2023 UDS Data Clinical Measures

HCHN Governance Council May 20, 2024

Lorraine Twohey-Jacobs, HCHN Data Manager



Agenda

- Provide an overview of UDS clinical measures
- Share 2023 results by race and ethnicity and trends over time for:
 - High Blood Pressure (Hypertension)
 - Diabetes
- Discussion
- Appendix: All other clinical measures (trends 2017-2023)



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

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



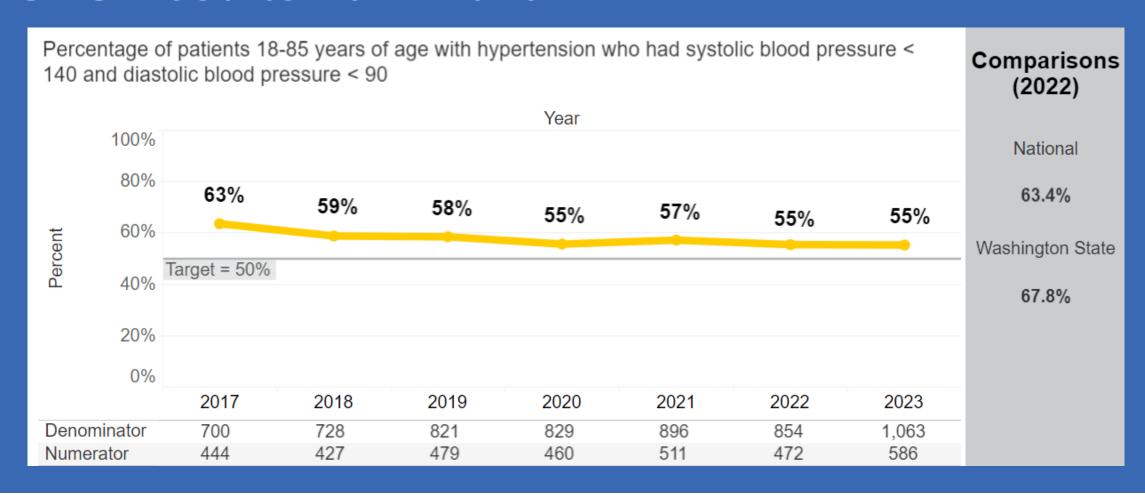
High Blood Pressure (Hypertension) Measure Criteria

- 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





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%

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%)



^{*}of any race

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.

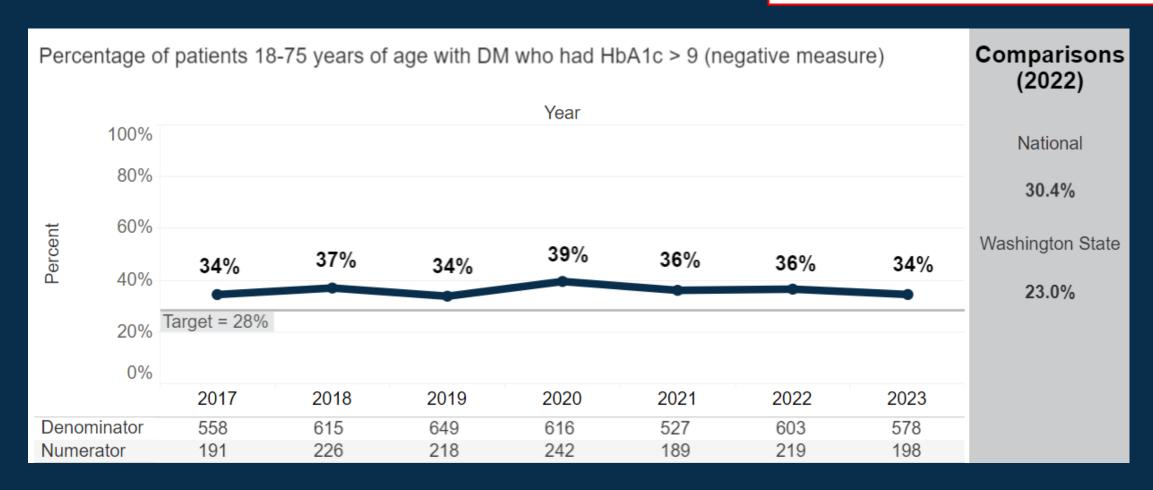
- Exclusions and exceptions:
 - Hospice during any part of the year
 - Palliative care during any part of the year
 - 66+ and living long term in a nursing home
 - 66-80 with an indication of frailty and have 1 inpatient visit, 2 outpatient visits, or taking dementia medications



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





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by I	Race	&	Ethnicity

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%

- 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

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%)



What is a negative measure?

