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 the most widely used healthcare quality measurement tool in the United States. HEDIS is designed to provide healthcare purchasers, consumers and others with a standardized way to compare health plans. HEDIS data are often used to produce health plan "report cards" and analyze the effectiveness of quality improvement activities. The NCQA library houses 95 measures across 7 domains of care. The 7 Domains of Care are:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

The Department of Healthcare Services (DHCS) selects a subset of measures across these domains for Managed Care Plans (MCPs) to report annually. 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 provides 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. DHCS uses HEDIS data as one component of its overall quality monitoring strategy. DHCS and 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.

Given PHC's goal to achieve NCQA accreditation, the importance of HEDIS becomes more prominent as HEDIS scores and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results make up 50% of the accreditation assessment. Becoming accredited will result in reporting on an expanded set of HEDIS measures.

HEDIS Annual Project

- NCQA Measure Technical Specifications Released: October of the reporting year
- Measurement year: January 1 – December 31
- Annual Project Timeline: February-May

Overview: Each year PHC has less than twelve weeks to execute the HEDIS annual project. This includes capturing data from claims and encounters, supplemental data sources, and through the collection of over 15,000 medical records in an effort to capture the care provided to our members over the measurement year.
PHC is required to contract with an external auditing firm, licensed by NCQA to ensure the HEDIS audit is executed according to NCQA guidelines. PHC is also required to use NCQA Certified Software to execute the HEDIS project and calculate rates.

Medical Record Retrieval Process: PHC contracts with both a medical record retrieval vendor and an abstraction vendor to ensure the project is executed within the mandated timeframe. PHC staff partner with each vendor to ensure successful record retrieval and abstraction accuracy. PHC piloted remote access for record retrieval in 2016, and has since expanded EMR Remote Access as the preferred method for medical record retrieval, yielding the best outcomes for both providers and project outcomes. To accommodate this change, PHC contracted with two retrieval vendors in 2018, one specific to remote access. Expanded efforts are planned to shift more record retrieval to EMR Remote access for qualified providers.

DUE each year: PHC is required to halt the annual project on May 9th to submit the results of its audit to Health Services Advisory Group (HSAG), PHC's licensed auditing firm. HSAG conducts a Medical Record Review Validation (MRRV) for Hybrid Measures, by selecting 4 measures for validation. PHC is required to submit medical record evidence for a specified sample of 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 reporting regions:

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. Because some counties are more populous within a region, PHC conducts a county level oversample where the denominator for a county is less than 50, to best gauge county level performance for improvement efforts.

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's certified software draws a statistically significant sample of the eligible population, and where a sample member was not made compliant by claims and/or encounter data, PHC is able to use medical record data to show compliance. Some measures, such as Controlling Blood Pressure, are solely dependent on medical record evidence. Several other measures utilize a combination of both to demonstrate measure compliance.
- 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's certified software determines appropriate enrollment spans per NCQA guidelines, and excludes those with dual eligibility and share of cost.

Types of Documentation Collected:
When collecting medical records, the health plan looks for specific information to satisfy the measure(s). Some examples of what may be collected is:

- History and Physicals
- Progress notes
- Lab reports
- OB flow charts
- Immunization and Disease Registries
- Handouts/counseling documentation

Review of the Measures:

HEDIS Acronyms	Hybrid HEDIS Measures
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CIS-3	Childhood Immunization Status – Combo 3
CDC	Comprehensive Diabetes Care
IMA-2	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 Measures
ACR	All-Cause Readmissions
AMB	Ambulatory Care
AMR	Asthma Medication Ratio
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
MPM	Annual Monitoring for Patients on Persistent Medications:
BCS	Breast Cancer Screening
LBP	Use of Imaging for Lower Back Pain

Minimum Performance Levels and High Performance Levels:
DHCS annually establishes a minimum performance level (MPL) and high performance level (HPL) for each required measure. The previous year's audit means, percentiles, and ratios are used to establish the MPLs and HPLs for the current reporting year. The MPLs for the current reporting year rates are based on the Medicaid national 25th percentiles, and the HPLs were based on the national Medicaid 90th percentiles. Therefore, the HEDIS benchmarks may shift year to year based on the average performance of health plans on a national level. MCPs are contractually required to perform at or above the established MPLs. MCPs that have rates below the MPLs are frequently assigned mandated improvement projects by DHCS. With repeated low performance, MCPs risk issuance of a formal DHCS Corrective Action Plan (CAP) as well as financial penalties. MCP performance in relation to the MPL and HPL for each measure becomes public record with the release of each annual HEDIS report.

