HRSA
Health Resources & Services Administration

UDS Clinical Tables Part 3: Chronic Disease Management

Thursday, October 13, 1:00–2:30 p.m. ET

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Vision: Healthy Communities, Healthy People

Opening Remarks

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Health Resources and Services Administration (HRSA)

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 2022 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.

Clinical Quality Measure (CQM) Reporting, Part 1

UDS Terminology in Clinical Quality Reporting

Key Resources

UDS Clinical Quality Measures

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%)

HRSA Health Center Program

UDS Clinical Quality Measures Webinars

Screening and Preventive Care

- UDS Clinical Tables Part 1: September 21, 2022, 1:00–2:30 p.m. ET

Maternal Care and Children's Health

- UDS Clinical Tables Part 2: October 5, 2022, 1:00–2:30 p.m. ET

Chronic Disease Management

- You are here!

Key Terms in UDS Clinical Quality Measurement

Term	Definition
Measure Description	The quantifiable indicator to be evaluated.
Denominator	Patients who fit the detailed criteria described for inclusion in the specified measure to be evaluated.
Numerator	Records (from the denominator) that meet the criteria for the specified measure.
Exclusions	Patients not to be considered for the measure or included in the denominator.
Exceptions	Patients removed from the denominator because the numerator criteria are not met.
Specification Guidance	Centers for Medicare & Medicaid Services (CMS) measure guidance that assists with understanding and implementing CQMs.
UDS Reporting Considerations	Additional BPHC requirements and guidance that must be applied to the specific measure and that may differ from or expand on the eCQM specifications.

Key Terms in UDS Clinical Quality Measurement (*cont.*)

Term	Definition
Electronic-Specified Clinical Quality Measures (eCQMs)	An electronic-specified clinical quality measure is a clinical quality measure expressed and formatted to use data from electronic health records (EHRs) and/or health information technology systems to measure healthcare quality, ideally data captured in structured form during the process of patient care.
Measure Steward	An individual or organization that owns a measure and is responsible for maintaining the measure. Each eCQM has a measure steward.
Measurement Period	Represents Calendar Year (CY) 2022 unless another timeline is specifically noted.
Look-Back Period	A period of time that requires data for some length of time prior to the measurement period.
Overlapping Measurement Period	The diagnosis is active/current during the measurement period (CY 2022) but could have been diagnosed prior to the measurement period.

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	Patients who fit the criteria (same as Column A), or a number equal to or greater than 80% of Column A	Number of records from Column B that meet the numerator criteria for the measure

Clinical Process and Outcome Measures (*cont.*)

Table 7 Format

- Report by race and ethnicity
- High blood pressure and diabetes:
  - **Column A:** Denominator
  - **Column B:** Total number of health center patients from the Column A for whom data have been reviewed, at least 80% of denominator
  - **Column C or F:** Number of patients in Column B who meet the requirements of the numerator for the measure

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number of Records Reviewed (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/Chose Not to Disclose 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/Chose Not to Disclose Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Chose Not to Disclose Race and Ethnicity			
h	Unreported/Chose Not to Disclose Race and Ethnicity			
i	**Total**			

See page 179 of the UDS Manual for Table 3B/7 crosswalk.

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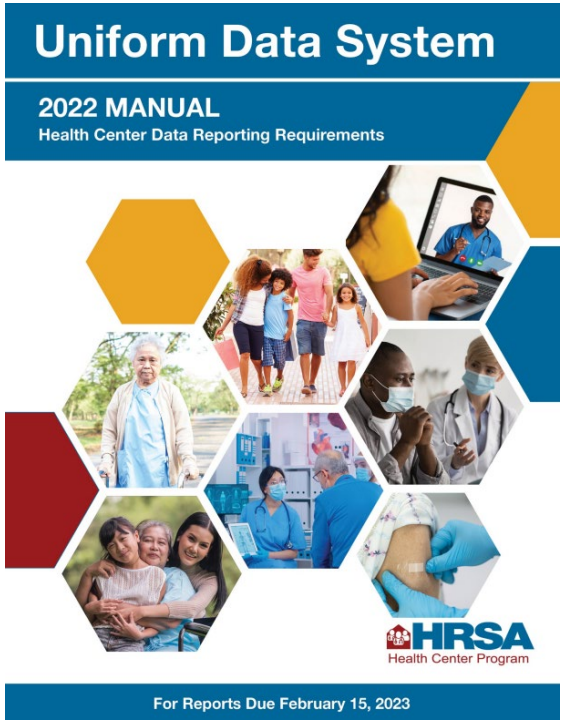
Clinical Quality Measure (CQM) Reporting, Part 2

