Chapter 1: Measurement Set Summaries

Brief Overviews of Current Measurement Systems

Purpose

To provide a brief and high level overview of each measurement set to increase understanding of why the measurement sets are in use, how data collection and reporting is managed, and any relevant benchmarks or targets.

Overview of Content

- Background and Terms
- Review of The Measures
- Minimum Performance Levels and High Performance Levels

Suggested Uses for This Material

- Use for training new quality improvement staff
- Share with board of directors when presenting quality improvement or other performance measurement reports
- Share with health care clinicians to increase awareness and gain buy-in for improvement efforts on quality measures

This section of the toolkit includes summaries of each quality improvement measurement set. The sets reviewed include the following:

HEDIS	Healthcare Effectiveness Data Information Set
QIP	Partnership HealthPlan of California Primary Care Provider Quality Improvement Program
FSR	Facility Site Reviews
UDS	Uniform Data System

Each summary includes information on the main purpose of the summary, overview of the summary content, and suggestions for use.

Healthcare Effectiveness Data Information Set (HEDIS)

Background and Terms

HEDIS, developed by the National Committee for Quality Assurance (NCQA), is a standardized set of performance measures used to provide health care purchasers, consumers, and others with a reliable comparison among health plans. HEDIS data are often used to produce health plan "report cards," analyze quality improvement activities, and benchmark performance. NCQA classifies the broad range of HEDIS measures across five domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

Performance measures within these domains provide information about a health plan's performance in such areas as providing timely access to preventive services, management of members with chronic disease, and appropriate treatment for members with select conditions. While HEDIS data provide an opportunity to compare health plans based on some aspects of health care delivered to members, the intent of the data is not to provide an overall, comprehensive assessment of health care quality for a health plan. The California Department of Health Care Services (DHCS) uses HEDIS data as one component of its overall quality monitoring strategy. DHCS and Managed Care Plans (MCPs) use MCP-specific data, aggregate data, and comparisons to State and national benchmarks to identify opportunities for improvement, analyze performance, and assess whether previously implemented interventions were effective.

Reporting Period: January 1 – December 31 (12 months)

Measurement Specifications are revised periodically. The NCQA's HEDIS Technical Specifications are released in October of the reporting year.

Medical Record Collection Project:

Timeline: February through May

Method: Since 2013, PHC has contracted with a medical record retrieval vendor to collect medical record evidence for HEDIS. We collect over 10,000 medical records in a 13-week time period.

Process: Starting in 2016, PHC contracted with a medical record abstraction vendor to review the records collected for compliance with the measures. PHC staff conduct over-read of those records to ensure accuracy.

DUE each year on May 15 PHC must submit the results of its audit to Health Services Advisory Group (HSAG), a DHCS contracted entity. HSAG conducts a Medical Record Review Validation (MRRV) audit on measures they select. PHC is required to submit medical record evidence for all numerator positive members for the measures selected. Failures in this audit may result in the inability to report performance on the measure. Once this audit is successfully completed, final rates can be calculated, which are reported to PHC and the public in late July/August.

Regional Reporting:
When PHC expanded in 2013 to cover 8 additional counties, PHC received approval from DHCS to allow HEDIS to be reported at a regional level. Please note below the following 4 regions HEDIS is required to be reported:

Northwest: Humboldt, Del Norte

Northeast: Shasta, Trinity, Modoc, Siskiyou, Lassen

Southwest: Sonoma, Marin, Mendocino, Lake

Southeast: Solano, Yolo, Napa

This means one rate per measure/per region is publicly reported. Reporting HEDIS at a regional level is challenging because the limited sample sizes make it difficult to gauge County level performance, which is key to identifying targeted opportunities for improvement. PHC conducts county-level over-sampling, where feasible, to collect enough data to address the challenges of reporting at a regional level.

There are two types of measures for HEDIS, Administrative and Hybrid

Administrative Measures:

- Measures the entire eligible population, which is measure specific. Each measure has eligible population criteria such as age, continuous enrollment, allowable gap, event, diagnosis, etc.
- Data collected through claims and/or encounter services billed. Look back is defined by measure through 12/31 of the measurement year
- The health plan looks at the entire eligible population using claims and encounter data, and pharmacy and lab data to satisfy each measure.
- Administrative measures do not allow data to be collected from the medical record.
- Timely and accurate billing practices are so important to ensure capture of all services provided to health plan members.

