2023 UDS Data

HCHN Governance Council
April 15, 2024

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Public Health
Seattle & King County

Agenda

- Brief the governance council on UDS overview and performance measurements, including clinical measures

- Share 2023 UDS numbers:
  - Patients
  - Demographics
  - Visits
  - Clinical Measures
    - High Blood Pressure (Hypertension)
    - Diabetes

Purpose

- GC responsibility is to make sure we are complying with HRSA needs assessment and board authority requirements

- This includes reviewing UDS/330h grant patient and service data

UDS Overview

The UDS is a standard data set that is reported annually by each Health Center Program (including 330h) to the Health Resources and Services Administration (HRSA). Our report includes patients and visits at our main and occasional sites.

- Core information includes:
  - patient demographics
  - services provided (visits)
  - clinical processes and health outcomes
  - staffing, costs, and revenues
- What is a visit?
  - Encounters between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing services that are: documented, individual, in-person or virtual, at an approved site
- What is a patient?
  - Clients with at least one visit (as defined above) in the calendar year
- Service categories, or types of services:
  - Medical
  - Dental
  - Behavioral Health
  - Substance Use
  - Enabling
  - Other (Nutrition)

2023 UDS Update to Race & Ethnicity Categories

- Update in 2023 expands options for how race & ethnicity are reported on in the UDS:
  - Asian
    - Asian Indian
    - Chinese
    - Filipino
    - Japanese
    - Korean
    - Vietnamese
    - Other Asian
  - Pacific Islander
    - Native Hawaiian
    - Other Pacific Islander
    - Guamanian or Chamorro
    - Samoan
  - Hispanic, Latino/a, or Spanish
    - Mexican, Mexican American, Chicano/a,
    - Puerto Rican
    - Cuban
    - Another Hispanic, Latino/a, or Spanish Origin
    - Hispanic, Latino/a, or Spanish Origin Combined
    - Not Hispanic, Latino/a, or Spanish Origin
- No change to:
  - Black/African American
  - American Indian/Alaska Native
  - White
  - More than one race
  - Unreported/Chose Not to Disclose

Health Care for the Homeless Network Performance Measurement Dashboard

Year 2023

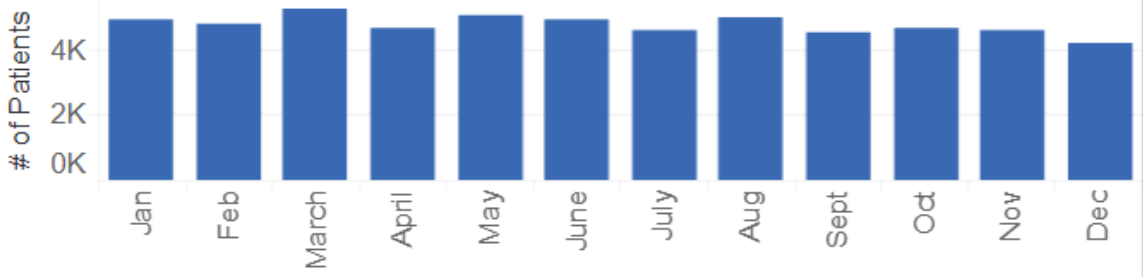
How many people living homeless are we reaching?

Target:	Total:	Percent Met:
21,957	**21,838**	**99.5%**

Patients served in previous years:

2022: 21,648
2021: 20,768
2020: 19,494

of Patients per Month



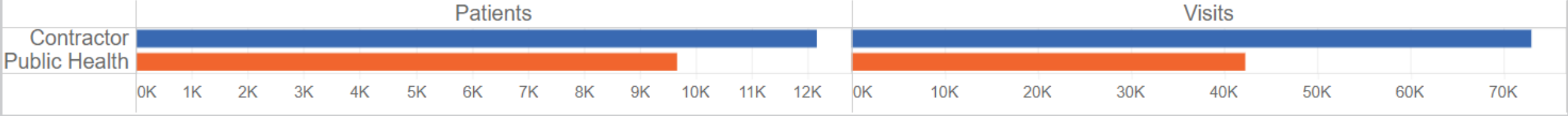
What services are patients receiving?

