U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

PROGRAM ASSISTANCE LETTER

DOCUMENT NUMBER: 2021-05

DOCUMENT TITLE: Approved Uniform Data System Changes for Calendar Year 2022

DATE: November 19, 2021

TO: Health Centers
Primary Care Associations
Primary Care Offices
National Training and Technical Assistance Partners

I. BACKGROUND

This Program Assistance Letter (PAL) provides an overview of approved changes to the Health Resources and Services Administration's (HRSA) calendar year (CY) 2022 Uniform Data System (UDS) to be reported by Health Center Program (HCP) Awardees and Look-alikes in February 2023. A forthcoming 2022 UDS Manual will provide additional details.

II. UPDATES FOR CY 2022 UDS REPORTING

A. UPDATE QUALITY OF CARE MEASURE TO TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

HRSA will include a measure representing *Long-Haul COVID-19* as a new diagnostic measure on Table 6A. This measure will be placed as Line 4d within the table's *Selected Infectious and Parasitic Diseases* diagnostic grouping of measures. The new measure's label will be: *Post COVID-19 condition, unspecified (ICD-10-CM,* U09.9).

Rationale: COVID-19 continues to have tremendous impact on health care infrastructure, health centers, and patients served by health centers. The addition of this measure will lead to better understanding the impact of COVID-19 on patients served by health centers post-acute infection.

B. UPDATE QUALITY OF CARE MEASURE SPECIFICATIONS TO ALIGN WITH E-CQMS: TABLE 6B: QUALITY OF CARE MEASURES AND TABLE 7: HEALTH OUTCOMES AND DISPARITIES

To support efforts across the federal government to standardize data collection and reduce reporting burden for entities participating in federal programs with data reporting mandates, the following UDS

clinical quality measures (CQMs) have been aligned with the versions of the Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs) designated for the 2022 reporting period. Alignment of UDS CQMs with CMS eCQMs most notably pertains to the measures captured in UDS Tables 6B and 7, illustrated in the tables below.

Rationale: Data-driven quality improvement efforts and full optimization of electronic health record (EHR) systems are strategic priorities for the Health Center Program. Clinical performance measure alignment across national programs promotes data standardization and quality, and decreases reporting burden. Additionally, measure alignment and harmonization with other national quality programs, such as the National Quality Forum (NQF) and the CMS Quality Payment Program (QPP), remains a federal priority. Hyperlinks to the Electronic Clinical Quality Improvement (eCQI) Resource Center have been included to provide additional details of the eCQM reporting requirements.

1. Childhood Immunization Status has been revised to align with CMS117v10 .
2. Cervical Cancer Screening has been revised to align with CMS124v10 .
3. Breast Cancer Screening has been revised to align with CMS125v10 .
4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents has been revised to align with CMS155v10 .
5. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan has been revised to align with CMS69v10 .
6. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention has been revised to align with CMS138v10 .
7. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease has been revised to align with CMS347v5 .
8. Colorectal Cancer Screening has been revised to align with CMS130v10 .
9. HIV Screening has been revised to align with CMS349v4 .
10. Preventive Care and Screening: Screening for Depression and Follow-Up Plan has been revised to align with CMS2v11 .
11. Depression Remission at Twelve Months has been revised to align with CMS159v10 .
12. Controlling High Blood Pressure has been revised to align with CMS165v10 .
13. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) has been revised to align with CMS122v10 .

C. Update Methodology for Reporting Clinical Quality Measures: Tables 6B and 7

Data from health centers' electronic health record (EHR) systems are increasingly being used to report on the full universe of patients whose characteristics fulfill UDS clinical quality measure specifications. The methodology for using patient chart sampling to report clinical quality measures on Tables 6B and 7 will no longer be an option beginning with 2022 UDS.

Rationale: Reporting on the actual number of patients served will provide more accurate health information of numerically smaller population groups and better supports federal efforts to address health disparities. Using EHR data to report UDS clinical quality measures among all patients for which each CQM applies allows for a more complete understanding of health centers' clinical quality performance and patient health status. Furthermore, transitioning away from chart sampling will move health centers towards leveraging EHR systems without using a statistical sample.

