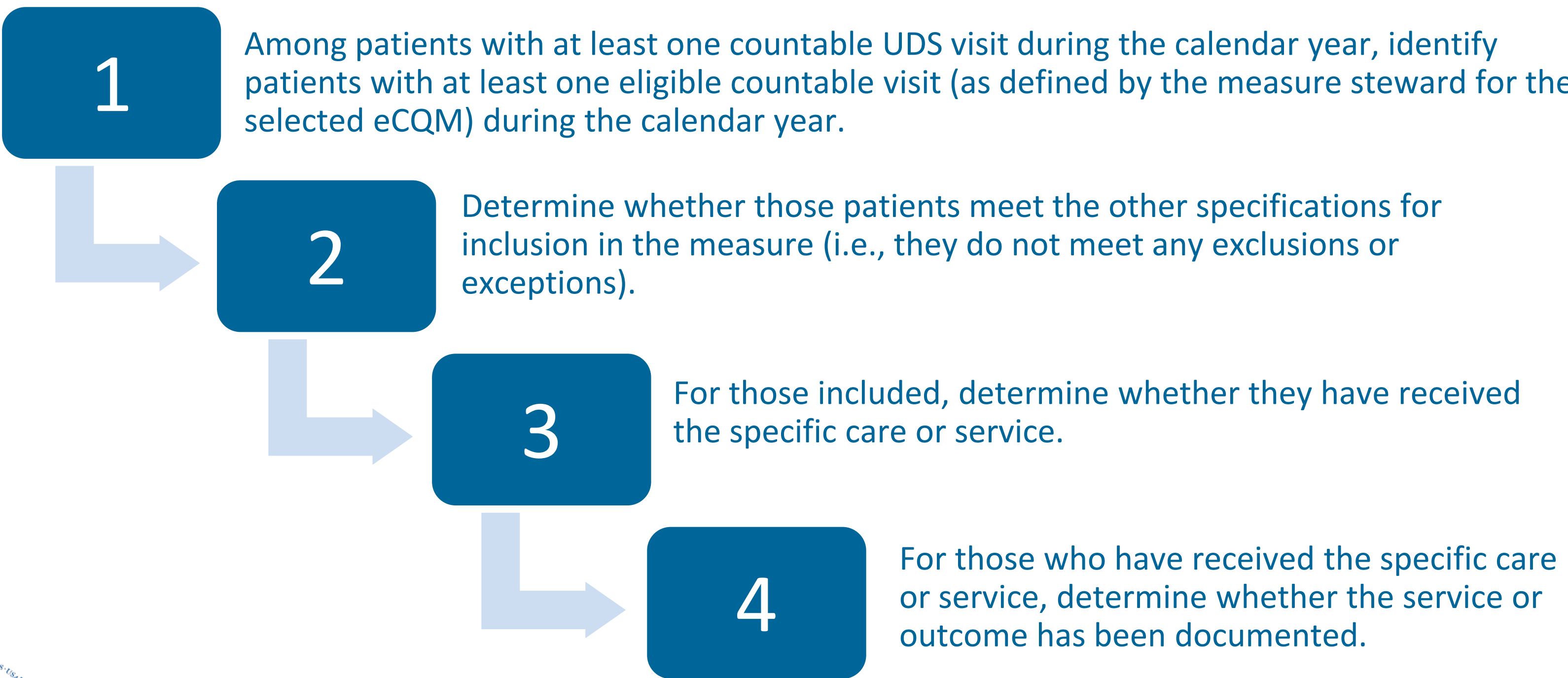
Chronic Disease Management Measures

Tables 6B and 7

Acronyms

- **AMI:** acute myocardial infarction
- **ASCVD:** atherosclerotic cardiovascular disease
- **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
- **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

General Flow of Chronic Disease Management Measures



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	CMS347v6
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	CMS159v11
Table 7, Columns 2A–2C	Controlling High Blood Pressure	CMS165v11
Table 7, Columns 3A–3F	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v11