	#	Target	% Met
Medical	12,007	16,314	73.6%
Dental	3,265	4,350	75.1%
Mental Health	3,492	5,438	64.2%
Substance Use	3,678	3,698	99.5%
Enabling	2,712	3,045	89.1%
Nutrition	553		

How many visits by service category?

	#	Target	% Met
Medical	59,756	76,765	77.8%
Dental	10,189	11,457	88.9%
Mental Health	19,169	16,040	119.5%
Substance Use	12,834	9,166	140.0%
Enabling	11,725	5,729	204.7%
Nutrition	1,700		

How do patients and visits compare between Public Health & HCHN contractors?



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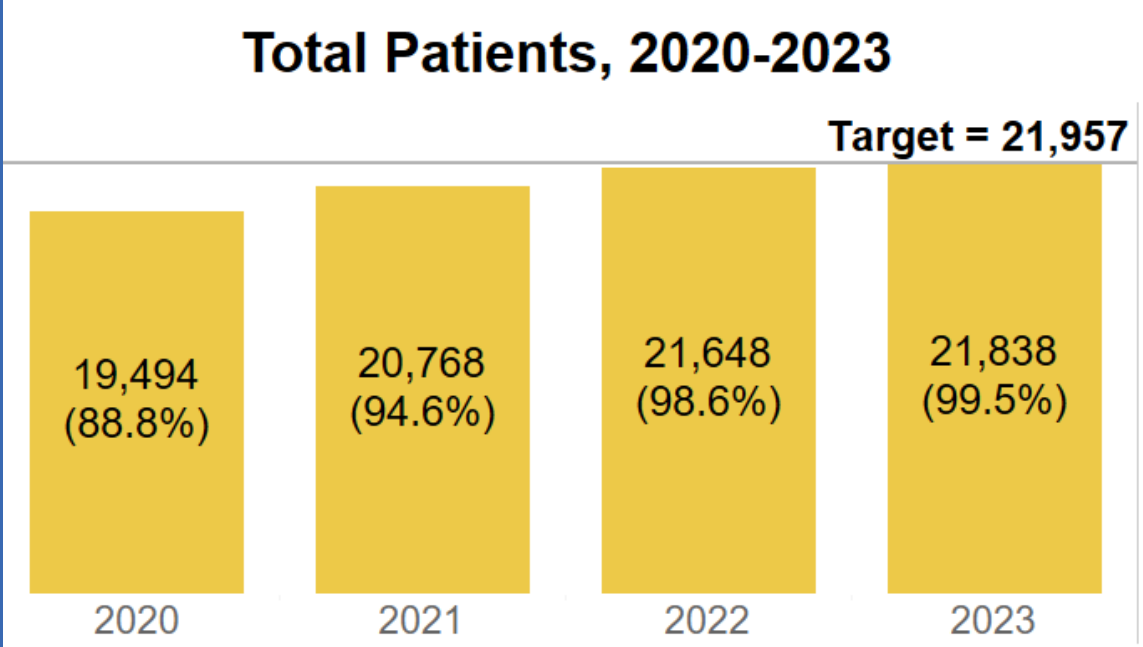
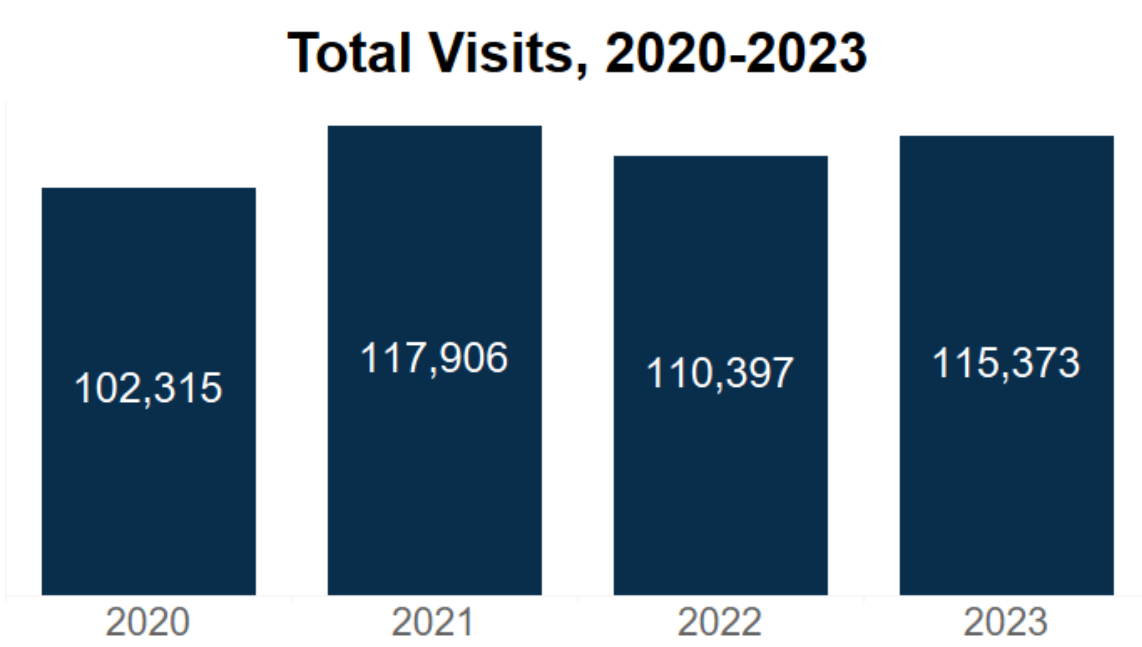
HCHN served 21,838 clients with 115,373 visits in 2023.