Hybrid Measures:

- Measures a statistically significant *sample* of the eligible population
- Data collected from both claims and/or encounter services billed and data collected from the medical record chart
- The health plan draws a statistically significant sample of the eligible population, and where it did not receive a claim and/or encounter for services, it pursues medical record data.
- The stronger the claims data, the fewer medical records need to be collected from provider sites.
- The health plan casts a very wide net to locate the data needed to satisfy the hybrid measures. For example, PHC considers which PCP the member is assigned to, which provider they saw most often during the measurement year, and if a measure includes services that a specialist provides, which specialist the member saw during the measurement year.

It is important to note that enrollment criteria are specific to the measure for both administrative and hybrid measures. PHC determines appropriate enrollment spans per NCQA guidelines and excludes ones such as those with dual eligibility and share of cost.

What types of documentation is collected?
When collecting medical records, the health plan looks for specific information to satisfy the measure(s). Some examples of what will be collected is:

- History and Physicals
- Progress notes
- Lab reports
- OB flow charts
- Immunization and Disease Registries
- BMI/ growth charts

Review of the Measures:

HEDIS Acronyms	Hybrid HEDIS Measures
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CIS	Childhood Immunization Status – Combo 3
CDC	Comprehensive Diabetes Care
IMA-Combo1	Immunizations for Adolescents
PPC	Prenatal & Postpartum Care
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
W-34	Well-Child Visits in the 3rd,4th, 5th, & 6th Years of Life

HEDIS Acronyms	Admin HEDIS Measure
ACR	All-Cause Readmissions
AMB	Ambulatory Care:
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
CAP	Children & Adolescents' Access to Primary Care Practitioners:
LBP	Use of Imaging Studies for Low Back Pain
MMA	Medication Management for People with Asthma
MPM	Annual Monitoring for Patients on Persistent Medications:

Minimum Performance Levels and High Performance Levels

DHCS annually establishes a minimum performance level (MPL) and high performance level (HPL) for each required performance measure. To establish the MPLs and HPLs for the 2016 rates, DHCS used the HEDIS 2015 Audit Means, Percentiles, and Ratios, which reflect the previous year's benchmarks (CY 2014). The MPLs for the 2016 rates were based on the Medicaid national 25th percentiles, and the HPLs were based on the national Medicaid 90th percentiles. MCPs are contractually required to perform at or above the established MPLs. MCPs that have rates below the MPLs must submit an improvement plan to DHCS outlining the steps they will take to improve care. MCP performance in relation to the MPL and HPL for each measure becomes public record with the release of the HEDIS report. For the Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) measure, the 10th percentile (rather than the 90th percentile) is used for the HPL, and the 75th percentile (rather than the 25th percentile) is used for the MPL because for this measure, a lower rate indicates better performance.

Technical Assistance: http://www.ncqa.org/

Primary Care Provider Quality Improvement Program (QIP)

Background and Terms

The Primary Care Provider (PCP) Quality Improvement Program (QIP), designed in collaboration with PHC providers, offers sizable financial incentives and technical assistance to primary care providers. Primary Care Providers include: Pediatric Medicine, Family Medicine, and Internal Medicine. To participate in the QIP, you must be a contracted provider for at least six months during the measurement year.

QIP program development is managed using a major and minor change timeline. This means major changes are made to the measurement set every other year, with only minor specification changes made in alternate years. Measurement development for the major change year typically starts six months prior to the start of the QIP year. Important stakeholders, both internal and external, come together to select the most meaningful measures. Two workgroups Technical Workgroup (internal) and Advisory Workgroup (external) collaborate to outline the details for the upcoming year. Along with these two groups a provider comment period is held which is typically two weeks long and used to gain additional feedback from our external stakeholders. Recommendations from all of these avenues are then presented to the Physician Advisory Committee (PAC), which is the final approval body for the QIP measurement set.

Reporting Period: July 1 – June 30 (12 Months) – Transitioning to a calendar year (Jan 1-Dec 31) in 2018!

Key Terms:

PMPM: Per member per month.