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%

Table 6B: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease CMS347v6

Denominator	Exclusions	Exceptions	Numerator
Patients with an active diagnosis of ASCVD, or who ever had an ASCVD procedure, or Patients who were 20 years of age and older at the start of the measurement period who: • Ever had a laboratory result of LDL-C greater than or equal to 190 mg/dL or • Were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or Patients 40 through 75 years of age with Type 1 or Type 2 diabetes; with an **eligible countable visit** during the measurement period	• Patients who are breastfeeding at any time during the measurement period • 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 • Patients who are receiving palliative or hospice care • Patients with active liver disease or hepatic disease or insufficiency • Patients with ESRD • 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: CMS347v6

Changes to This Measure

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)

2022 Denominator	2023 Denominator
• All patients **who were previously diagnosed with or currently have an active diagnosis of ASCVD**, including an ASCVD procedure, or	• All patients **with an active diagnosis of ASCVD**, or who ever had an ASCVD procedure, or
• Patients 20 years of age or older who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or	• Patients 20 years of age or older who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or
• Patients 40 through 75 years of age with a diagnosis of diabetes	• Patients 40 through 75 years of age with a diagnosis of diabetes

- The Statin Therapy measure denominator changed from requiring a **current *or prior* diagnosis** of ASCVD to now requiring an ***active*** diagnosis of ASCVD.
- Patients with a diagnosis of pregnancy are no longer excluded from the denominator.
- Patients with a telephone-only visit during the year are excluded from the denominator.
- Patients with a documented medical reason for not being prescribed statin therapy has been added as a denominator exception.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (*cont.*)

Clarifications, Tips, and Frequently Asked Questions

- Current statin therapy must be documented in the patient's current medication list or ordered during the measurement period.
- Intensity of statin therapy or lifestyle modification coaching is NOT being assessed for this measure.
- DO NOT count other cholesterol-lowering medications as meeting the numerator.
- Although a telehealth-only visit may qualify a patient for the denominator, a telephone-only visit WILL NOT qualify for inclusion in the denominator.
- The denominator for this measure is expansive, with three separate denominator criteria. Ensure patients are not counted 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.
    - Refer to the eCQM workflow for this measure (CMS347v6).

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

eCQM Workflow

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

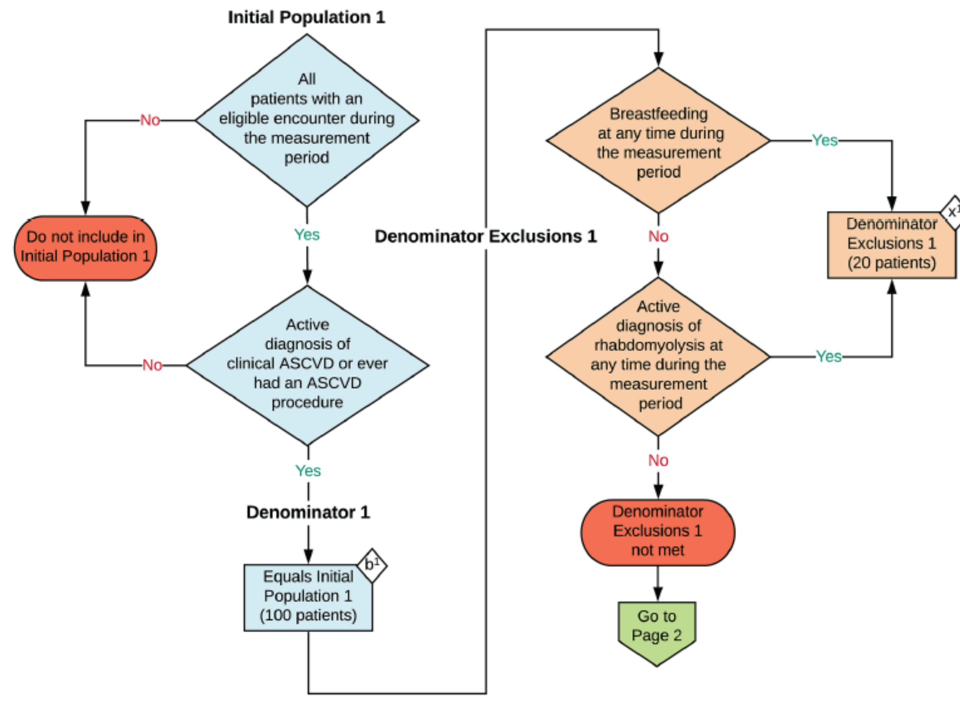


Table 6B: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet CMS164v7

Denominator	Exclusions	Exceptions	Numerator
Patients 18 years of age and older with an **eligible countable 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