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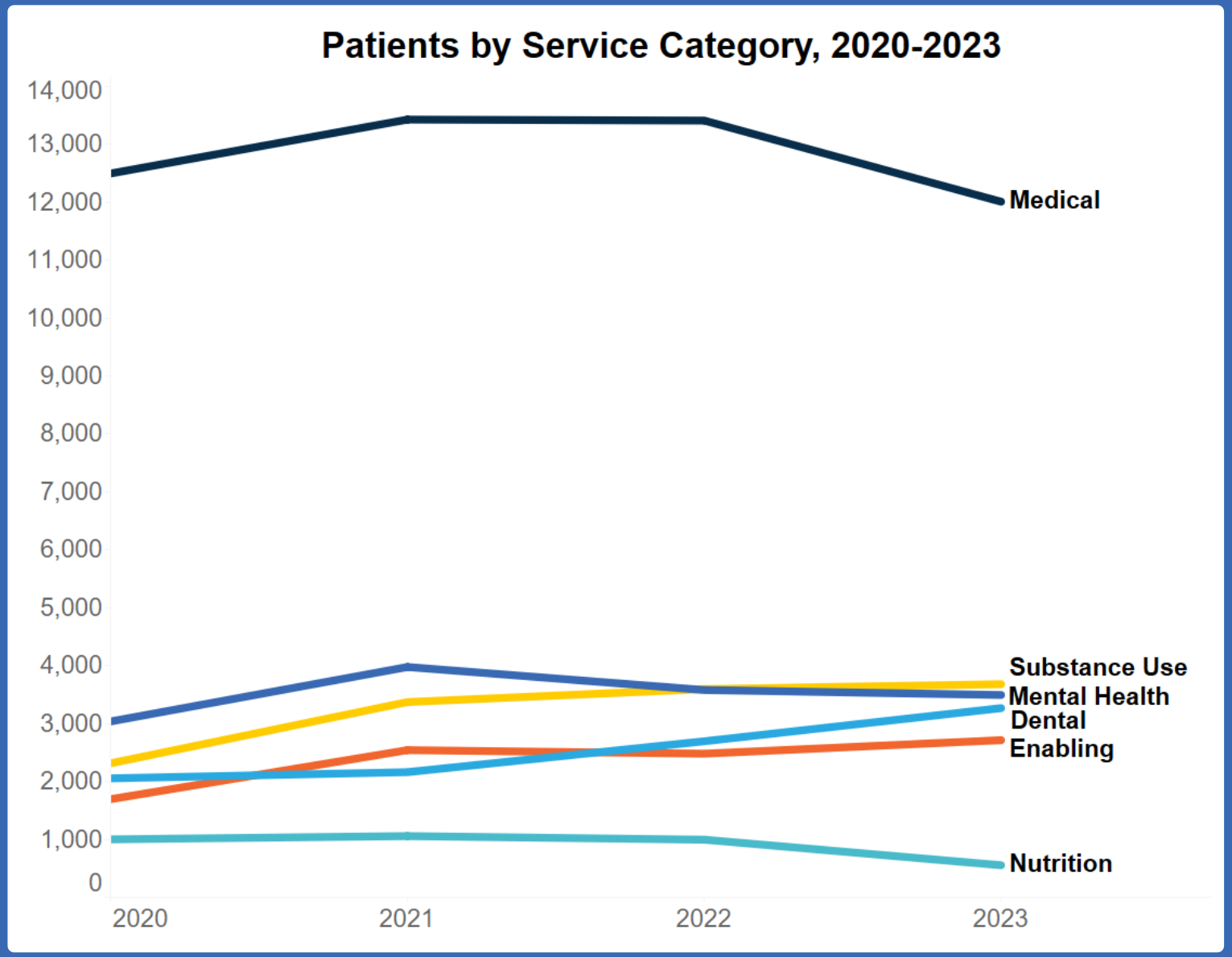
Patients and Visits by Service Category have largely stayed consistent over the past 4 years.



