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

PROGRAM ASSISTANCE LETTER

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DOCUMENT TITLE: Proposed Uniform Data System Changes for Calendar Year 2020

TO: Health Centers
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

I. BACKGROUND

This Program Assistance Letter (PAL) provides an overview of proposed changes to the Health Resources and Services Administration's (HRSA) calendar year (CY) 2020 Uniform Data System (UDS) to be reported by Health Center Program awardees and look-alikes in February 2021. Additional details regarding these changes will be included in the approved changes for CY 2020 UDS PAL and 2020 UDS Manual.

II. PROPOSED CHANGES FOR CY 2020 UDS REPORTING

A. UPDATE QUALITY OF CARE MEASURES TO ALIGN WITH E-CQMS: TABLES 6B AND 7

To support efforts across the federal government that standardize data collection and reduce reporting burden for entities participating in federal programs with data reporting mandates, the following clinical quality measures have been aligned with the versions of the Center for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs) designated for the 2020 reporting period.

Rationale: Data-driven quality improvement and full optimization of electronic health record (EHR) systems are strategic priorities for the Health Center Program. Clinical measure alignment across national programs significantly decreases reporting burden and improves data consistency. Additionally, measure alignment and harmonization with other national quality programs such as the National Quality Forum (NQF) (http://www.qualityforum.org/QPS/) and the CMS Quality Payment Program (QPP) (https://qpp.cms.gov/mips/quality-measures), remains a federal priority.

1. Childhood Immunization Status has been revised to align with CMS117v8.
2. Cervical Cancer Screening has been revised to align with CMS124v8.

3. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents has been revised to align with CMS155v8.
4. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan has been revised to align with CMS69v8.
5. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention has been revised to align with CMS138v8.
6. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease has been revised to align with CMS347v3.
7. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet has been revised to align with CMS164v7.
8. Colorectal Cancer Screening has been revised to align with CMS130v8.
9. Preventive Care and Screening: Screening for Depression and Follow-Up Plan has been revised to align with CMS2v9.
10. Controlling High Blood Pressure has been revised to align with CMS165v8.
11. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) has been revised to align with CMS122v8.

B. RETIRING THE ASTHMA MEASURE: USE OF APPROPRIATE MEDICATIONS FOR ASTHMA

The current eCQM asthma measure, CMS126v5, reported in the UDS captures the percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately ordered medication during the measurement period. The measure is proposed to be removed from UDS reporting.

Rationale: CMS 126v5 is no longer being updated by the measure steward, National Committee for Quality Assurance. As a result, when new asthma medications are approved for use they are not reflected in the eCQM. This asthma measure was also retired from the Healthcare Effectiveness Data and Information Set (HEDIS) and lost National Quality Forum (NQF) endorsement. As there is currently not an eCQM for asthma, no replacement is recommended at this time.

C. REPLACING THE DENTAL SEALANTS FOR CHILDREN BETWEEN 6–9 YEARS MEASURE (CMS277) WITH PRIMARY CARIES PREVENTION INTERVENTION AS OFFERED BY PRIMARY CARE PROVIDERS, INCLUDING DENTISTS MEASURE (CMS74V9)

The draft dental sealant measure, CMS277, captures the percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period. The Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists measure (CMS74v9) captures the percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period (to be reported on Table 6B).

Rationale: The application of fluoride varnish to the teeth of children reduces the risk of development of caries. Increasing the use of non-dental providers (i.e., primary care providers) providing fluoride varnish to their patients can reduce the incidence of caries and promote better oral health.

The current oral health eCQM in the UDS provides limited data on oral health care in HRSA-funded health centers. The target population is four years of high risk children, 6-9, and the data can only be captured in health centers who employ or contract with a dentist, as only dentists can apply sealants. The fluoride varnish measure, CMS74, increases the target population as well as captures oral health preventative measures that health centers without dentists can employ.

D. ADDING THE DEPRESSION REMISSION AT TWELVE MONTHS MEASURE (CMS159V8)

The depression remission measure, CMS159v8, captures the percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event (to be reported on Table 6B).

Rationale**:** Currently, the UDS contains CMS2v8 Screening for Depression and Follow-Up Plan measure which asks health centers to screen patients aged 12 and older for depression and provide follow-up care if the patient has a positive screen. While screening increases intervention for mental illness, it does not provide data on the outcome of patients with depression. The addition of the Depression Remission Measure at 12 Months will collect outcome data on how health centers are helping patients reach remission. Improvement in the symptoms of depression and an ongoing assessment of the current treatment plan is crucial to the reduction of symptoms and psychosocial well-being of patients.