It's important to refer to the specifications and value sets for all the needed details: CMS164v7

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

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, while most others are now version 11). Version 7, which is the same as last year's version, should continue to be used for 2023 reporting.
- SNOMED CT and ICD-10 codes are available for determining if a patient has IVD; be sure to review those in the value set. 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.

Table 6B: 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 eligible **countable** 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 (*cont.*)

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 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.
- 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* required that the patient start antiretroviral therapy (ART) medication at the visit.
    - Documentation that the visit was completed (from the provider to whom the patient was referred) is required.

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

Table 6B: Depression Remission at Twelve Months

CMS159v11

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, 2021, through October 31, 2022, and at least one eligible **countable** 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

It's important to refer to the specifications and value sets for all the needed details: CMS159v11

Depression Remission at Twelve Months (*cont.*)

Clarifications, Tips, and Frequently Asked Questions

- 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.
- 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.
- 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.
- 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.

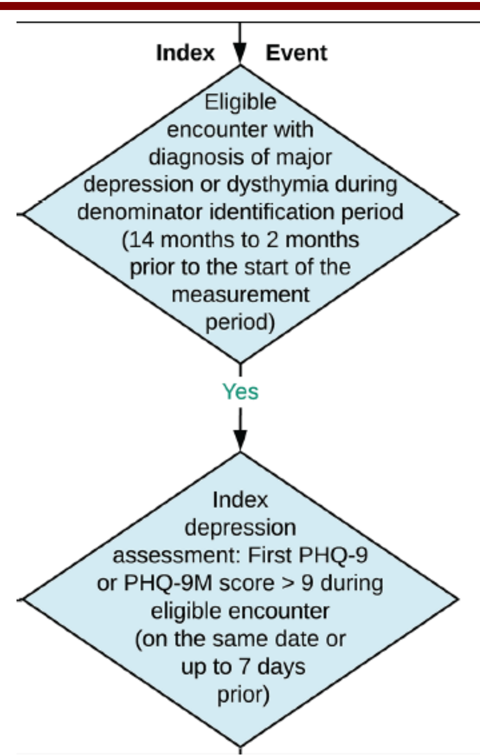


Table 7: Controlling High Blood Pressure

CMS165v11

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 85 years of age by the end of the measurement period who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period, with an eligible **countable** 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 for any part of the measurement period • 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 • Patients aged 66–80 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 • Patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period • Patients who received palliative care during measurement period	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 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: CMS165v11

Controlling High Blood Pressure (*cont.*)

Clarifications, Tips, and Frequently Asked Questions

- 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.
- Use the last day that blood pressure reading was taken and recorded in 2023 to determine if the specified measure requirements are met.
- Blood pressure readings taken at any type of visit at the health center can be counted toward the Controlling High Blood Pressure measure compliance. 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.
- Only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for the numerator.

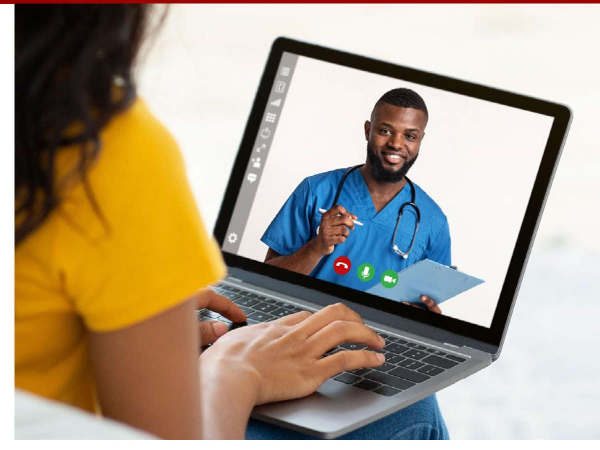
Poll #2

Has your health center implemented remote patient monitoring for patients with high blood pressure?