UDS Tables 6B and 7

Getting Started with Clinical Quality Measures

UDS Guidance



UDS Manual:

- Follow the definitions and instructions in the 2022 UDS Manual.
- Remember that UDS measures limit reporting to patients who had at least one UDS countable medical visit during the calendar year (dental visit for dental sealant measure).
- CQMs include links to eCQMs as well as UDS-specific considerations.

Year-over-Year Changes:

- Program Assistance Letter (PAL)
- UDS Changes Webinar (held in May)
- eCQI Resource Center Measure Compare (new resource)

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Resources to Help with Understanding Clinical Quality Measures

UDS CQM Handout (Quick Reference)

HRSA Health Center Program — UNIFORM DATA SYSTEM

UDS Clinical Quality Measures 2022

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions
6B	7-9	Early Entry into Prenatal Care	no eCQM	Percentage of prenatal care patients who entered prenatal care during their first trimester	Patients seen for prenatal care during the year	Patients who began prenatal care at the health center or with a referral provider (Column A), or who began care with another prenatal provider (Column B), during their first trimester	None
6B	10	Childhood Immunization Status	CMS117 v10	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday	Exclusions: •Patients who were in hospice care for any part of the measurement period

Telehealth Impacts on UDS CQMs

Telehealth Impact on 2021 Uniform Data System (UDS) Clinical Measure Reporting

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

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

Exclusions and Exceptions for UDS CQMs

HRSA Health Center Program — UNIFORM DATA SYSTEM

The Uniform Data System (UDS) Clinical Measures Exclusions and Exceptions resource was developed to support accurate clinical quality measure reporting on UDS Tables 6B and 7 for the 2022 UDS Report. It is provided to assist health centers with reporting of clinical quality measure numerators and denominators. The denominator exclusions (patient records removed from the denominator before determining if numerator criteria are met) and the denominator exceptions (patient records removed from the denominator because they meet specified exception criteria) are excerpted from the full reporting criteria.

Please visit the HRSA's Health Center Data & Reporting page to view complete clinical quality measure reporting criteria and other available resources.

2022 UDS Clinical Measures Exclusions and Exceptions		
Measure	Denominator	
	Exclusions	Exceptions
Childhood Immunization Status CMS117v10	• Patients who were in hospice care for any part of the measurement period	• Not Applicable
Cervical Cancer Screening CMS124v10	• Women who had a hysterectomy with no residual cervix or a congenital absence of cervix • Patients who were in hospice care for any part of the measurement period • Patients who received palliative care during the measurement period	• Not Applicable
Breast Cancer Screening CMS125v10	• Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy • Patients who were in hospice care for any part of the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 consecutive days during the measurement period • Patients aged 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the	• Not Applicable

All available on HRSA's Clinical Care webpage.

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Tips for Clinical Measure Reporting Success

- Review the birthdates in the 2022 UDS Manual for each measure.
  - For example, some measures look at patients within a range as of the beginning of the year, while some look at age as of the last visit within the year.
- Be sure that the documentation within your health center's EHR aligns with reporting specifications.
  - For example, each measure requires certain coding, such as for diagnoses and/or procedures, so be sure those codes align with what your clinicians are using.
- Ensure there is a process for documenting results from external providers, labs, etc.
  - For example, a scanned PDF generally will not be sufficient.