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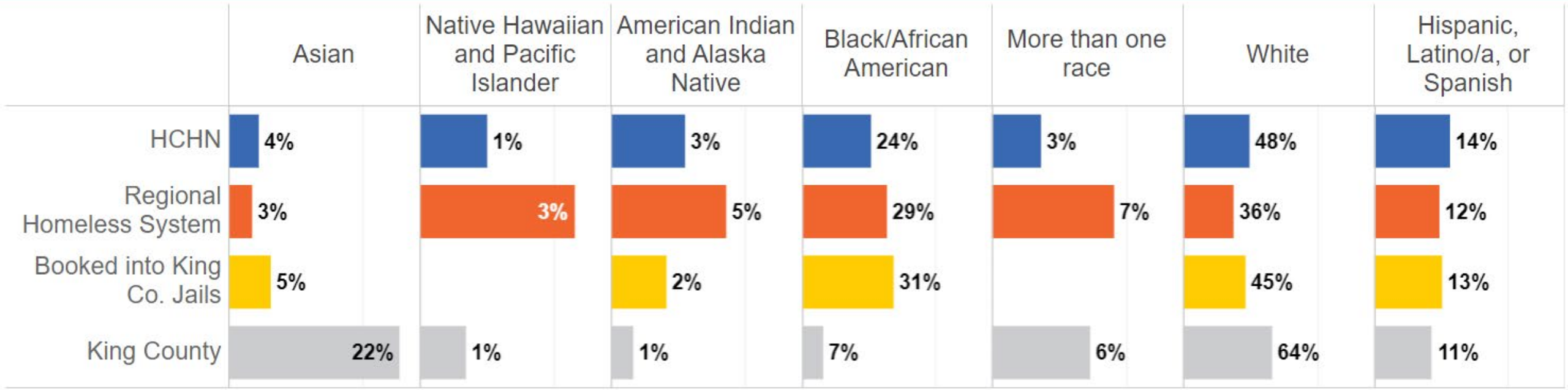
People of color face continued disparities and are overrrepresented in homelessness counts

King County is increasingly racially and ethnically diverse. Asian and Hispanic populations have increased in the past 20 years, and even more so in the past 3-5 years. Additionally, the number of people born outside US continues to rise.

However, county population changes and different poverty rates alone do not explain why people of color are persistently overrepresented among those who experience homelessness. Understanding how racism, historical and persistent, impacts the experience of individuals within our health and housing systems is key.