E. **REVISING THE HIV LINKAGE TO CARE MEASURE (NO ECQM)**

The HIV linkage to care measure captures the percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis. This measure will be modified to change the follow-up treatment timeline from 90 days to 30 days.

Rationale: HRSA is one of the lead federal agencies in the 'Ending the HIV Epidemic' Initiative. To support this effort and to align with the Centers for Disease Control and Prevention (CDC), guidance on the Continuum of Care patients with an HIV diagnosis should be seen for follow up treatment within 30 days.[1]

F. **ADDING THE HIV SCREENING MEASURE (CMS349V2)**

The HIV Screening measure, CMS349v2, captures the percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV (to be reported on Table 6B).

Rationale: HRSA is one of the lead federal agencies in the 'Ending the HIV Epidemic' Initiative and is building upon the following key strategies: diagnosing, treating, preventing, and responding.[2] Approximately 1.1 million people are living with HIV in the US; 15% of them are unaware that they are infected.[2] The addition of the HIV screening measure will collect data on the detection of HIV in health center patients.

G. ADDING DATA ON PRESCRIPTIONS FOR PRE-EXPOSURE PROPHYLAXIS (PREP)

Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication to prevent HIV infection and is used by people who are at high risk of being exposed to HIV. Table 6A will be modified to capture data on patients prescribed tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC) (brand name Truvada®) during the reporting year for PrEP.

The following ICD codes are recommended to help identify patients at risk for HIV and potentially candidates for PrEP:

- Z20.6 Contact with and (suspected) exposure to HIV
- Z72.51 High risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High-risk bisexual behavior
- Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Z11.4 Encounter for screening for human immunodeficiency virus
- Z11.59 Encounter for screening for other viral diseases
- Z20.5 Contact with and (suspected) exposure to viral hepatitis
- Z71.7 Encounter for HIV counseling
- F19.20 Injection drug use exposure risk
- Z70.1 Counseling related to patient's sexual behavior and orientation
- Z20.82 Contact with and (suspected) exposure to other viral communicable diseases
- Z77.21 Contact with and (suspected) exposure to potentially hazardous body fluids
- Z77.9 Other contact with and (suspected) exposure hazardous to health
- W46 Contact with hypodermic needle: "the appropriate7th character is to be added to each code from category W46" A- initial encounter, D-subsequent encounter, S-sequela
- W46.0 Contact with hypodermic needle (hypodermic needle stick NOS)
- W46.1 Contact with contaminated hypodermic needle
- Other ones to consider to identify target population:
    - Z86.59 Personal history of other mental and behavioral disorders
    - F11.20 Opioid dependence, uncomplicated
    - F11.21 Opioid dependence in remission
    - F11.10 Opioid abuse, uncomplicated

- F11.90 Opioid use, uncomplicated

Possible CPT codes to search:

- 99401 PreventionCounseling (15 minutes)
- 99402 PreventionCounseling (30 minutes)
- 99403 PreventionCounseling (45 minutes)
- 99404 PreventionCounseling (60 minutes)

Potential codes for PrEP prescriptions:

- Z79- Long term (current) drug therapy. Includes long term (current) drug use for prophylactic purposes
  - Z79 Long term (current) drug therapy
  - Z79.0 Long term (current) use of anticoagulants and antithrombotics/antiplatelets
  - Z79.01 Long term (current) use of anticoagulants
  - Z79.02 Long term (current) use of antithrombotics/antiplatelets
  - Z79.1 Long term (current) use of non-steroidal anti-inflammatories (NSAID)
  - Z79.2 Long term (current) use of antibiotics
  - Z79.3 Long term (current) use of hormonal contraceptives
  - Z79.4 Long term (current) use of insulin
  - Z79.5 Long term (current) use of steroids
  - Z79.51 Long term (current) use of inhaled steroids
  - Z79.52 Long term (current) use of systemic steroids
  - Z79.8 Other long term (current) drug therapy
  - Z79.81 Long term (current) use of agents affecting estrogen receptors and estrogen levels
  - Z79.810 Long term (current) use of selective estrogen receptor modulators (SERMs)
  - Z79.811 Long term (current) use of aromatase inhibitors
  - Z79.818 Long term (current) use of other agents affecting estrogen receptors and estrogen levels
  - Z79.82 Long term (current) use of aspirin
  - Z79.83 Long term (current) use of bisphosphonates
  - Z79.84 Long term (current) use of oral hypoglycemic drugs
  - Z79.890 Hormone replacement therapy
  - Z79.891 Long term (current) use of opiate analgesic
  - Z79.899 Other long term (current) drug therapy