Chronic Disease Management Measures

UDS Tables 6B and 7

General Flow of Chronic Disease Management Measures

1. **Identify patients with the disease or condition** who had a medical visit during the reporting year.
2. Determine whether those patients meet the other specifications for **inclusion in the measure** (e.g., they do not meet any exclusions or exceptions).
3. For those included, determine whether they have **received** the specific care or service.
4. For those who have received the specified care or service, determine whether the **outcome has been documented.**

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Tables 6B and 7: Chronic Disease Management Measures

UDS Table	Measure	eCQM
Table 6B, Line 17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v5
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	CMS159v10
Table 7, Columns 2A–2C	Controlling High Blood Pressure	CMS165v10
Table 7, Columns 3A–3F	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v10

Poll #1

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

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

Acronyms

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

Statin Therapy for Prevention & Treatment of Cardiovascular Disease

CMS347v5

Denominator	Exclusions	Exceptions	Numerator
Patients who were previously diagnosed with or currently have an active diagnosis of ASCVD, including 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 a medical visit during the measurement period	• Patients who have a diagnosis of pregnancy at any time 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 who are actively using or who received an order (prescription) for statin therapy at any time during the measurement period

Statin Therapy for the Prevention & Treatment of Cardiovascular Disease

Clarifications, Tips, and Frequently Asked Questions

- 2022 UDS changed the denominator:
  - Criteria for ASCVD component was changed from age 21 and older to **all patients with ASCVD**.
  - For patients with LDL-C ≥ 190 mg/dL, the age changed from 21 and older to **20 and older**.
  - For patients with diabetes, **the LDL-C level of 70–189 mg/dL criteria was removed**.
- 2022 UDS changed denominator exceptions:
  - **Added hospice care** as a denominator exception.
  - Removed denominator exception: patients 40 through 75 years of age with diabetes whose most recent fasting or direct LDL-C laboratory test result was less than 70 mg/dL and who are not taking statin therapy.

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

Clarifications, Tips, and Frequently Asked Questions

- Current statin therapy must be ordered during the measurement period to count for this measure.
- 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 (CMS347v5).

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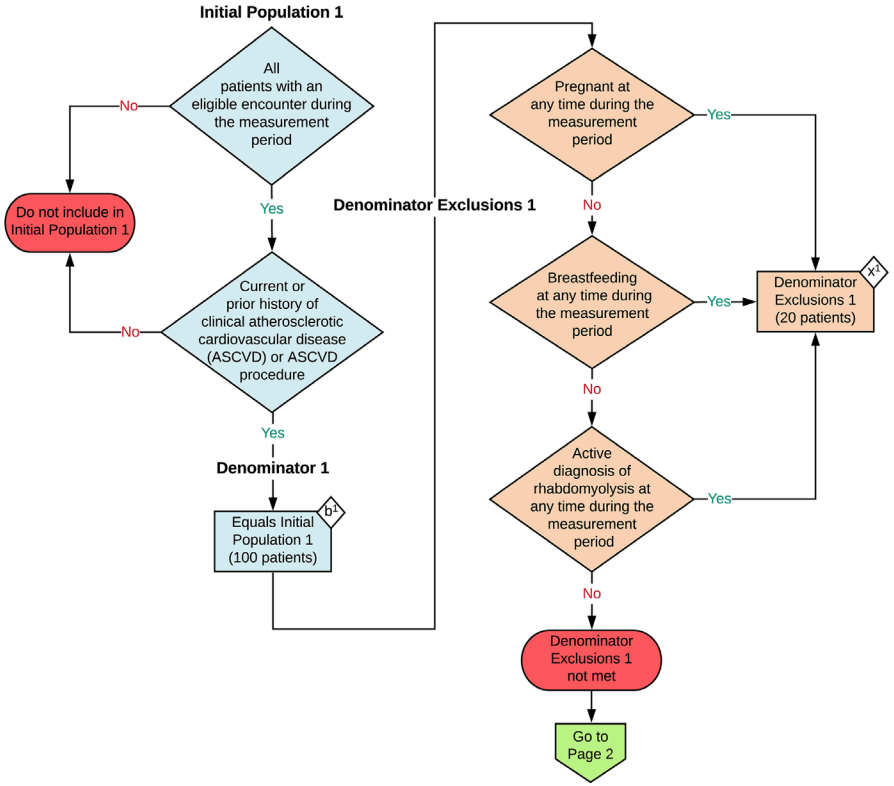
Statin Therapy for the Prevention & Treatment of Cardiovascular Disease

eCQM Workflow

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



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

CMS164v7

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

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

Clarifications, Tips, and Frequently Asked Questions

- Allergies to medication are **not an exclusion** for this measure, so patients with allergies are *not* excluded from the denominator.
- This eCQM has not been updated by the measure steward (it is still version 7, as opposed to most others which are now version 10). Version 7, which is the same as prior year, should continue to be used for 2022 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.