D. Update to Appendix D: Health Center Health Information Technology (HIT) Capabilities Form

A question is being added to Appendix D: Health Center Health Information Technology (HIT) Capabilities Form to measure the total number of patients screened for such factors. Health centers will be asked to: *Provide the total number of patients that were screened for social risk factors during the calendar year.*

Rationale: With focused priority, across federal government, on understanding the effects of social risk factors on health, the addition of this question will support broader understanding of the impact of social determinants on the health of patients served by health centers. There is great analytical value to the addition of this question when assessed with existing question focused on number of patients screening positive for common domains of social risk: food insecurity, housing insecurity, financial strain, and lack of transportation/access to public transportation.

III. Contacts

For questions or comments regarding the updates to the CY 2022 UDS, contact the Office of Quality Improvement at OQIComments@hrsa.gov.

Sincerely

/S/

Jim Macrae
Associate Administrator

Attachments:

1. Exhibit A: Excerpt of Table 6A: Selected Diagnoses and Services Rendered
2. Exhibit B: Table 6B: Quality of Care Measures and Table 7: Health Outcomes and Disparities
3. Exhibit C: Excerpt of Appendix D: Health Center Health Information Technology (HIT) Capabilities Form

Exhibit A
Excerpt of Table 6A: Selected Diagnoses and Services Rendered

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

Calendar Year: January 1, 2021, through December 31, 2021

SELECTED DIAGNOSES

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1–2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64-		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-		
4b	Hepatitis C	B17.1-, B18.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1		
	Selected Diseases of the Respiratory System			
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40 (count only when code U07.1 **is not** present), J41- through J44-, J47-		
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.89, J20.8, J40 (count only when code U07.1 **is** present), J22, J98.8, J80		

Exhibit B

Table 6B: Quality of Care Measures and Table 7: Health Outcomes and Disparities

TABLE 6B: QUALITY OF CARE MEASURES

Calendar Year: January 1, 2021, through December 31, 2021

0	**Prenatal Care Provided by Referral Only (Check if Yes)**	

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15–19	
3	Ages 20–24	
4	Ages 25–44	
5	Ages 45 and over	
6	**Total Patients (Sum of Lines 1–5)**	

Section B—Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Section C—Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday			

Section D—Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23–64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screening**	**Total Female Patients Aged 51 through 73 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients with Mammogram (c)**
11a	MEASURE: Percentage of women 51–73 years of age who had a mammogram to screen for breast cancer			

Section E—Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 16 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–16 years of age with a BMI percentile **and** counseling on nutrition **and** physical activity documented			

Section F—Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 12 months, **and** (2) if identified to be a tobacco user received cessation counseling intervention			

Section H—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy			

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

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J—Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 74 years of age who had appropriate screening for colorectal cancer			

Section K—HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center personnel between December 1 of the prior year and November 30 of the measurement period and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			
Line	**HIV Screening**	**Total Patients Aged 15 through 65 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Tested for HIV (c)**
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range			

Section L—Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented			
Line	**Depression Remission at Twelve Months**	**Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients who Reached Remission (c)**
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days)			

Section M—Dental Sealants for Children between 6–9 Years

Line	Dental Sealants for Children between 6–9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

Exhibit B (CONT'D)

Table 7: Health Outcomes and Disparities

Section A: Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Patients	
2	Deliveries Performed by Health Center's Providers	

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	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**				

Section B: Controlling High Blood Pressure

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**			

Section C: Diabetes: Hemoglobic A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
	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**			

Exhibit C

Excerpt of Appendix D: Health Center Health Information Technology (HIT) Capabilities Form

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply.)
    a. Quality improvement
    b. Population health management
    c. Program evaluation
    d. Research
    e. Other (please describe__)
    f. We DO NOT utilize HIT or EHR data beyond direct patient care
11. Does your health center collect data on individual patients' social risk factors, outside of the data countable inthe UDS?
    a. Yes
    b. No, but we are in planning stages to collect this information
    c. No, we are not planning to collect this information
12. Which standardized screener(s) for social risk factors, if any, did you use during the calendar year? (Select allthat apply.)
    a. Accountable Health Communities Screening Tools
    b. Upstream Risks Screening Tool and Guide
    c. iHELLP
    d. Recommend Social and Behavioral Domains for EHRs
    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
    f. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
    g. WellRx
    h. Health Leads Screening Toolkit
    i. Other (please describe__)
    j. We DO NOT use a standardized screener

12a. Please provide the total number of patients that screened positive for the following at any point during thecalendar year:

    a. Food insecurity ____
    b. Housing insecurity_____
    c. Financial strain ____
    d. lack of transportation/access to public transportation_____