Member Months: Final PMPM payments will be based on all capitated member months accrued throughout the measurement year – not just for those continuously enrolled. Member months is defined as the total number of capitated Medi-Cal patients assigned to a site each month (i.e. if a provider has 100 Medi-Cal Partnership patients assigned each month for all 12 months of the measurement year, the provider's total member months will be 1,200).

Denominator: The eligible population.

Numerator: The eligible population who are compliant with measure specifications.

Measurement Set

The QIP has two main categories with subcategories/domains within its measurement set, as illustrated below. For the Fixed Pool measures, the total sum of financial incentives distributed for any given measurement year– known as the "payment pool" – is based on all capitated member months accrued throughout the measurement year.

Member months is defined as the total number of capitated Medi-Cal patients assigned to a site each month (i.e. if a provider has 100 Medi-Cal Partnership patients assigned each month for all 12 months of the measurement year, the provider's total member months will be 1200). Each year, PHC budgets a base per member per month (PMPM) amount, which determines the QIP payment pool. All of the payment pool is distributed among all participating QIP sites at the end of the measurement year. Because the payment pool is fixed, the incentive payment a site is able to earn is based on the site's performance in the measures, its number of member months, and the relative performance of other sites.

For the Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the QIP fixed payment pool. A site receives payment according to the measure specifications if the requirements for one or more Unit of Service measures are met.

Fixed Pool PMPM

- Clinical Measures
- Non-Clinical Measures
    - Appropriate Use of Resources
    - Access & Operations
    - Patient Experience

Unit of Service Measures

- Advanced Care Planning
- PCMH Certification
- Peer-Led Self Mgmt Supports Groups
- Utilization of CAIR
- Access/Extended Office Hours
- Buprenorphine Qualified Provider

Eligible Patient Population: The eligible population used to calculate the final rates is based on capitated Medi-Cal members. For clinical measures, the members also have to be continuously enrolled with their PHC assigned provider for 11 out of the 12 months of the measurement year. A member's "Assigned Provider" is defined as the reporting entity designated for the QIP. Medi-Medi members (dually eligible members) are excluded from all measures, except the Unit of Service measure Advance Care Planning.

Sample Size: All of the eligible population for fixed pool measures. Unit of service measures are optional, therefore the sample size can vary depending on the measure, and provider engagement and participation.

Data Tracking: Clinical measures are tracked by eReports, an online system built for the QIP Clinical Care measures, and is the mechanism by which providers can monitor their performance and upload supplemental data to PHC to enhance their performance. You can access eReports at: https://qip.partnershiphp.org/.

For more information on how to create an eReports account and navigate the site, please refer to the eReports User Manual on the PHC website through this link. Non-Clinical measures are tracked by Providers and PHC staff and specific instructions and timelines can be found on the PHC website.

Points Calculations: Points for clinical measures are determined by thresholds obtained from the NCQA national averages for Medicaid Health Plans, reported in the year prior to the QIP measurement year. The thresholds used include the 50th, 75th, and 90th (25th used in special exceptions) percentiles calculated from the previous year's HEDIS data. When a measure is new to the clinical domain, there is only one threshold set. All measures other than Colorectal Cancer, which is a special exception under the 25th percentile, are measured against the 50th percentile in their first year.

Providers can earn full points available per measure by meeting the threshold assigned. After a measure's first year in the clinical domain, it will be held against the 75th and 90th percentiles. If the 75th percentile is reached, half of the measures points available are awarded. If the 90th percentile is reached than full points are earned. Points can also be earned by a provider's relative improvement from the year before. Relative improvement is calculated by the following formula:

$$\frac{\text{(Current year performance)} - \text{(Previous year performance)}}{\text{(100} - \text{Previous year performance)}}$$

Points for relative improvement will be assigned based off of the following:

- ≥ 15% (Full Points)
- 10% - 14% (75% Points)
- 5% - 9% (50% Points)
- 1% - 4% (25% Points)

2016-17 Fixed Pool Breakdown of Points:

Clinical Measures:

Clinical Measures	Family	Internal	Pediatric	Tracked by
Adolescent Immunizations (13 years)			10	eReports
Asthma Care (5-18 years)			5	eReports
Cervical Cancer Screening	5	5		eReports
Childhood Immunization – DTaP (2 yrs)	5		10	eReports
Childhood Immunization – MMR (2 yrs)			10	eReports
Colorectal Cancer Screening (51-75 years)	5	5		eReports
Controlling High Blood Pressure (18-85 yr)	5	10		eReports
Diabetes Management (18-75 years) – HbA1c good control, Retinal eye exam, Nephropathy *5pts each	15	15		eReports
Monitoring for Patients on Persistent Medications	5	10		eReports
Nutrition Counseling (3-17 years)			10	eReports
Physical Activity Counseling (3-17 years)			10	eReports
Well Child Visits (3-6 years)	5		10	eReports
Total Points:	45	45	65	

Non-Clinical Measures:

Appropriate Use of Resources	Family	Internal	Pediatric	Tracked by
Admissions/1000 or Follow up Post	7.5	7.5		PHC
Readmission Rate or Follow-up Post Discharge	7.5	7.5		PHC & Providers
Pharmacy Utilization	10	10	10	PHC
Opioid Safety	5	5		PHC
Total Points:	30	30	10	
Access and Operations	**Family**	**Internal**	**Pediatric**	**Tracked by**
Avoidable ED Visits	5	5	5	PHC
Practice Open to PHC Members	5	5	5	PHC
PCP Office Visits	5	5	5	PHC
Total Points:	15	15	15	
Patient Experience	**Family**	**Internal**	**Pediatric**	**Tracked by**
CAHPS Survey *or* Survey/Training Option	10	10	10	NA/Provider
Total Points:	10	10	10	

Unit of Service (Optional): Providers receive payment for each unit of service they provide.

2016-17 Unit of Service breakdown of measures:

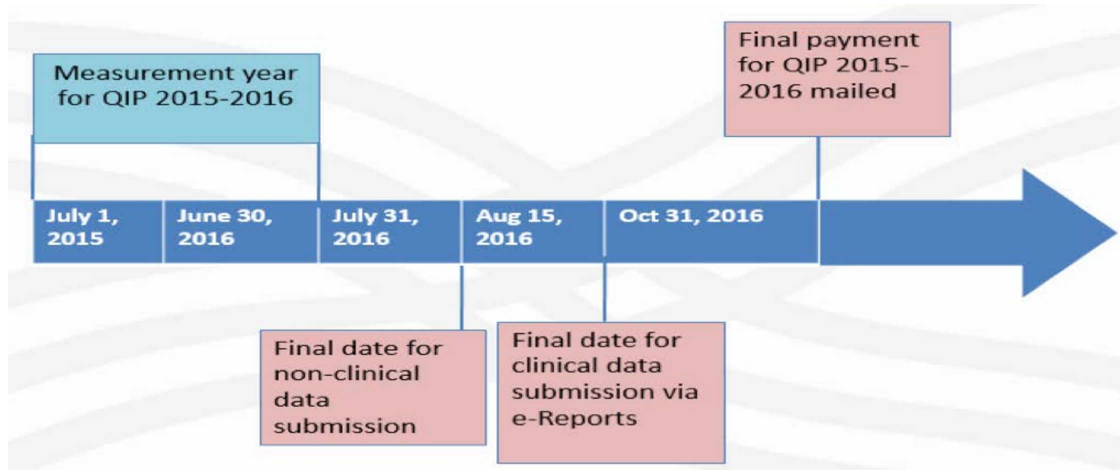
Measures	Incentive Amount	Tracked By	System for Monitoring	System for Submission
Advance Care Planning	$100 Per Attestation and $100 per submitted Advanced Directive or POLST	Providers	Summary & Quarterly Checks	Submission Template
PCMH Certification	Level 1: $2,000 Level 2: $3,000 Level 3: $3,500	Providers	Year-end Reports	Submission Template
Peer-Led Self Mgmt. Support Groups	$1,000 Per Group per Year	Providers	Year-end Reports	Submission Template
Utilization of CAIR	Based on Relative Improvement	PHC & Providers	Year-end Reports	Submission Template
Access/Extended Office Hours	Equivalent Payment of 10% Cap	PHC	Summary & Quarterly Checks	Provider Relations Dept.
Buprenorphine Qualified Provider	$500 Per Credential Prescriber (Max. 5)	PHC	Year-end Reports	Provider Relations Dept.
SBIRT	$5 Per Screening	PHC	Year-end Reports	Claims
Health Information Exchange	1x $2500 incentive for signing on with a local or regional HIE	PHC	Year-end Reports	Submission Template