Each system collects demographics differently, and all struggle to fully capture Hispanic and Latinx identities.



Note: Demographic percentages may not total 100% due to overlap across race and Hispanic/Latinx ethnicity.

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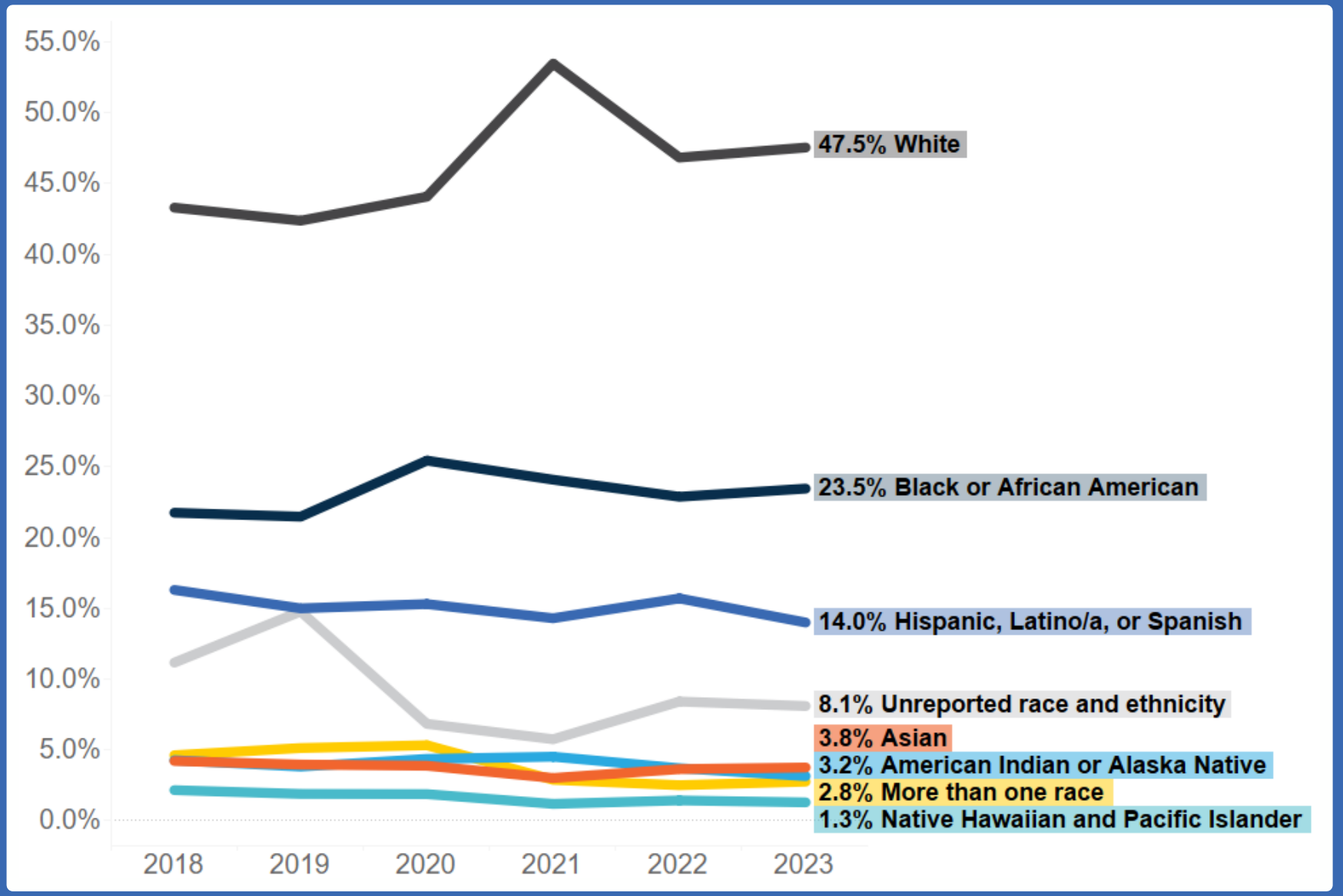
Race & Ethnicity, 2018-2023

No major changes in client reported racial/ethnic demographics have been observed over the past 6 years.