Resources:

http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx

http://www.ncqa.org/hedis-quality-measurement

http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx

Primary Care Provider Quality Improvement Program (PCP QIP)

Background and Terms

The Primary Care Provider 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.

The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

Reporting Period: Calendar Year, January 1 – December 31 (12 Months)

Core Measurement Set

The Primary Care Provider QIP is comprised of two measurement sets each with its own payment methodology, see below.

The Primary Care Provider QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. There is a fixed per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

The Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the Core Measurement Set. 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
- Extended Office Hours
- Patient-Centered Medical Home (PCMH) Recognition
- Screening, Brief Intervention, Referral, and Treatment (SBIRT)
- Health Information Exchange Participation
- Initial Health Assessment Improvement Plan
- Timely Data Submission via eReports

Provider eligibility criteria: All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated PHC Medi-Cal only members and are contracted with PHC for at least six months during the measurement year are automatically enrolled in the QIP.

If the provider site is contracted for at least nine out of 12 months during the measurement year, it reports on all applicable measures. If a provider site is contracted for more than six but less than 11 months during the measurement year, it only reports on measures that rely on administrative data; Clinical and Patient Experience measures in the Core Measurement Set do not apply.

Sample Size: All of the eligible population for the Core Measurement Set. 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 developed and maintained internally by PHC's Web Applications IT team.

Functions offered to you in eReports are:

- The ability to track your clinical performance in real time

- The ability to download patient reports for each of the clinical measures
- The ability to upload supplemental data for your patients-which is an important feature of eReports.

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 PHC's QIP Team 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 percentiles calculated from the previous year's HEDIS data. All new clinical measures are measured against the 50th percentile in their first year, with exception of colorectal cancer screening where a plan-wide target is used.

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: In order to be eligible to earn relative improvement points on a given clinical measure:

1) Sites must first meet the 25th percentile performance target, also known as the minimum performance level or MPL.
2) A minimum of 15% relative improvement.

Below is calculated by the following formula:

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

Total available relative improvement points: partial points

Payment Methodology: Based on individual sites' performance on Core Measurement set. A single per member per month (PMPM) dollar amount will be established and approved by the PHC Board of Commissioners. Each site's maximum

potential earnings will be the PMPM amount multiplied by the number of member months (MM) accumulated over the course of the year.

Here is the payment formula:

$$\textbf{QIP Score } \% * \textbf{ Annual MMs } * \textbf{ PMPM} = \textbf{Incentive}$$

Key Terms of the PCP QIP:

Eligible Population: Assigned and/or Capitated Medi-Cal members, excludes Medi-Medi or members with other insurance primary, and Special Members.

Continuous Enrollment: Members assigned for nine out of the 12 months between January 1, 2018 and December 31, 2018. December is the anchor month. Applies to Clinical measures only.

Member Months (MM): The sum of monthly enrollment counts over the course of the 12-month measurement period.

- Example: If a site has 1,000 members each month, for the full measurement year the site has accumulated 12,000 member months

Per member per month (PMPM): amount budgeted for the incentive payment

- Note: The per member per month (PMPM) amount may change annually based on the plan's financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

Points Earned: The total number of points earned out of the total available points across the Core Measurement Set. Total available points are 100.

Denominator: The total number of persons during a defined time period who are eligible for the numerator event.

Numerator: The number of persons in the denominator who received the appropriate preventive or diagnostic screening or test.

2018 Core Measurement Set Breakdown of Points:

Clinical Measures:

Clinical Measures	Family	Internal	Pediatric	Tracked by
Monitoring Patients on Persistent Medications (MPM)	10	10	n/a	eReports
Cervical Cancer Screening (CCS)	10	10	n/a	eReports
Colorectal Cancer Screening, 51-75 years (COL)	5	5	n/a	eReports
Diabetes - Retinal Eye Exam (CDC – Eye)	5	5	n/a	eReports
Diabetes – HbA1C Control (CDC – A1c)	5	10	n/a	eReports
Diabetes – Nephropathy (CDC – Neph)	5	10	n/a	eReports
Breast Cancer Screening (BCS)	5	5	n/a	eReports
Childhood Immunization Status, Combo 3 (CIS-3)	5	n/a	15	eReports
Well Child Visits, 3-6 years (W34)	5	n/a	15	eReports
Immunizations for Adolescents (IMA)	5	n/a	15	eReports
Asthma Medication Ratio (AMR)	n/a	n/a	15	eReports
Nutrition Counseling, 3-17 years	n/a	n/a	10	eReports
Physical Activity Counseling, 3-17 years	n/a	n/a	10	eReports
Total Points:	65	65	80	