- ❑ Yes
- ❑ No
- ❑ I do not know

Remote Patient Monitoring

What is acceptable in terms of remote 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.
- This cannot be audio-only (clinician must see the reading).
- The measure **allows** patient-reported data using most methods of digital collection/reporting and **prohibits** patient-reported data taken with non-digital devices, such as with a manual blood pressure cuff and stethoscope.
- There is not a list of valid remote monitoring devices for this measure.
- It would be up to the clinician to determine that the reading came from a digital device before documenting it.
- It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record.

HRSA Health Center Program

Table 7: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

CMS122v11

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 75 years of age by the end of the measurement period with diabetes with an eligible **countable** visit during the measurement period	• Patients who were in hospice care for any part of the measurement period • 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 • 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 • 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: CMS122v11

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

Clarifications, Tips, and Frequently Asked Questions

- Specification guidance no longer indicates that patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) are to be excluded from the denominator.
  - Review measure specifications and associated codes to determine if secondary conditions are to be considered.
- 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).
- 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.
- Lower is better for this measure.

Poll #3

Blood pressure readings performed via a remote monitoring device are acceptable for numerator compliance if which of the following are true?

- ❑ Observed by a clinician or member of the care team
- ❑ Documented in the patient's chart
- ❑ Not performed on an audio-only visit
- ❑ All of the above

Poll #3 (answer)

Blood pressure readings performed via a remote monitoring device are acceptable for numerator compliance if which of the following are true?

- ❑ Observed by a clinician or member of the care team
- ❑ Documented in the patient's chart
- ❑ Not performed on an audio-only visit
- ❑ **All of the above**

Chronic Disease Management Measures: Tips

Tips for Quality Improvement and Success

Tips for Success with Chronic Disease Management Measures

- **Review underlying data regularly, to be sure documentation aligns with measure specifications and EHR guidance.**
  - 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 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 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 and be sure those are documented.**
  - 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:
    - ESRD
    - 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.

["Diagnosis": "End Stage Renal Disease"]

eCQM Data Element

Performance/Reporting Period: 2023

Value Set Description from VSAC

CLINICAL FOCUS: The purpose of this value set is to represent concepts for diagnoses of end stage renal disease (ESRD).

DATA ELEMENT SCOPE: This value set may use a model element related to Diagnosis.

INCLUSION CRITERIA: Includes concepts that represent a diagnosis of end stage renal disease (ESRD).

EXCLUSION CRITERIA: No exclusions.

Constrained to codes in the Diagnosis: End Stage Renal Disease value set (2.16.840.1.113883.3.526.3.353)

QDM Datatype and Definition

"Diagnosis"

Data elements that meet criteria using this datatype should document the Condition/Diagnosis/Problem and its corresponding value set. The *on dateTime* corresponds to the implicit start dateTime of the datatype and the *abatement dateTime* corresponds to the implicit stop dateTime of the datatype. If the *abatement dateTime* is not present, then the diagnosis is considered to still be active. When this datatype is used with timing relationships, the criterion is looking for an active diagnosis for the time frame indicated by the timing relationships.

Timing: The *prevalencePeriod* references the time from the *onset date* to the *abatement date*.

eCQMs using this data element:

CMS249v5 - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
CMS165v11 - Controlling High Blood Pressure
CMS347v6 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
CMS951v1 - Kidney Health Evaluation

QDM Attributes

Clinical Measure Reporting Success

It's essential to be familiar with the specifications for the CQMs.