Approximately half of clients are Black, Indigenous, and People of Color (BIPOC) - defined by Community Health Services as reporting their ethnicity as Hispanic, Latino/a, or Spanish, and/or their race as non-white.



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Clinical Measures Overview

- UDS Clinical Measures are used to:
  - evaluate and improve health-center performance
  - ensure compliance with legislative mandates
  - identify trends in health centers' impact on expanding access, addressing health disparities, improving quality, and reducing health care costs.
- All health centers report on the same 18 clinical measures.
- Clinical measures primarily consider patients with medical visits (one dental measure).

Clinical Measures Performance Considerations

- Most clinical measurements are based on ability to follow up with people, requiring more than one visit or ability to reach patients via text, phone, etc. About 1/3 of HCHN medical patients only have one visit annually.
- Each measure has specific inclusion or exclusion criteria, based on age, sex assigned at birth, prior diagnoses, pregnancy, palliative and/or hospice care. Definitions may slightly change year to year to align with national standards.
- Exclusion and exception criteria are difficult to consistently diagnose and chart, particularly in outreach and field-based settings.
- Essentially all clinical measures have higher performance associated with increased housing stability.

List of UDS Clinical Measures

Screening and Preventive Care	Maternal Care and Children's Health	Disease Management
• Cervical Cancer Screening • Breast Cancer Screening • Body Mass Index (BMI) Screening and Follow-Up Plan • Tobacco Use: Screening and Cessation Intervention • Colorectal Cancer Screening • HIV Screening • Screening for Depression and Follow-Up Plan	• Early Entry into Prenatal Care • Childhood Immunization Status • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Dental Sealants for Children between 6-9 Years • Low Birth Weight*	• Statin Therapy for the Prevention and Treatment of Cardiovascular Disease • Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet • HIV Linkage to Care • Depression Remission at Twelve Months • Controlling High Blood Pressure (Hypertension)* • Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9 percent)*

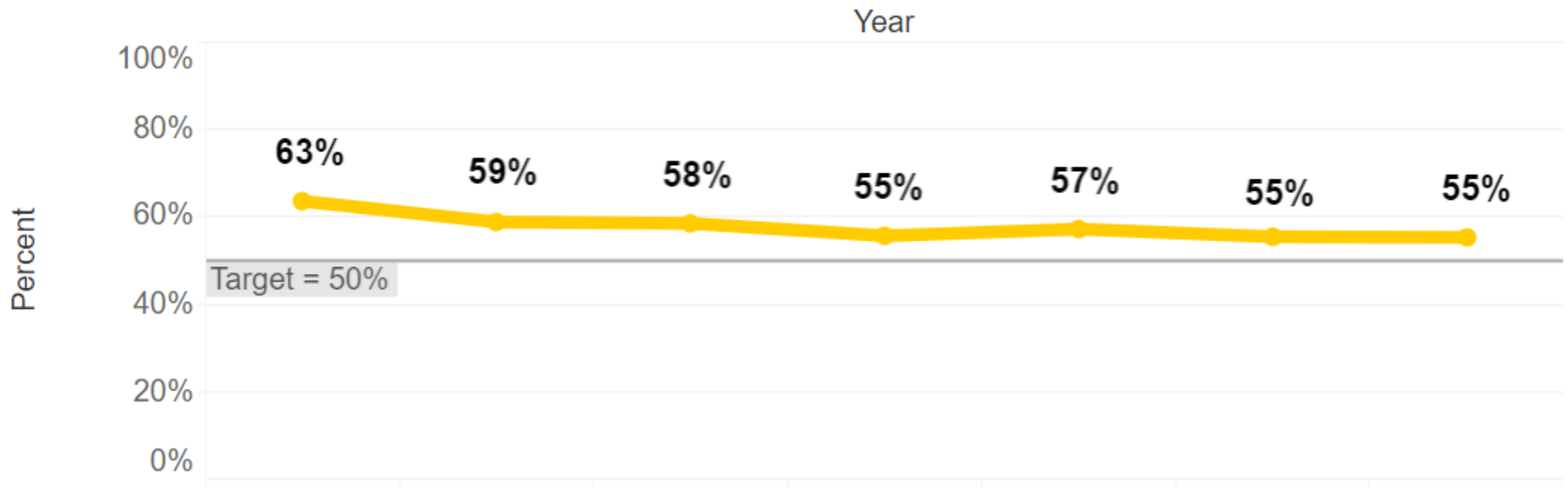
* Reported in UDS by race and ethnicity. All other measures analyzed internally by race and ethnicity