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HIV Linkage to Care

No eCQM

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

HIV Linkage to Care

Clarifications, Tips, and Frequently Asked Questions

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

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

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Depression Remission at Twelve Months

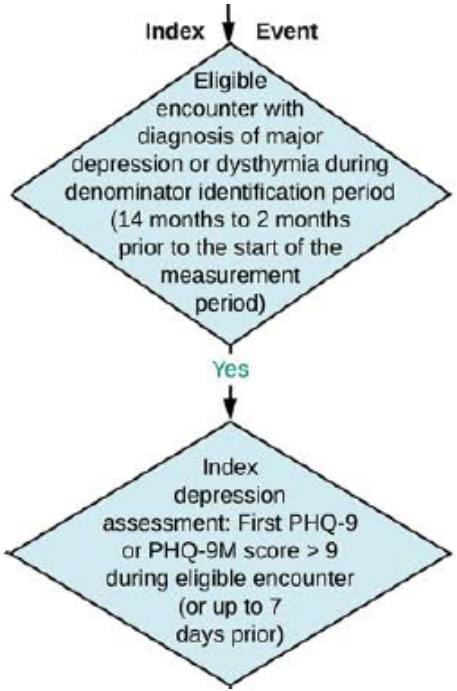
CMS159v10

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, 2020, through October 31, 2021, and at least one medical visit during the measurement period.	Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder Patients who: • Died • Received hospice or palliative care services • Were permanent nursing home residents	None	Patients who achieved remission at 12 months as demonstrated by the most recent 12-month (+/- 60 days) PHQ-9 or PHQ-9M score of **less than 5**

Depression Remission at Twelve Months

Clarifications, Tips, and Frequently Asked Questions

- For this measure, the **PHQ-9 must be used**. The depression screening measure (which is a separate screening measure) does not specify a required tool, but this measure does.
- Patients may be screened using the PHQ-9 or PHQ-9M up to 7 days prior to the office visit, including 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.



Controlling High Blood Pressure

CMS165v10

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 84 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period with a medical visit during the measurement period	• Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period • Patients with a diagnosis of pregnancy during the measurement period • Patients who were in hospice care for any part of the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 consecutive days during the measurement period • Patients aged 66 and older with 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 of the year prior • 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.

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Controlling High Blood Pressure

Clarifications, Tips, and Frequently Asked Questions

- For 2022 UDS reporting:
  - The hypertension measure has been changed to **remove the term "overlapping the measurement period."**
  - The measure denominator criteria is "Patients 18 through 84 years of age who had a diagnosis of essential hypertension **starting before and continuing into, or starting during the first six months of the measurement period."**
- 2022 UDS adds palliative care as a denominator exclusion.

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.
- Only the last blood pressure reading taken and recorded in the reporting year (Calendar Year 2022) is used to determine if the specified measure requirements are met.
- Blood pressure readings taken at any visit type at the health center can be counted toward the Controlling High Blood Pressure measure compliance. So for example, blood pressure readings done at a dental visit could count so long as the result is from the most recent visit.
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

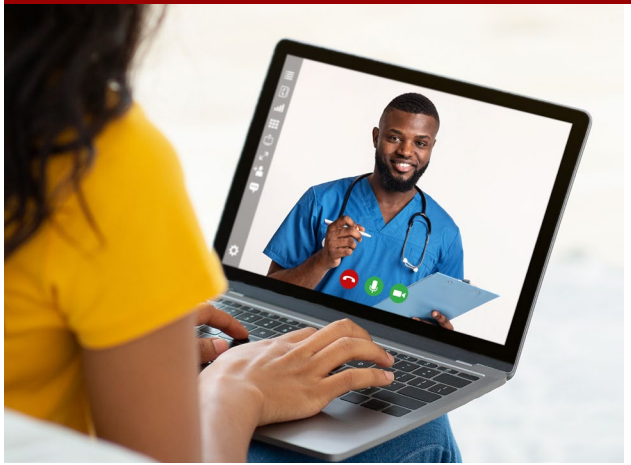
Poll #2

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?



Only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.