- Thoroughly read definitions and instructions in the 2023 UDS Manual.
- Other available guidance:
  - eCQI Resource Center
  - Telehealth Impact on Clinical Measures
  - Clinical Measures Handout
  - eCQM Flows: Workflows for each eCQM, updated annually and downloads as a ZIP file
  - Guide for Reading eCQMs v8.0: 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

Clinical Measure Reporting Success (*cont.*)

Disease Management CQM	2020	2021	2022	2022 v 2020	2022 v 2021
Ischemic Vascular Disease – Use of Aspirin	78.80%	78.25%	76.83%	Negative Trend	Negative Trend
Statin Therapy for Cardiovascular Disease	71.92%	73.10%	76.07%	Positive Trend	Positive Trend
Hypertension Control (less than 140/90 mm Hg)	57.98%	60.15%	63.40%	Positive Trend	Positive Trend
Uncontrolled Diabetes (HbA1c >9%) *Inverse Measure*	35.60%	32.29%	30.42%	Positive Trend	Positive Trend
HIV Linkage to Care	81.41%	82.70%	82.20%	Positive Trend	Negative Trend
Depression Remission at Twelve Months[1]	13.69%	13.84%	13.64%	Negative Trend	Negative Trend

Source: Uniform Data System 2020-2022 – Table 6B, Table 7

[1] New CQM for 2020

Available Resources

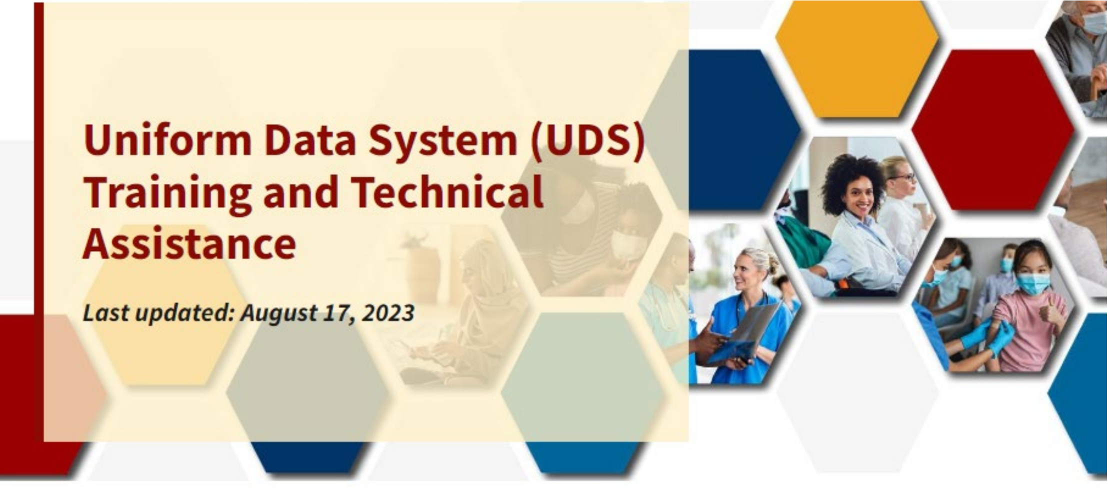
Resources are available to support your UDS reporting!

Find Resources to Help: Clinical Care

HRSA BPHC's UDS Resources site Clinical Care section includes the following resources:

- UDS Clinical Quality Measures (CQM) Criteria
- UDS Clinical Measures Exclusions and Exceptions
- Telehealth Impact on Uniform Data System (UDS) Clinical Measure Reporting

And much more!



HRSA Health Center Program

UDS Training and Technical Assistance Resources

- UDS Reporting Resources on the BPHC website
  - Introduction
  - Reporting Training Schedule
  - Reporting Guidance
  - Patient Characteristics
  - Staffing and Utilization
  - Clinical Care
  - Financials
  - Appendices
  - Additional Reporting Topics
  - UDS Data

Announcement

Calendar year 2023 UDS reporting submission

All health centers are required to submit a full, aggregated UDS Report through HRSA's Electronic Handbooks (EHBs) by February 15, 2024. Additionally, beginning with 2023 UDS reporting, health centers may also voluntarily submit de-identified patient-level data (UDS+) using Health Level Seven International (HL7®) developed Fast Healthcare Interoperability Resources (FHIR®) version release 4 (R4) standards. View updates about UDS patient-level submission (UDS+) on the UDS Modernization Overview and UDS Modernization FAQ webpages.