Non-Clinical Measures:

Appropriate Use of Resources	Family	Internal	Pediatric	Tracked by
Admissions/1000	7.5	7.5	n/a	PHC
Readmission Rate	7.5	7.5	n/a	PHC
Total Points:	15	15	0	

Access and Operations	Family	Internal	Pediatric	Tracked by
Primary Care Utilization	10	10	10	PHC
Total Points:	10	10	10	

Patient Experience	Family	Internal	Pediatric	Tracked by
CAHPS Survey *or* Survey Option	10	10	10	NA/Provider
Total Points:	10	10	10	

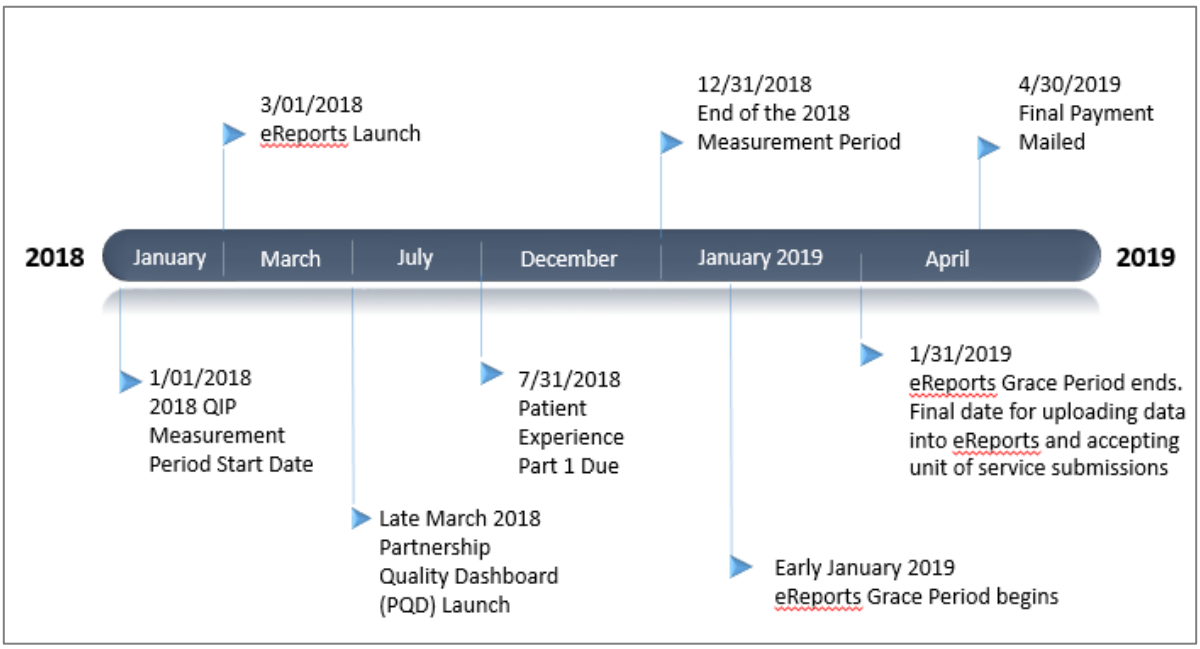
Unit of Service (Optional): Providers receive payment for each unit of service they provide.

2018 Unit of Service breakdown of measures:

Measures	Incentive Amount	Tracked By	System for Monitoring	System for Submission
Advance Care Planning	$5,000 for 50-99 Attestations $10,000 for 100+ Attestations And $5,000 for 50-99 Advance Directive or POLST $10,000 for 100+ Advance Directive or POLST	PHC QIP Team	Summary & Quarterly Checks	Submission Template
PCMH Certification	$1,000 yearly for maintaining certification	PHC QIP Team	Year-end Reports	Submission Template
Peer-Led Self Mgmt. Support Groups	$1,000 Per Group per Year Maximum of five groups per site	PHC QIP Team	Year-end Reports	Submission Template
Timely Data Submission via eReports	1% of site's potential earning pool or $1000 whichever is higher	PHC QIP Team	Year-end Reports	eReports
Access/Extended Office Hours	Equivalent Payment of 10% Capitation Must meet: 1) Earned at least 35% in previous measurement year 2) Open for extended office hours <8 hours beyond business hours	PHC QIP Team	Year-end Reports	Provider Relations Dept.
Initial Health Assessment	$2,000 for submitting all required parts of improvement plan	PHC QIP Team	Year-end Reports	Submission Template
SBIRT	$5 Per Screening	PHC QIP Team	Year-end Reports	Claims
Health Information Exchange	1x $2500 incentive for signing on with a local or regional HIE	PHC QIP Team	Year-end Reports	Submission Template

Program Timeline:

The figure below displays the current PCP QIP program cycle.