- The blood pressure reading can be performed by the patient electronically through a virtual visit so long as it is **observed** by a clinician or member of the care team and **documented** by them in the patient's chart.
- Do not include blood pressure taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
- Cannot be audio-only (clinician must see the reading).

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

CMS122v10

Denominator	Exclusions	Exceptions	Numerator
Patients 18 through 74 years of age with diabetes with a medical visit during the measurement period	• Patients who were in hospice care for any part of the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 consecutive days during the measurement period • Patients aged 66 and older with 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 during 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.

HRSA Health Center Program

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

Clarifications, Tips, and Frequently Asked Questions

- 2022 UDS reporting added palliative care as a denominator exclusion.
- Only include patients with an active diagnosis of Type 1 or Type 2 diabetes in the denominator of this measure.
  - Patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) are NOT included in the denominator.
- If a patient who is included in the denominator does not have an HbA1c in their chart in the year (whether they did not have a test or the result is missing), then the patient is reported as 9% or no test in the year (Column 3F).
- Lower is better for this measure.

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

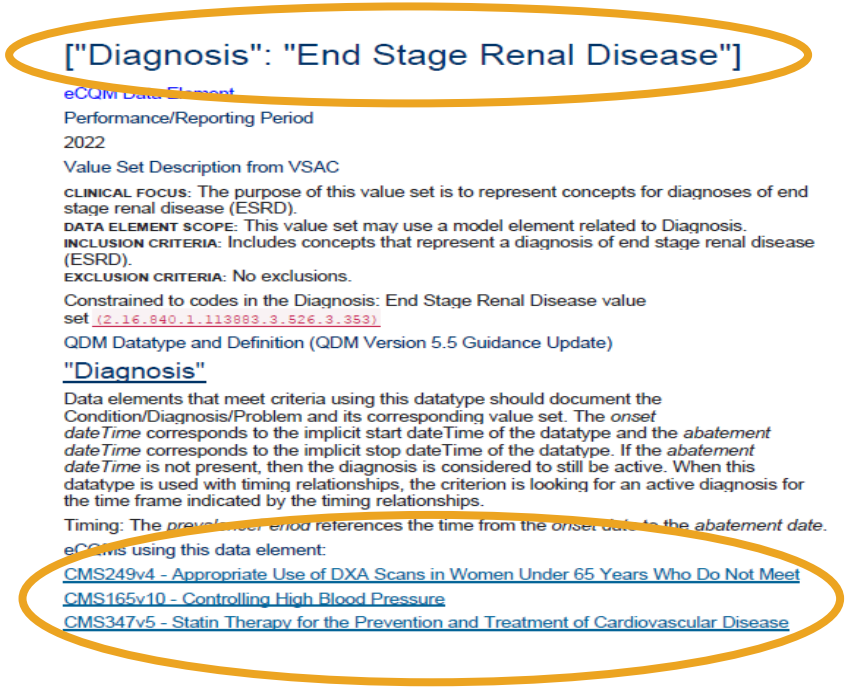
Tips for Quality Improvement and Success

Tips for Success with Chronic Disease Management Measures

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

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

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



Clinical Measure Reporting Success

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

- Thoroughly read definitions and instructions in the 2022 UDS Manual.
- Other available guidance:
  - eCQI Resource Center
  - Telehealth Impacts on Clinical Measures
  - Clinical Measures Handout
  - eCQM Flows: Workflows for each eCQM, updated annually and downloads as a ZIP file
  - Guide for Reading eCQMs 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 Clinical Quality Measure	2019	2020	2021	2021 v 2019	2021 v 2020
Ischemic Vascular Disease – Use of Aspirin	80.78%	78.80%	78.25%	Negative Trend	Negative Trend
Statin Therapy for Cardiovascular Disease	70.09%	71.92%	73.10%	Positive Trend	Positive Trend
Hypertension Control (less than 140/90 mm Hg)	64.62%	57.98%	60.15%	Negative Trend	Positive Trend
Uncontrolled Diabetes (HbA1c >9%) *Inverse Measure*	31.95%	35.60%	32.29%	Negative Trend	Positive Trend
HIV Linkage to Care	87.21%	81.41%	82.70%	Negative Trend	Positive Trend
Depression Remission at Twelve Months[1]	--	13.69%	13.84%	New CQM for 2020	Positive Trend