Fixed Pool Payment Methodology: Each site has the opportunity to earn up to 100 points distributed across the fixed pool measure sets, which includes clinical and non-clinical measures. The points are calculated after the end of the measurement year, along with each sites total member months. Partnership HealthPlan has a budgeted amount of money set aside to distribute to sites based off their own score in points, the points scored by other sites, and the amount of member months accumulated during the measurement year. The budget may fluctuate due to unforeseen state budget

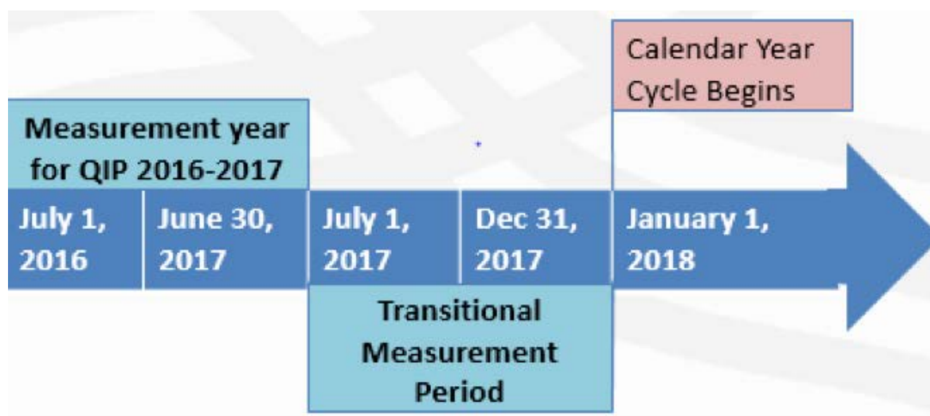
impacts. Final payment for the 2015-16 PCP QIP measurement year is expected by the end of October 2016.

Program Timeline:

The figure below displays the current QIP program cycle.



Please note that there will be a transition of the QIP cycle to a calendar year timeframe in 2018. The figure below displays the revised program timeline.



Resources:

QIP Website:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

QIP Inbox: qip@partnershiphp.org

eReports: https://qip.partnershiphp.org/

eReports User Manual:
https://qip.partnershiphp.org/QIPData/Help/eReports%20User%20Manual.pdf

Facility Site Review

Background and Terms

Partnership HealthPlan of California is mandated by the California Department of Health Care Services (DHCS) to review contracted providers within our Network to ensure:

Contracted primary care provider sites are reviewed as a condition of participation in our provider network. Other contracted provider sites, like OB/GYN and Substance Abuse providers will also have an Initial Site Review conducted. These site reviews are conducted during the initial provider credentialing process. Additional site reviews will be conducted as part of the ongoing provider re-credentialing process at least every three years to assure that each provider continues to meet the standards set forth by local, state, and federal regulations. A registered nurse, certified by the California Department of Health Care Services (DHCS) using the DHCS approved review tools, conducts the review. The review tools and guidelines as well as a preparation checklist are provided to the site at the time the review is scheduled. The **Site Review (SR)** consists of the **Facility Site Review and Medical Record Review.** In addition, a **Physical Accessibility Review Survey (PARS)** is also conducted at the time of the SR.

What is a Facility Site Review? The Site Review is an assessment of the facility's physical site (includes building, accessibility, equipment, and policies/procedures), and the DHCS approved site review tool is used to determine compliance in meeting the standards in the following areas:

- Accessibility/Safety
- Clinical Services
- Personnel
- Preventative Services
- Office Management
- Infection Control

Benchmarks:

Exempted Pass:	Conditional Pass:	Not Pass:
90% or above without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control	80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical Services or Infection Control	Below 80%

A corrective action plan (CAP) is required for a Conditional Pass.
A corrective action plan (CAP) for all deficiencies identified for critical element criteria, which are bolded and underlined in the site review tool, should be submitted to the Health Plan within 10 business days of the review. A corrective action plan for deficiencies on non-critical element criteria is due to the Health Plan within 45 calendar days from the date of the review.