Possible RXNorm codes:

- TDF 322248
- FTC 276237

Be sure to limit reporting to TDF/FTC for PrEP (exclude prescriptions for TDF/FTC that were made for other known indications, such as HIV treatment, post-exposure prophylaxis, and chronic hepatitis B management).

Rationale: The 'Ending the HIV Epidemic' Initiative is a national priority and HRSA is one of the lead federal agencies. The Centers for Disease Control and Prevention (CDC) reports that daily PrEP reduces the risk of contracting HIV from sex by more than 90% and from injection by more than 70%.[3] The addition of PrEP prescriptions will allow HRSA to assess health center progress on this important HIV prevention effort.

H. ADDING INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)-10 CODES TO CAPTURE HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE (IPV)

IPV is defined as "physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner[4] and human trafficking occurs when a trafficker exploits an individual with force, fraud, or coercion to make them perform commercial sex or work[5] (to be reported on Table 6A).

The following ICD codes are recommended to help identify patients at risk for or effected by Human Trafficking:

Human Trafficking

- T74.5 Forced sexual exploitation, confirmed
  - T74.51 Adult forced sexual exploitation, confirmed
  - T74.52 Child sexual exploitation, confirmed
- T74.6 Forced labor exploitation, confirmed
  - T74.61 Adult forced labor exploitation, confirmed
  - T74.62 Child forced labor exploitation, confirmed
- T76.5 Forced sexual exploitation, suspected
  - T76.51 Adult forced sexual exploitation, suspected
  - T76.52 Child sexual exploitation, suspected
- T76.6 Forced labor exploitation, suspected
  - T76.61 Adult forced labor exploitation, suspected
  - T76.62 Child forced labor exploitation, suspected
- Z04.8 Encounter for examination and observation for other specified reasons
  - Z04.81 Encounter for examination and observation of victim following forced sexual exploitation
  - Z04.82 Encounter for examination and observation of victim following forced labor exploitation
- Z62.813 Personal history of forced labor or sexual exploitation in childhood
- Z91.42 Personal history of forced labor or sexual exploitation

The following ICD codes are recommended to help identify patients effected by Intimate Partner Violence:

Intimate Partner Violence

- T74.11 Adult physical abuse, confirmed
- T74.21 Adult sexual abuse, confirmed

- T74.31 Adult emotional/psychological abuse, confirmed
- Z69.11 Encounter for mental health services for victim of spousal or partner abuse
- Y07.0* Spouse or partner, perpetrator of maltreatment and neglect used to identify perpetrator in cases of confirmed abuse (T74 codes)

Rationale: HRSA is aware that human trafficking[6] and intimate partner violence[7] are serious public health issues and complex social determinants of health (SDOH) that can affect a wide range of health and quality of life outcomes. Addressing SDOH is a HRSA objective to improve the health and well-being of health center patients and the broader community in which they reside.

I. ADDING DIABETES: EYE EXAM (CMS131V8), DIABETES: FOOT EXAM (CMS123V7), AND DIABETES: MEDICAL ATTENTION TO NEPHROPATHY (CMS134V8)

Diabetes: Eye Exam, CMS131v8, measures the percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period (to be reported on Table 6B).

Diabetes: Foot Exam, CMS123v7, measures the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year (to be reported on Table 6B).

Diabetes: Medical Attention for Nephropathy, CMS134v8, measures the percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period (to be reported on Table 6B).

Rationale: Improving the treatment of diabetes is a HRSA priority. Addition of these eCQMs informs HRSA of the breadth of preventative care that patients with diabetes receive in the health center setting. Preventative eye care can reduce the incidence of blindness in patients with diabetic retinopathy. Studies have illustrated that there is a large discrepancy in screening rates among safety-net minority communities and that may have important implications for consequent risk of blindness.[8]

Diabetes patients of lower socio-economic status are at greater risk for lower limb amputation. At least 50% of all amputations occur in individuals with diabetes mostly commonly from an infected diabetic foot ulcer.[9] Lower limb amputation results in higher mortality rates, reduced quality of life, and increased medical cost. Increasing preventative care through foot exams can lead to reduced number of amputations and improved quality of life.