Source: Uniform Data System 2019-2021 – Table 6B, Table 7; 1 New CQM for 2020

HRSA Health Center Program

Resources, Questions, and Answers

NEW: UDS Training and Technical Assistance Microsite

- Central, user-friendly hub for health centers to access UDS reporting training and technical assistance (TTA)
- Organized by UDS topic areas, such as:
  - Patient characteristics
  - Staffing and utilization
  - Clinical care
  - Financials

Visit the BPHC UDS TTA page

Available Assistance

- UDS content support
  - Support line 866-837-4357
  - udshelp330@bphcdata.net
- Technical assistance materials, including local trainings, are available online:
  - UDS Training and Technical Assistance - Clinical Care Page
- Health Center Program Support for questions about the Health Center Program.
- Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) JIRA project eCQM Issue Tracker:
  - Sign up for an OITS account
  - Post questions in the eCQM Issue Tracker
- EHBs support
  - UDS Report and Preliminary Reporting Environment access (in EHBs)
  - EHBs system issues: 877-464-4772, Option 1
  - EHBs account access and roles: 877-464-4772, Option 3
- National Training and Technical Assistance Partners

Resources for Clinical Quality Measures

National Resources

- U.S. Preventive Services Task Force
- Healthy People 2030
- CDC National Center for Health Statistics State Facts
- Health Information Technology, Evaluation, and Quality Center (HITEQ)
- Healthcare Effectiveness Data and Information Set (HEDIS)

Health Center Data and Resources

- Adjusted Quartile Ranking
- National Health Center Program UDS Awardee Data

HRSA Priority Areas

- Behavioral Health and Primary Care Integration
- Ending the HIV Epidemic

eCQM Resources

- eCQI Resource Center
- Value Set Authority Center

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** Thurs. Oct. 20
  - **Successful Submission Strategies** Thurs. Nov. 3
- Past webinars are archived on HRSA's UDS TTA page.
  - **UDS Basics: Orientation to Terms and Resources**
  - **The Foundation of the UDS: Counting Visits and Patients**
  - **UDS Clinical Tables Part 1: Screening and Preventive Care Measures**
  - **UDS Clinical Tables Part 2: Maternal Care and Children's Health**

Community Health Quality Recognition (CHQR) Badges

Community Health Quality Recognition (CHQR) Badge Eligibility Criteria

- **CHQR badge eligibility criteria have been established for clinical quality measures (CQMs) that do not currently have established national benchmarks.**
  - Criteria will be used to award CHQR badges for the 2021–2023 UDS reporting periods
  - Provides health centers with clear targets to shape quality improvement strategies
- **Benchmarks, new badges, and criteria changes will take effect for the 2021 UDS reporting period, including:**
  - Incorporating Look-Alikes (LALs) into Adjusted Quartile Rankings. As a result, LALs will be eligible for Health Center Quality Leader badges.
  - Adding new CHQR badge categories: HIV, maternal and child health, and addressing social risk factors to health.
  - Awarding one COVID-19 response badge using UDS-reported data on COVID-19 testing and vaccinations.
  - Adopting updated criteria for the Health Disparities Reducer badge.