^{*}of any race

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

Lorraine Twohey-Jacobs, HCHN Data Manager ltwoheyjacobs@kingcounty.gov

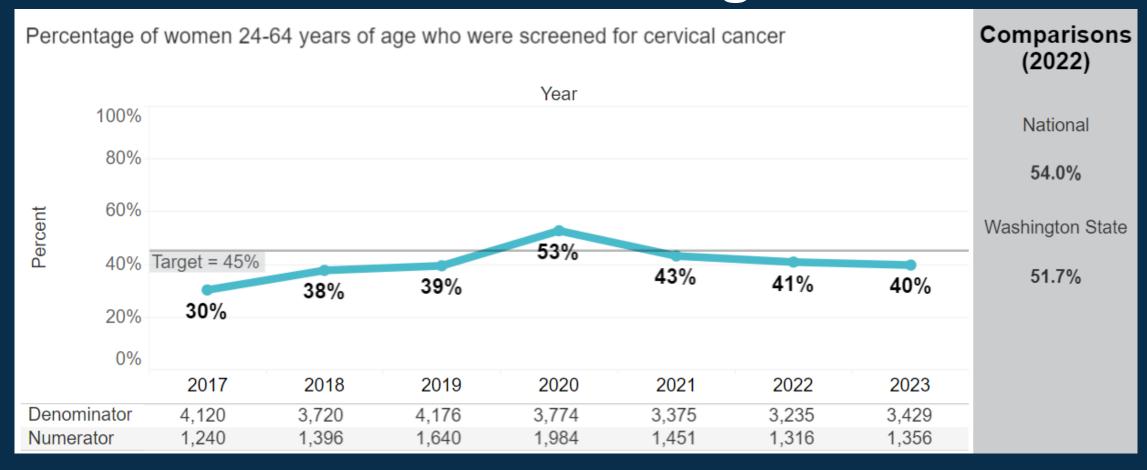


Appendix: UDS Clinical Measures

Screening and Preventive Care Measures

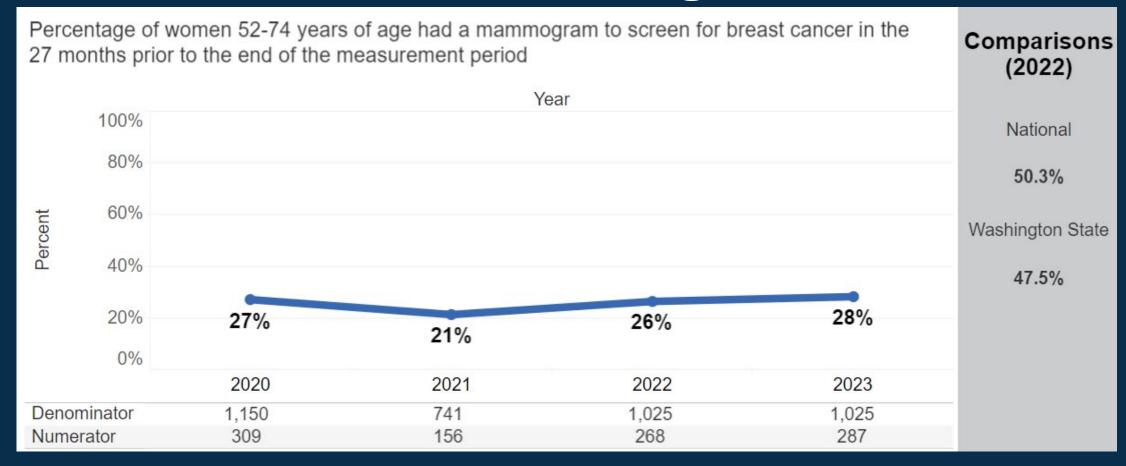