Nephropathy (an umbrella term for kidney-related complications due to diabetes) is the leading cause of kidney failure in the U.S. Approximately 1 out of 4 individuals with diabetes develop kidney nephropathy.[10] Nephropathy increases patients' risk of cardiovascular disease and mortality. Screening for nephropathy provides an opportunity for early intervention, slowing the progression of kidney disease, reducing mortality and maintaining a patient's quality of life.

J. ADDING THE BREAST CANCER SCREENING MEASURE (CMS125V8)

Breast Cancer Screening, CMS125v8, measures the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period (to be reported on Table 6B).

Rationale: Breast cancer is the most common cancer in women and the fourth leading cause of cancer death in the U.S.[11] There is substantial geographic and demographic variation in breast cancer death rates suggesting that there are social and structural factors that affect breast cancer mortality. Preventative screening through timely access to mammograms can lead to early detection, better treatment prognosis, and has the potential to reduce health disparities.

K. **ADDING A QUESTION TO APPENDIX D: HEALTH CENTER HEALTH INFORMATION TECHNOLOGY (HIT) CAPABILITIES**

Including a question in Appendix D to determine whether health centers are accessing Prescription Drug Monitoring Programs (PDMPs) or have them integrated into health information systems such as Health Information Exchanges, electronic health records (EHR) systems, and/or pharmacy dispensing software (PDS) to streamline provider access controlled substances prescription data.

Rationale: PDMPs are effective tools for reducing prescription drug abuse and diversion. Improving provider utilization and access to real-time data have demonstrated meaningful results in reducing over prescribing of medication. Currently, 49 states, the District of Columbia, and Guam have created and are operating PDMPs that collect information from dispensers and report information to authorized users.

L. **REVISING QUESTIONS IN APPENDIX D: HEALTH CENTER HEALTH INFORMATION TECHNOLOGY (HIT) CAPABILITIES**

The CMS program commonly known as Meaningful Use has changed. Questions in the appendix regarding Meaningful Use have been revised to address the aspects of the new program Promoting Interoperability. In addition, the current question regarding standardized screener(s) for social risk factors that are used by health centers as been revised to gain a better understanding of how this information is being used in the primary care setting.

Rationale: CMS has made changes to the Medicare and Medicaid EHR Incentive Programs that will now be known as the Promoting Interoperability programs[12]. In light of these changes, revisions have been made to questions regarding Meaningful Use.

Research has shown that social determinants of health (e.g. food, housing, finances, and transportation) can account for up to 40 percent of individual health outcomes, particularly among vulnerable populations[13]. Increasingly, health care leaders and clinicians are developing ways to discuss these unmet social needs with these patients and connect them to supportive services. As the healthcare landscape changes, health centers are becoming more diverse and comprehensive in the care and services provided and it is important to reflect this work in the data collected.

III. CONTACTS

For questions or comments regarding the proposed changes to the CY 2020 UDS contact the Office of Quality Improvement at OQIComments@hrsa.gov.

Sincerely,

/S/
Jim Macrae
Associate Administrator

Attachments:

1. Proposed Changes to UDS Instructions for Tables 6A and 6B; and Appendix D

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2020, through December 31, 2020

Table 6A: Selected Diagnoses

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic / Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
2a	Pre-Exposure Prophylaxis (PrEP) Prescription	F19.20, F11.20, F11.21, F11.10, F11.90, W46, W46.0, W46.1, Z20.2, Z20.6, Z20.82, Z72.51, Z72.52, Z11.3, Z11.4, Z11.59, Z20.5, Z70.1, Z71.7, Z51.81, Z77.21, Z77.9, Z86.59, Z79, Z79.0 through Z79.02, Z79.1 through Z79.5, Z79.51, Z79.52, Z79.8, Z79.81 through Z79.811, Z79.818, Z79.82 through Z79.84, Z79.89, Z79.891, Z79.899 (limit to TDF/FTC for PrEP) Possible CPT codes to search: 99401 through 99404 Possbile RXNorm Codes: TDF 32248, FTC 276237		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-		
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21		
	Selected Diseases of the Respiratory System			
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40- through J44-, J47-		
	Selected Other Medical Conditions			