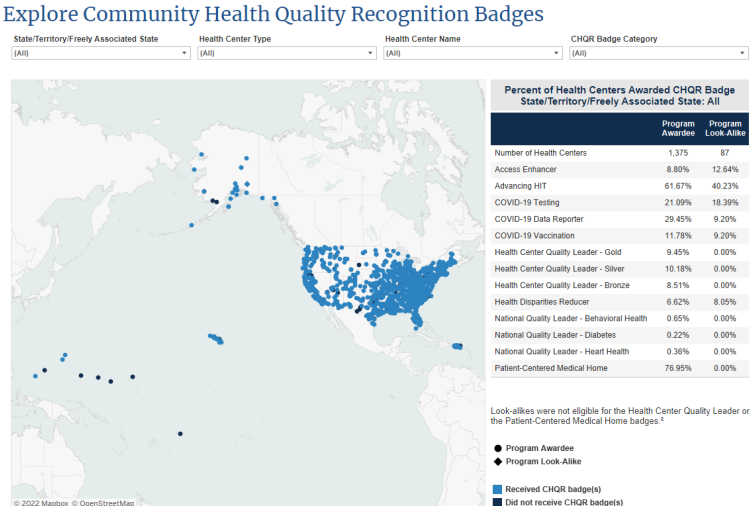
Access CHQR Overview and CHQR FAQ

HRSA Health Center Program

Access Community Health Quality Recognition Data

Community Health Quality Recognition (CHQR) Dashboard

- Dashboard available publicly on the data.hrsa.gov website.
- Provides visualization, national-level summary, state-level summaries of CHQR badges awarded.
- Identifies program awardees and look-alikes that have made notable quality improvement achievements.
- Updated annually with UDS data release.



Access CHQR Dashboard

Looking Forward to 2023 UDS Reporting

UDS Patient Level Submission (UDS+)

UDS+ is...

- Beginning with the 2023 UDS, BPHC will accept patient-level report data.
  - UDS Tables PBZC, 3A, 3B, 4, 6A, 6B, and 7

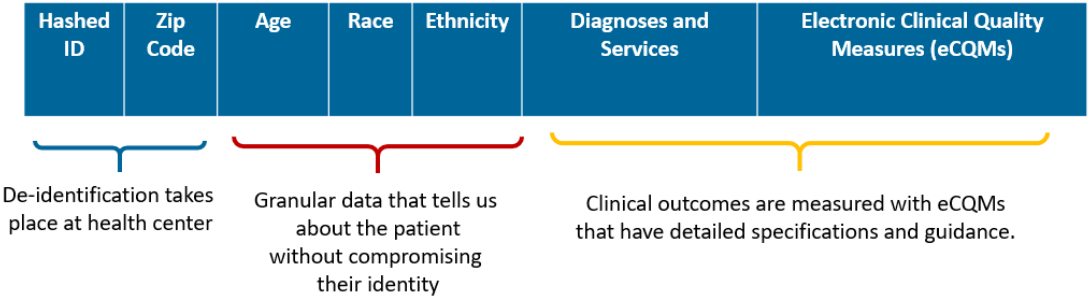
UDS+ does not...

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

BPHC plans to accept UDS+ data in two ways:

- Manual file upload system & Fast Healthcare Interoperability Resources (FHIR)

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



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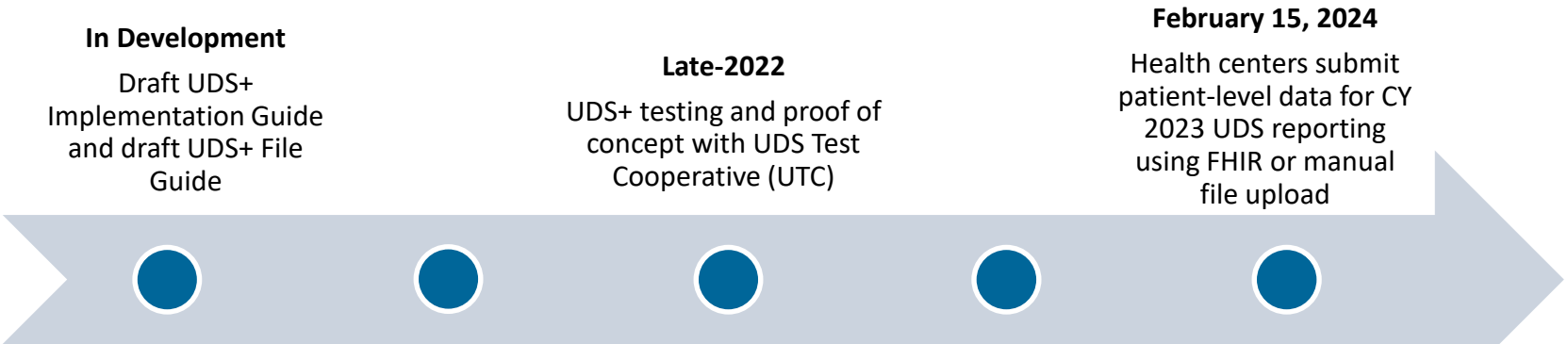
UDS+ Implementation Timeline



UDS Modernization FAQs

HRSA Health Center Program

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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www.HRSA.gov

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