The nine (9) Critical Element Deficiencies are:

Critical Element	Deficiencies
Access/Safety	Exit doors and aisles are unobstructed and egress (escape) accessible. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.
Personnel	Only qualified/trained personnel retrieve, prepare or administer medications.
Office Management	Physician review and follow-up of referral/consultation reports and diagnostic test results.
Pharmaceutical Services	Only lawfully authorized persons dispense drugs to patients.
Infection Control	Personal protective equipment is readily available for staff use. Needle-stick safety precautions are practiced on site. Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport, or shipping. Spore testing of autoclave/steam sterilizer with documented results (at least monthly)

Typically, a facility site review takes 3-4 hours to complete. Your site can operate as usual during the review. An office representative that is highly knowledgeable in the site's daily operations and policy/procedures is needed during the review. This person will be called upon to answer questions from the reviewer, demonstrate knowledge of how to use certain types of medical equipment and provide evidence of policies and procedures in place at the facility. The reviewer may also ask additional personnel (i.e. MA/LVN) questions regarding their area of expertise.

What is a Medical Record Review? A Medical Record Review is conducted at primary care provider sites, 3-6 months after an Initial Site Review has been completed, and at least every three years thereafter. The DHCS approved tool and guidelines used

by the DHCS-certified nurse reviewer are sent to the site at the time the review is scheduled. A list of patients whose records will be reviewed is provided 1-2 weeks before the review. The records for this type of review are not collected, they are reviewed onsite. Only the score of the review is submitted to DHCS.

The specific areas being reviewed are:

Format	Documentation	Continuity of care
Pediatric Preventive Care (comparable to HEDIS, QIP, UDS)	Adult Preventive Care (comparable to HEDIS, QIP, UDS)	OB/CPSP Preventive Care (comparable to HEDIS,QIP, UDS)

Benchmarks:

Exempted Pass 90% or above: (Total score is ≥ 90% and all section scores are 80% or above)	**Conditional Pass** 80-89%: (Total MRR is 80-89% OR any section(s) score is < 80%)	**Not Pass:** Below 80%

Note: Any section score of < 80% requires a Corrective Action Plan (CAP) for the entire MRR, regardless of the Total MRR score. There are no critical elements in this portion of the review. An MRR CAP must be submitted within 45 calendar days.

Typically, a medical record review can take up to 4 hours for 10 records. The number of physicians working at the site determines the number of records to be reviewed which ranges from 10-30 records. Your site can operate as usual during the review. A staff person may be needed to help acquaint the reviewer with the electronic health record layout (only a few minutes) if applicable.

The records are assessed for compliance in the areas listed above: Format, Documentation, etc. All of the areas are assessed for each record as applicable based on the age of the member.

What is a Physical Accessibility Review Survey (PARS)? This review is unique among the programs included in this overall tool. While an important part of the site review process, there are no corresponding criteria among the other programs covered in this tool.

Physical Accessibility Review Survey (PARS) are conducted for all contracted Primary Care Provider sites, as well as High Volume Ancillary and Specialty Provider (HVASP) sites. The PARS tool was developed by a collaborative coalition made up of staff from

the DHCS and Medi-Cal Managed Care Health Plans to address the accessibility of providers' offices, clinics, and other health care providers that provide medical care to seniors and people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventative medical care than people without disabilities.

Our provider directories are updated with the areas met by each site. The reviewer will evaluate accessibility related to the following indicators:

• **P** = Parking	• **EB** = Exterior Building	• **R** = Restroom
• **IB** = Interior Building	• **E** = Exam Room	• **T** = Exam Table/Scale
• ME = Medical Equipment (PCP only):	• Height adjustable exam table	• Wheelchair Accessible Weight scale

Level of Access

- Basic Access means the facility demonstrates access in regards to all of the mentioned features.
- Limited access means one or more of the features are missing or incomplete.

* The assessment is for informational purposes only.

Reporting Period: Every three years

DUE each year on January 31st and July 31st PHC must submit the results of our Facility Site Reviews to DHCS

Uniform Data System (UDS)

Background and Terms

The Uniform Data System (UDS) is administered by the U.S. Department of Health & Human Services, Health Resources and Services Administration (HRSA) – Bureau of Primary Health Care as part of the Health Center Program – Section 330 of the Public Health Service Act (42 U.S.C. §254b).

Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. Entities included as a health center are Federally Qualified Health Centers (FQHC's), health center look-alikes, and Bureau of Primary Health Care clinics.

Reporting Period: January 1 – December 31 (12 months)

The UDS Report is revised yearly and a Program Assistance Letter or PAL is released around February 1st and explains changes for the upcoming year. The UDS Manual is generally released between September – December of the reporting year.

DUE each year on February 15 (The report is examined by a HRSA reviewer and they submit possible problems with your report based on trend data or inconsistencies. The health center must respond to the reviewer's summary and the UDS report must be finalized by March 31)

Definitions:
Visit: To be counted as having met the visit criteria, the interaction must be:

- Documented,
- Face-to-face contact between a patient and a
- Licensed or otherwise credentialed provider, who
- Exercises independent, professional judgment in the provision of services to the patient.

Patient: A patient must have received one or more qualifying/reportable visits during the reporting period to be counted in the UDS report. Each patient is counted once no matter how many visits he/she may have had.

Sample Size:

- Scientifically drawn *sample of 70* patients selected from all patients who fit the criteria, *-or-*
- A number equal to or greater than 80% of all patients who fit the criteria

A review of a sample of charts must be used in lieu of full universe reporting from an EHR if:

- The EHR does *not include* a minimum of 80% of health center patients who meets the criteria described below for inclusion in the specific measure's universe.
- The EHR does *not exclude* every single health center patient who meets one or more exclusion criteria from the universe (e.g. EHR report cannot distinguish between medical and dental-only patients for childhood immunization measure or for a chart review, a dental-only patient can be excluded from the sample for the childhood immunization measure).
- The look-back period data necessary for many of the UDS clinical quality measures has not been in place in the EHR long enough to be able to find the data required in prior year's activities or this documented data was not collected from the patient as part of the visit.

UDS Report Tables: Note: HRSA is moving towards alignment with CMS and HEDIS measure definitions

- Patients By ZIP Code
- Table 3A: Patients By Age and Gender – Universal
- Table 3B: Patients By Hispanic or Latino Ethnicity / Race / Linguistic Barriers to Care – Universal
- Table 4: Select Patient Characteristics – Universal (% Poverty Level, Insurance Status, Managed Care utilization)
- Table 5: Staffing and Utilization
- Table 5A: Tenure for Health Center Staff
- Table 6A: Select Diagnoses and Services Rendered – Universal
- **Table 6B: Quality of Care Measures**
  - Section A: Age Categories for Prenatal Patients
  - Section B: Trimester of Entry into Prenatal Care
  - Section C: Childhood Immunization Status (CMS117)
  - Section D: Cervical Cancer Screening (CMS124)
  - Section E: Weight assessment and counseling for children and adolescents (CMS155)
  - Section F: Adult weight screening and follow-up (CMS69)
  - Section G: Tobacco Use Screening and Cessation Intervention (CMS138)
  - Section H: Use of Appropriate Medications for Asthma (CMS126)
  - Section I: Coronary Artery Disease (CAD): Lipid Therapy
  - Section J: Ischemic vascular disease: Use of Aspirin or Another Antithrombotic (CMS164)
  - Section K: Colorectal Cancer Screening (CMS130)
  - Section L: HIV Linkage to Care – F/U within 90 days of diagnoses
  - Section M: Depression Screening and Follow-up (CMS2)
  - Section N: Dental Sealants for children (CMS277)
- **Table 7: Health Outcomes and Disparities – By Race and Hispanic/Latino Ethnicity**
  - Section A: Deliveries and Births By Weight/Ounces
  - Section B: Controlling High Blood Pressure – Hypertension (<140/90) (CMS165)
  - Section C: Diabetes: Hemoglobin A1c Poor Control (<8%, >9%/No Test) (CMS122)
- Table 8A: Financial Costs
- Table 9D: Patient Related Revenues
- Table 9E: Other Revenues
- Appendix: Health Center Electronic Health Record (EHR) Capabilities and Quality Recognition

Technical Assistance: http://www.bphc.hrsa.gov/datareporting/reporting/index.html