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-		
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820		
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-		
11	Hypertension	I10- through I16-, O10-, O11-		
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-		
13	Dehydration	E86-		
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-		
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)		
	Selected Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	H65- through H69-		
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89		
17	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3		
	Selected Mental Health Conditions and Substance Use Disorders, and Victimizations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		
20e	Human Trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.8-, Z62.813, Z91.42		
20f	Intimate Partner Violence	T74.11, T74.21, T74.31, Z69.11, Y07.0		

Table 6A: Selected Services Rendered

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/ Preventive Services			
21	HIV test	**CPT-4**: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806		
21a	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350		
21b	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522		
22	Mammogram	**CPT-4**: 77065, 77066, 77067 OR **ICD-10**: Z12.31		
23	Pap test	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)		

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748		
24a	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756		
25	Contraceptive management	**ICD-10**: Z30-		
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-		
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4**: 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050		
26c	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F, 4004F		
26d	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
	Selected Dental Services			
27	Emergency services	**ADA:** D0140, D9110		
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis – adult or child	**ADA:** D1110, D1120		
30	Sealants	**ADA:** D1351		
31	Fluoride treatment – adult or child	**ADA:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**ADA:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**ADA:** D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2020, through December 31, 2020

0	Prenatal Care Provided by Referral Only (Check if Yes)	[blank for demonstration]

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

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

Section B - Early Entry into Prenatal Care

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

Section C - Childhood Immunization Status

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

Section D - Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screening**	**Total Female Patients Aged 50 through 74 (a)**	**Number Charts Sampled or EHR total (b)**	**Number of Patients with Mammogram (c)**
11a	MEASURE: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer			

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

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented			

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

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

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

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR total (b)	Number of patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention			

Section I - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

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

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

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

Section K - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer			

Section L - HIV Measures

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

Section M – Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented			
Line	**Depression Remission at 12 Months**	**Total Patients Aged 18 and Older with Major Depression or Dysthymia (a)**	**Charts Sampled or EHR Total (b)**	**Number of Patients who Reached Remission (c)**
21a	MEASURE: Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Section N – Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Line	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Total Patients Aged 0 through 20 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Fluoride Varnish Application (c)
22a	MEASURE: Percentage of children, age 0-20 years, who received a fluoride varnish application			

Section O – Diabetes Measures

Line	Diabetes: Eye Exam	Total Patients Aged 18 through 75 with Diabetes (a)	Charts Sampled or EHR Total (b)	Number of Patients with Eye Exam (c)
23a	MEASURE: Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam or a negative retinal exam			
Line	**Diabetes: Foot Exam**	**Total Patients Aged 18 through 75 with Diabetes (a)**	**Charts Sampled or EHR Total (b)**	**Number of Patients with Foot Exam (c)**
23b	MEASURE: Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam			
Line	**Diabetes: Medical Attention for Nephropathy**	**Total Patients Aged 18 through 75 with Diabetes (a)**	**Charts Sampled or EHR Total (b)**	**Number of Patients with Nephropathy Screening Test or Evidence of Nephropathy (c)**
23c	MEASURE: Percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy			

Appendix D: Health Center Electronic Health Record (EHR) Capabilities and Quality Recognition

Instructions

The HIT Capabilities Form includes a series of questions on HIT capabilities, including EHR interoperability and eligibility for Meaningful Use. The HIT Form must be completed and submitted as part of the UDS submission. The form includes questions about the health center's implementation of an EHR, certification of systems, and how widely adopted the system is throughout the health center and its providers.

Questions

The following questions appear in the EHBs. Complete them before you file the UDS Report. Instructions for the HIT questions are on screen in EHBs as you complete the form. Respond to each question based on your health center *status as of December 31*.

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?

    a. Yes, installed at all sites and used by all providers
    b. Yes, but only installed at some sites or used by some providers

If the health center installed it, indicate if it was in use by December 31, by:

a. **Installed at all sites and used by all providers**: For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response a. For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients and does not include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. You may check this option even if a few, newly hired, untrained employees are the only ones not using the system.

b. **Installed at some sites or used by some providers:** Select option b if one or more permanent sites did not have the EHR installed, or in use (even if this is planned), or if one or more medical providers (as defined above) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do not select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.

c. No
   Select "no" if no EHR was in use on December 31, even if you had the system installed and training had started.