Screening and Preventive Care Cervical Cancer Screening



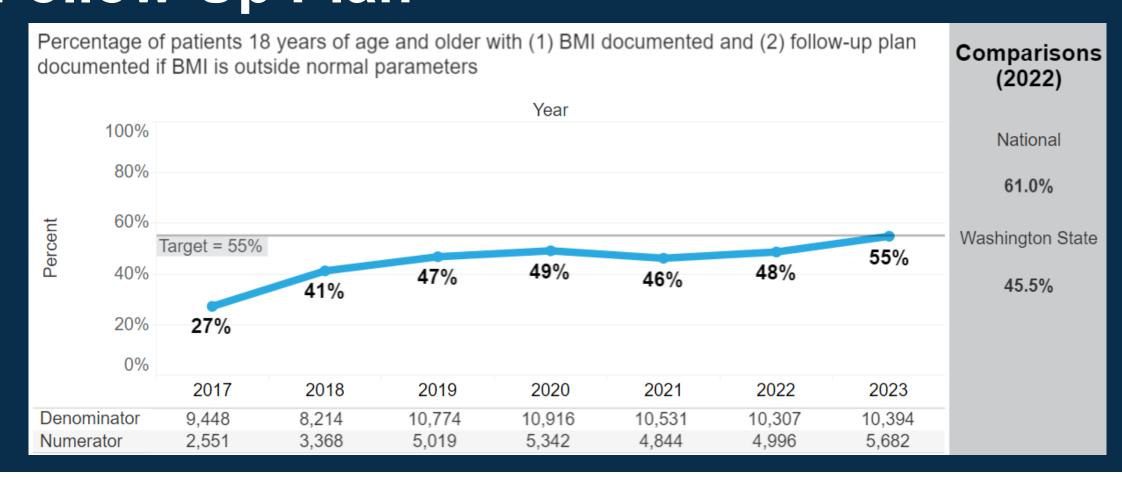


Screening and Preventive Care Breast Cancer Screening





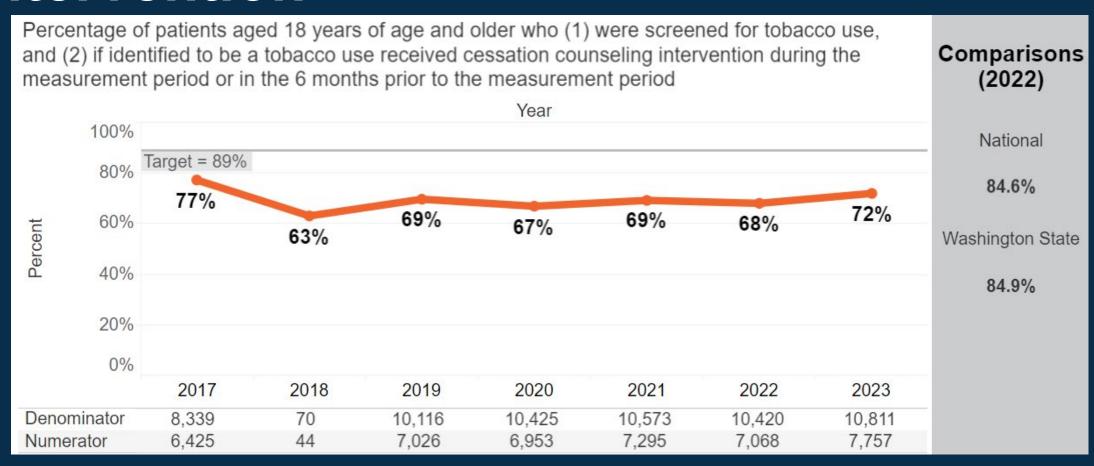
Screening and Preventive Care Body Mass Index (BMI) Screening and Follow-Up Plan