High Blood Pressure (Hypertension)
Measure Criteria

- Denominator (patients to include):
  - Patients 18-85 by the end of the year
  - Had a diagnosis of essential hypertension before or within the first 6 months of the year
- Numerator (patients who ‘met’ the criteria):
  - Blood pressure at the most recent visit was controlled, or less than 140/90 mmHg
- Exclusions and exceptions:
  - ESRD, dialysis, or renal transplant within the year
  - Pregnant during any part of the year
  - Hospice during any part of the year
  - Palliative care during any part of the year
  - 66+ and living long term in a nursing home
  - 66-80 with an indication of frailty *and* have 1 inpatient visit, 2 outpatient visits, or taking dementia medications
  - 81+ with an indication of frailty

High Blood Pressure (Hypertension)
UDS Results 2017-2023

Percentage of patients 18-85 years of age with hypertension who had systolic blood pressure < 140 and diastolic blood pressure < 90



	2017	2018	2019	2020	2021	2022	2023
Denominator	700	728	821	829	896	854	1,063
Numerator	444	427	479	460	511	472	586

Comparisons (2022)

National

63.4%

Washington State

67.8%

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High Blood Pressure (Hypertension)
by Race & Ethnicity

2023	Patients 18-85+ with hypertension	Blood pressure controlled	% Met
Asian	42	28	67%
Native Hawaiian and Pacific Islander	9	2	22%
Black/African American	316	178	56%
American Indian and Alaska Native	23	13	57%
White	567	309	54%
More than one race	18	9	50%
Unreported race	88	47	53%
Hispanic, Latino/a, or Spanish Origin*	126	75	60%
Total	**1063**	**586**	**55%**

*of any race

No significant disparities in overall performance by race and ethnicity in the last few years.

Communities to prioritize outreach & engagement efforts:

- Clients living on the street (35%)

High Blood Pressure (Hypertension) Discussion

- What factors or HCHN-specific context should be considered when reviewing performance on this measure?
- What strategies do we currently use to reach clients with hypertension?
- Can we use this data to adjust practices?
- What can the GC do to support?

Diabetes
Measure Criteria

- Denominator (patients to include):
  - Patients 18-75 by the end of the year
  - Had an active diagnosis of diabetes

- Numerator (patients who 'met' the criteria):
  - Hemoglobin A1c (HbA1c) at the most recent visit was greater than 9.0 percent, or
  - No HbA1c measurement in the whole year

  Diabetes is a negative, or inverse, measure. This means a lower percent = less uncontrolled diabetes, and the <u>better</u> the performance on the measure.