UDS test cooperative stakeholder group

Health centers, Primary Care Associations (PCAs), Health Center-Controlled Networks (HCCNs), and health information technology (IT) vendors are welcome to join the UDS Test Cooperative (UTC) stakeholder group. To join, contact us through the BPHC Contact Form and select Uniform Data System (UDS), UDS Modernization, then How to Join the UDS Test Cooperative.

Featured Resources

- **2022 UDS Trends Webinar Registration**
  A detailed overview of 2022 UDS data trends
- **2023 UDS Final Program Assistance Letter (PAL) (PDF - 553 KB)**
  An overview of final updates to the CY 2023 UDS reporting
- **2023 UDS Manual (PDF - 2 MB)**
  Provides health centers with detailed reporting instructions and example data tables that support calendar year 2023 UDS reporting, including information about voluntary UDS patient-level submission (UDS+)
- **2023 UDS Tables PDF (PDF - 1 MB) and Excel (XLSX - 386 KB)**
  Resources to help health centers prepare UDS submissions in advance with an organized, standard structure
- **2023 UDS Reporting Changes TA Webinar Recording and Presentation (PDF - 2 MB)**

Recorded Training Modules

1. UDS Overview
2. Patient Characteristics
3. Clinical Services and Performance
4. Operational Costs and Revenues
5. Submission Success

Find the modules on HRSA BPHC's UDS Resource site.

Support Available

Description	Contact	E-mail or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: UDS Reporting and most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical Support > EHBs Tasks/Technical Issues > EHBs Privileges	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical Support, EHBs Tasks/Technical Issues, Other EHBs Submission Types	877-464-4772
UDS+ FHIR R4 IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: UDS Modernization	877-464-4772

Resources for Clinical Measures

National Resources

- Healthy People 2030
- U.S. Preventive Services Task Force
- CDC National Center for Health Statistics State Facts
- eCQI Resource Center
- Value Set Authority Center (VSAC)

HRSA Priority Areas

- Diabetes
- HIV/AIDS Bureau
- Behavioral Health

Health Center Data and Resources

- Community Health Quality Recognition
- Quality Payment Program

Join Us!

There are several more UDS webinars this fall. Please register for those and access any past webinars that you have missed.

- Upcoming UDS Webinars (all 1:00–2:30 p.m. ET)
  - **UDS Clinical Tables Part 3: Chronic Disease Management**
    Today
  - **Reporting UDS Financial and Operational Tables**
    November 7
  - **Successful Submission Strategies**
    November 16
- Past webinars are archived on HRSA's UDS TTA page.
  - **UDS Basics: Orientation to Terms and Resources**
  - **UDS 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**

Preliminary Reporting Environment Launch

- **The 2023 Uniform Data System (UDS) Preliminary Reporting Environment (PRE) will open tomorrow, October 27, 2023.**
- Learn more about the PRE from this technical assistance webinar:

Uniform Data System Reporting 2023 - Preliminary Reporting Environment

November 9, 2023

1:30 – 3:00 PM ET

Register

Find the links to the recording and presentation on the Reporting Training Schedule page

View Accessing Uniform Data System (UDS) Reporting Guidance Resources on the Electronic Handbooks for additional instructions.