Resources:

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

QIP Inbox: qip@partnershiphp.org

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

Facility Site Review

Background and Terms

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

Contracted primary care provider sites are reviewed as a condition of participation in our provider network. Other contracted provider sites, like OB/GYN 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 Facility 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	1. Exit doors and aisles are unobstructed and egress (escape) accessible. 2. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.
Personnel	3. Only qualified/trained personnel retrieve, prepare or administer medications.
Office Management	4. Physician review and follow-up of referral/consultation reports and diagnostic test results.
Pharmaceutical Services	5. Only lawfully authorized persons dispense drugs to patients.
Infection Control	6. Personal protective equipment is readily available for staff use. 7. Needle-stick safety precautions are practiced on site. 8. Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof*, *labeled* containers for collection, handling, processing, storage, transport, or shipping. 9. 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	**Conditional Pass**	**Not Pass:**
90% or above: (Total score is ≥ 90% and all section scores are 80% or above)	80-89%: (Total MRR is 80-89% OR any section(s) score is < 80%)	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.

The UDS is a standard data set that is reported annually and provides consistent information about health centers. It is a core set of information, including patient demographics, services provided, clinical processes and results, patients' use of services, costs, and revenues that document how health centers perform. HRSA routinely reports these data and related analyses, making them available to health centers in HRSA's Electronic Handbook (EHB) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website at http://bphc.hrsa.gov/datareporting/index.html.

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 random *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.
- The required data were 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 by Sex Assigned at Birth
- Table 3B: Demographic Characteristics – Universal (Ethnicity / Race / Linguistic Barriers to Care, Sexual Orientation, Gender Identity)
- Table 4: Select Patient Characteristics – Universal (% Poverty Level, Insurance Status, Managed Care utilization, Special Populations)
- 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**

Measure	2017	2018 (Proposed)
➢ Section A: Age Categories for Prenatal Patients	Manual	HRSA PAL
➢ Section B: Trimester of Entry into Prenatal Care	Manual	HRSA PAL
➢ Section C: Childhood Immunization Status	CMS117v5	CMS117v6
➢ Section D: Cervical Cancer Screening	CMS124v5	CMS124v6
➢ Section E: Weight assessment and counseling for children and adolescents	CMS155v5	CMS155v6
➢ Section F: Adult weight screening and follow-up	CMS69v5	CMS69v6
➢ Section G: Tobacco Use Screening and Cessation Intervention	CMS138v5	CMS138v6
➢ Section H: Use of Appropriate Medications for Asthma	CMS126v5	CMS126v5
➢ Section I: Coronary Artery Disease (CAD): Lipid Therapy	Manual	HRSA PAL
➢ Section J: Ischemic vascular disease: Use of Aspirin or Another Antithrombotic	CMS164v5	CMS164v6
➢ Section K: Colorectal Cancer Screening	CMS130v5	CMS130v6
➢ Section L: HIV Linkage to Care – F/U within 90 days of diagnoses	Manual	HRSA PAL
➢ Section M: Depression Screening and Follow-up	CMS2v6	CMS2v7
➢ Section N: Dental Sealants for children	CMS277	CMS277

- **Table 7: Health Outcomes and Disparities – By Race and Hispanic/Latino Ethnicity**

➢ Section A: Deliveries and Births By Weight/Ounces	No eCQM	HRSA PAL
➢ Section B: Controlling High Blood Pressure – Hypertension (<140/90)	CMS165v5	CMS165v6
➢ Section C: Diabetes: Hemoglobin A1c Poor Control (<8%, >9%/No Test)	CMS122v5	CMS122v6

- Table 8A: Financial Costs
- Table 9D: Patient Related Revenues
- Table 9E: Other Revenues
- Appendix: HIT/EHR, Meaningful Use, Telehealth, Medication-Assisted Treatment Questionnaires

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