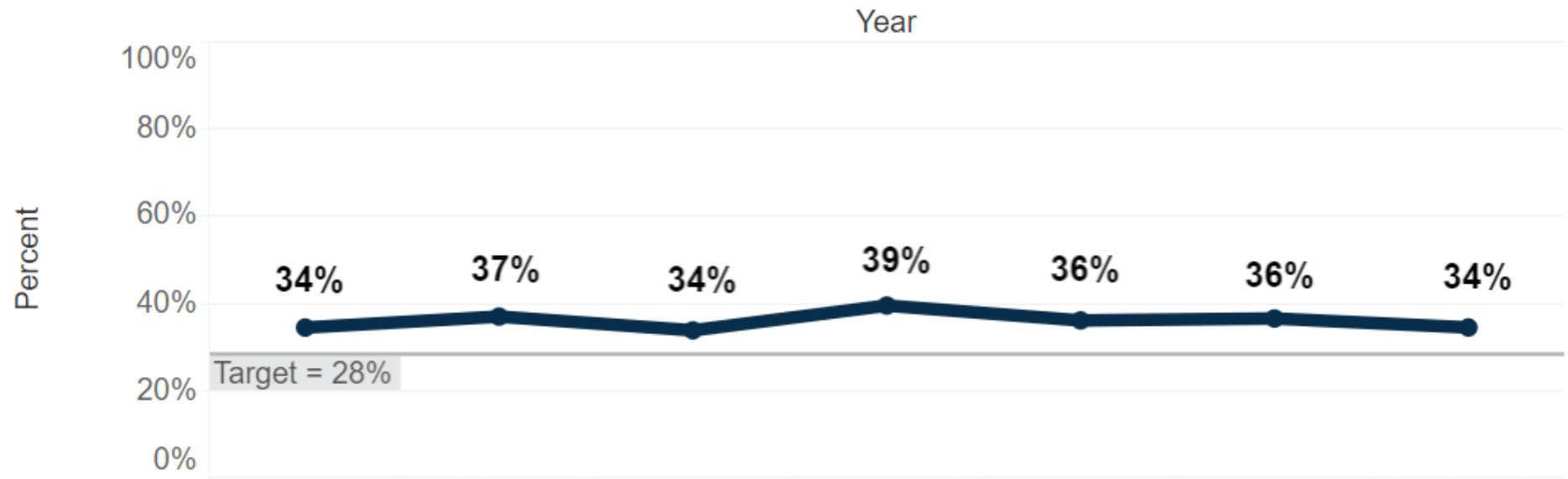
- Exclusions and exceptions:
  - Hospice during any part of the year
  - Palliative care during any part of the year
  - 66+ and living long term in a nursing home
  - 66-80 with an indication of frailty *and* have 1 inpatient visit, 2 outpatient visits, or taking dementia medications

Diabetes
UDS Results 2017-2023

What is a negative measure?

- For most measures, higher % = better, more patients are meeting the measure
- For diabetes, lower % = better → **fewer patients with *uncontrolled* diabetes** and **more patients with *controlled* diabetes**

Percentage of patients 18-75 years of age with DM who had HbA1c > 9 (negative measure)



	2017	2018	2019	2020	2021	2022	2023
Denominator	558	615	649	616	527	603	578
Numerator	191	226	218	242	189	219	198

Comparisons (2022)

National

30.4%

Washington State

23.0%

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Diabetes
by Race & Ethnicity

What is a negative measure?

- For most measures, higher % = better, more patients are meeting the measure
- For diabetes, lower % = better → **fewer patients with *uncontrolled* diabetes** and **more patients with *controlled* diabetes**

2023	Patients 18-75 with diabetes	HbA1c uncontrolled	% Met
Asian	22	7	32%
Native Hawaiian and Pacific Islander	7	1	14%
Black/African American	168	54	32%
American Indian and Alaska Native	16	4	25%
White	288	105	36%
More than one race	13	4	31%
Unreported race	64	23	36%
Hispanic, Latino/a, or Spanish Origin*	104	36	35%
Total	**578**	**198**	**34%**

*of any race

No significant disparities in overall performance by race and ethnicity in the last few years.

Communities to prioritize outreach & engagement efforts:

- Clients without an A1c measurement in the year
- Clients with uncontrolled diabetes (A1c over 9%)
- Clients living on the street (52%)

Diabetes
Discussion

- What factors or HCHN-specific context should be considered when reviewing performance on this measure?
- What strategies do we currently use to reach clients with diabetes?
- Can we use this data to adjust practices?
- What can the GC do to support?

Additional Resources

- 2023 UDS Manual (hrsa.gov)
- UDS Clinical Quality Measures 2023 (hrsa.gov)
- Health Center Program Uniform Data System (UDS) Data Overview (hrsa.gov)

Thank you!

Contact

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