Changes for CY 2014 UDS Reporting

1. Patient Characteristics The number of public housing patients is reported on line 26 of Table 4 – Selected Patient Characteristics

   Justification: Residents of public housing that receive health center services are a statutory special population. This change aligns UDS reporting for public housing patients with two other funded special populations, i.e., homeless and agricultural workers. The number of public housing patients would be reported in the UDS on a calendar year basis for 2014, and then be pre-populated in health center grant applications and budget period renewals starting in 2015.

2. Patients Counts – The number of patients with a first time diagnosis of HIV is reported on line 1-2(a) of Table 6A – Selected Diagnoses and Services Rendered.

   Justification : The number of patients with a first time diagnosis of HIV and their subsequent follow up within 90 days of the diagnosis are measures being incorporated into the UDS in response to an HHS-wide action plan grown out of the President's National HIV/AIDS Strategy (NHAS) http://www.whitehouse.gov/administration/eop/onap/nhas/. The NHAS charged HHS with developing a set of common core HIV/AIDS indicators to be collected across the Department, as well as other federal agencies. The new HIV metrics in the UDS derive from the a set of core indicators spearheaded by the Office of the Assistant Secretary for Health (Dr. Howard Koh) and the Office of HIV/AIDS and Infectious Disease Prevention (Dr. Ron Valdiserri).

3. The check box for no prenatal care provided is removed from the top line of Table 6B - Quality of Care Indicators

   Justification: Prenatal and perinatal services are required services for health centers pursuant to Section 330 of the Public Health Services Act. The program expectation is that patients will be tracked by the referring health center in order to assure continuity of care upon their return to the health center. The effect of this change is that all health center grantees report patients (even if 0) for this required service.

4. *Quality of Care Measures:*

   Table 6B – Quality of Care Indicators is modified by removing the check box for no prenatal care provided (described above) and

   - combining the tobacco screening and cessation intervention pair into a single measure
   - removing the lipid therapy measure, and
   - adding a new behavioral health measure for clinical depression screening and follow up.

Justification: The single measure for tobacco cessation and intervention (reported in Section G, line 14a) is aligned with the National Quality Forum measure and meaningful use.

The lipid therapy measure has been replaced by a lipid control measure for NQF and meaningful use. (The lipid control measure is added in Table 7 as described below.)

The clinical depression screening and follow up measure (added as Section J, line 20) has been endorsed by the HHS Measures Policy Council and is aligned with the NQF and meaningful use measure. Standardized reporting of this measure by health centers underscores the importance of behavioral health quality measurement for the Health Center Program.

5. *Health Outcomes and Disparities Measures:*

Table 7 – Health Outcomes and Disparities has been modified by:

- revising the diabetes control measure to no longer require reporting for Hba1c levels less than 7 and
- adding a replacement measure for the lipid therapy measure no longer reported in Table 6B.

Justification:

Diabetes Control - NQF and meaningful use measures do not record Hba1c levels less than 7. Alignment with these measures (which record Hba1c levels of 8 and 9) reduces health center reporting burden.

Lipid Control - The lipid control measure encourages stabilization of coronary artery disease by realizing or planning to achieve (with prescription of a statin) an LDL-C result < 100mg/dl. This measure is the lipid control outcomes measure that has been identified by the National Quality Forum to replace the lipid therapy measure. It is added as Section D, Coronary Artery Disease to Table 7.

6. Electronic Health Records Capabilities and Quality Recognition

The questions on electronic health records capabilities and quality recognition through patient centered medical home accreditation have been revised and streamlined to capture essential information with reduced reporting burden.

Justification: Ensuring that health centers adopt Electronic Health Records (EHR) is a critical priority for HRSA, including helping grantees use EHR functionality to obtain Meaningful Use (MU) incentive payments from the Center for Medicare and Medicaid Services (CMS). The annual UDS report contains data on EHR capabilities required of all health centers. This

information is essential for the provision of necessary and appropriate technical assistance to grantees. Updated information on PCMH designation and accreditation is essential for describing the quality and continuity of care provided to health center patients.

Attachments:

UDS Tables 4, 6A, 6B, and 7; Questions for Grantee Electronic Health Record (EHR) Capabilities and Quality Recognition