UDS Modernization Updates

UDS Modernization Initiative

Reduce Reporting Burden

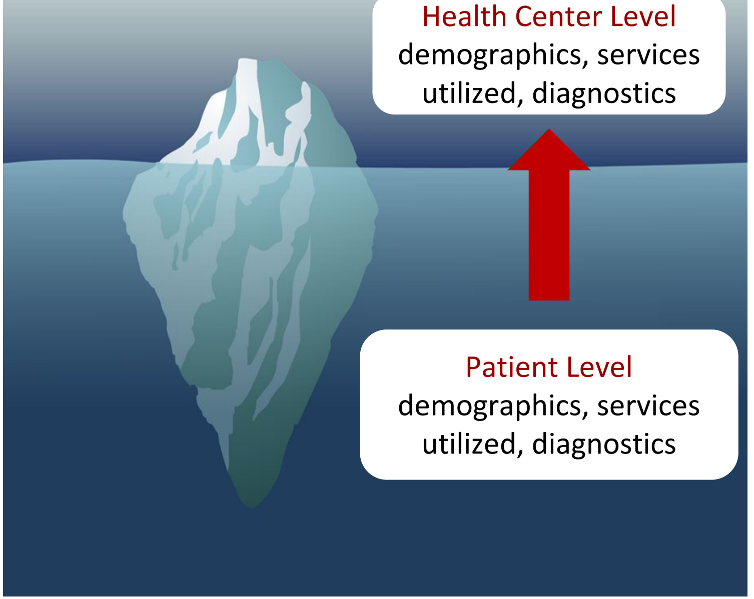
Automate data submission, provide enhanced UDS reporting capabilities, promote transparency, and integrate stakeholder feedback.

Better Measure Impact

Improve the quality of UDS data to reflect improvements in patient-centered care and an evolving primary health care setting.

Promote Transparency

Provide an open, transparent decision-making process on UDS changes such as measure selection, information technology, and reporting improvements.



UDS Modernization Initiative

Benefits of UDS+

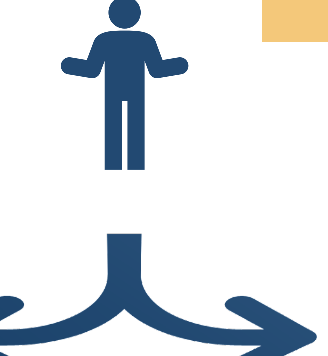
Patient-level data collection will enable HRSA to better:

- Articulate the **unique characteristics** and **needs** of health center patients
- Illustrate the **breadth and depth** of health center **services** and their impact on **health outcomes**
- Inform **TTA, research and evaluation**, and **health equity** work
- Improve **preparedness** for public health emergencies
- Improve ability to communicate the **complexity of the patient populations** health centers serve and provide **evidence for aligned reimbursements** for care provided
- Inform **investments and interventions** based on trends identified in patient-level data (e.g., targeted needs of specific communities/patients, social determinants of health)

2023 Calendar Year: UDS Reporting

All health centers are **required** to submit **aggregated** UDS data.

Health centers also have the **option** to submit **patient-level data (UDS+)**.



- 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

UDS+ FHIR Implementation Guide provides architectural details and technical reporting specifications for submission.

2023 Calendar Year: Optional UDS+ Submission

1. Submit data for your entire universe of patients (not a subset)

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

3. Submit ***all or part of*** the clinical tables data
   - **Table 6A**: Selected Diagnoses and Services Rendered – optional
   - **Table 6B**: Quality of Care Measures – submit 2 or more eCQMs from this table
   - **Table 7**: Health Outcomes and Disparities – submit 2 or more eCQMs from this table

2023 Calendar Year: Optional UDS+ Submission cont'd

- The UDS Test Cooperative (UTC) suggests health centers may be the most ready to submit these eCQMs:
  - **Table 6B: Quality of Care Measures**
    - ✓ Cervical Cancer Screening
    - ✓ Colorectal Cancer Screening
  - **Table 7: Health Outcomes and Disparities**
    - ✓ Controlling High Blood Pressure
    - ✓ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

REMEMBER:

Submit both demographic and clinical data for the entire patient population, not a subset of patients

- Health centers may choose any eCQM from these tables as long as they submit at least two measures from each table

Resources

For the latest UDS Test Cooperative (UTC) and UDS+ information, please subscribe to the Primary Health Care Digest and visit the UDS+ technical assistance webpages:

- UTC
- UDS Modernization Initiative
- UDS Modernization FAQ

Submit a ticket via the BPHC Contact Form to:

- Join the UTC
- Access the UDS+ Health Center Program Community
- Participate in a readiness assessment to discuss UDS+ submissions use cases
- Learn more about the UDS+ FHIR Implementation Guide

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

Connect with HRSA

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www.hrsa.gov

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