This question seeks to determine whether the health center installed an EHR by December 31 and, if so, which product is in use, how broad is access to the system, and what features are available and in use. Do not include PMSs or other billing systems even though they can often produce much of the UDS data. If the health center purchased an EHR, but has not yet placed it into use, answer "no."

If a system is in use (i.e., if a or b has been selected above), indicate it has been certified by the Office of the National Coordinator - Authorized Testing and Certification Bodies.

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

a. Yes
b. No

Health centers are to indicate in the blanks the vendor, product name, version number, and ONC-certified health IT product list number. (More information is available at https://chpl.healthit.gov/#/search) If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system.

Vendor
Product Name
Version Number
ONC-certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

a. Yes
b. No

If "yes, but only at some sites or for some providers" is selected above, a box expands for health centers to identify how many sites have the EHR in use and how many (medical) providers are using it. Please enter the number of sites (as defined above) where the EHR is in use and the number of providers who use the system (at any site). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one site as just one provider.

1c. Do you use more than one EHR or data system across your organization?

If yes, what is the reason?

- Second EHR/data system is used during transition to primary EHR
- Second EHR/data system is specific to one service type (e.g. dental, behavorial health)
- Secon EHR/data system is used at specific sites with no plan to transition
- Other (please specify) _____

1d. Is your EHR up to date with the latest software and system patches?

1e. When do you plan?

2. Question removed.
3. Question removed.
4. Which of the following key providers / health care settings does your center electronically exchange clinical information with? (Select all that apply)

    a. Hospitals / Emergency rooms
    b. Specialty clinicians
    c. Other primary care providers
    d. Labs or imaging
    e. Health information exchange (HIE)
    f. None of the above
    g. Other (please describe _____)

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply)

    a. Patient portals
    b. Kiosks
    c. Secure Messaging
    d. Other (please describe _____)
    e. No, we do not engage patients using HIT

6. Question removed.
7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?

    a. We use the EHR to extract automated reports
    b. We use the EHR but only to access individual patient charts
    c. We use the EHR in combination with another data analytic system
    d. We do not use the EHR

8. Question removed.
9. Question removed.
10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply)

    a. Quality improvement
    b. Population health management
    c. Program evaluation
    d. Research
    e. Other (please describe _____)
    f. We do not utilize HIT or EHR data beyond direct patient care

11. Does your health center collect data on individual patients' social risk factors or social determinants of health, outside of the data reportable in the UDS?

    a. Yes
    b. No, but in planning stages to collect this information

c. No, not planning to collect this information

12. Which standardized assessment(s) to collect information on the social determinants of health or social risk factors, if any, do you use? (Select all that apply)

a. Accountable Health Communities Screening Tools
b. Upstream Risks Screening Tool and Guide
c. iHELP
d. Recommend Social and Behavioral Domains for EHRs
e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)
g. WellRx
h. Health Leads Screening Toolkit
i. Other (please describe _____)
j. We do not use a standardized assessment

12a. Please provide the total number of patients that screened positive for the following:

a. Food insecurity _____
b. Housing insecurity _____
c. Financial strain _____
d. Lack of transportation/access to public transportation _____

12b. If you do not use a standardized assessment to collect this information, please comment why (Select all that apply)

a. Have not considered/unfamiliar with assessments
b. Lack of funding for addressing these unmet social needs of patients
c. Lack of training for staff to discuss these issues with patients
d. Inability to include in patient intake and clinical workflow
e. Not needed
f. Other (Please specify:_____)

13. Does your center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems such as Health Information Exchanges, electronic health record (EHR) systems, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?

a. Yes
b. No
c. Not sure

[1] https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf
[2] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[3] https://www.cdc.gov/hiv/basics/prep.html
[4] https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

[5] https://www.acf.hhs.gov/otip/about/what-is-human-trafficking
[6] https://www.acf.hhs.gov/otip/about/what-is-human-trafficking
[7] https://www.hrsa.gov/sites/default/files/hrsa/HRSA-strategy-intimate-partner-violence.pdf
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[10] Afkarian M, Zelnick LR, Hall YN, et.al. Clinical manifestations of kidney disease among US adults with diabetes. Journal of the American Medical Association. 2016;316(6):602–610.
[11] https://seer.cancer.gov/statfacts/html/breast.html
[12] https://www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms
[13] https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/