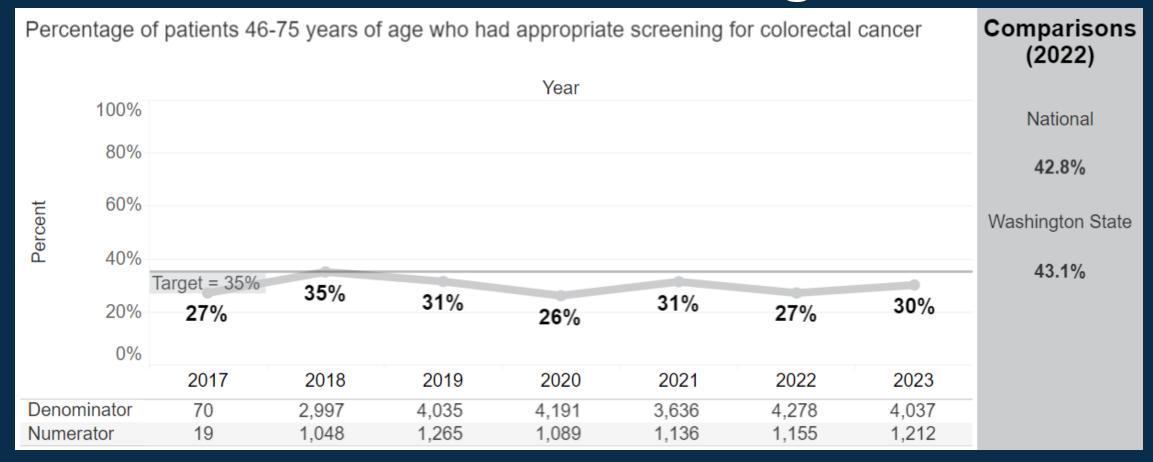
Screening and Preventive Care

Tobacco Use: Screening and Cessation Intervention



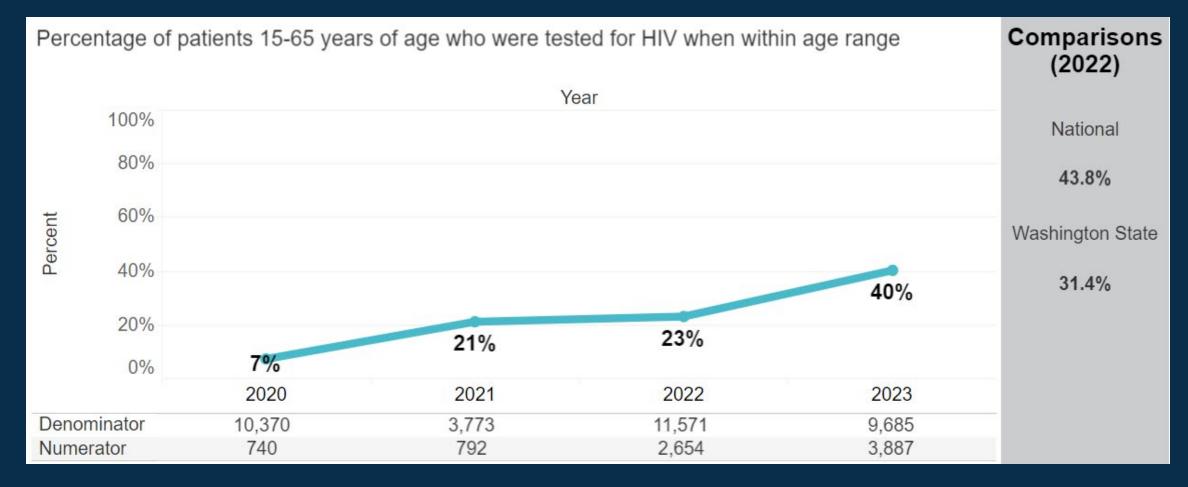


Screening and Preventive Care Colorectal Cancer Screening



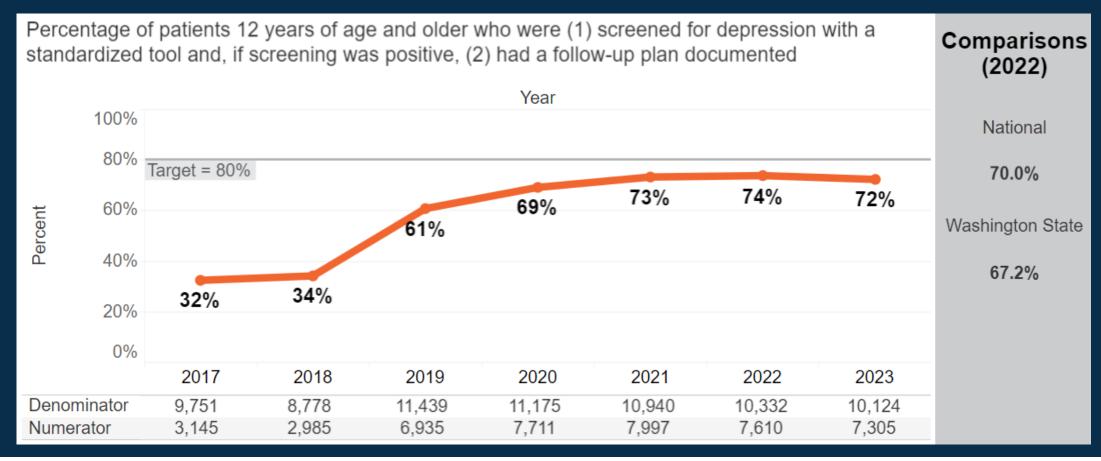


Screening and Preventive Care HIV Screening





Screening and Preventive Care Screening for Depression and FollowUp Plan



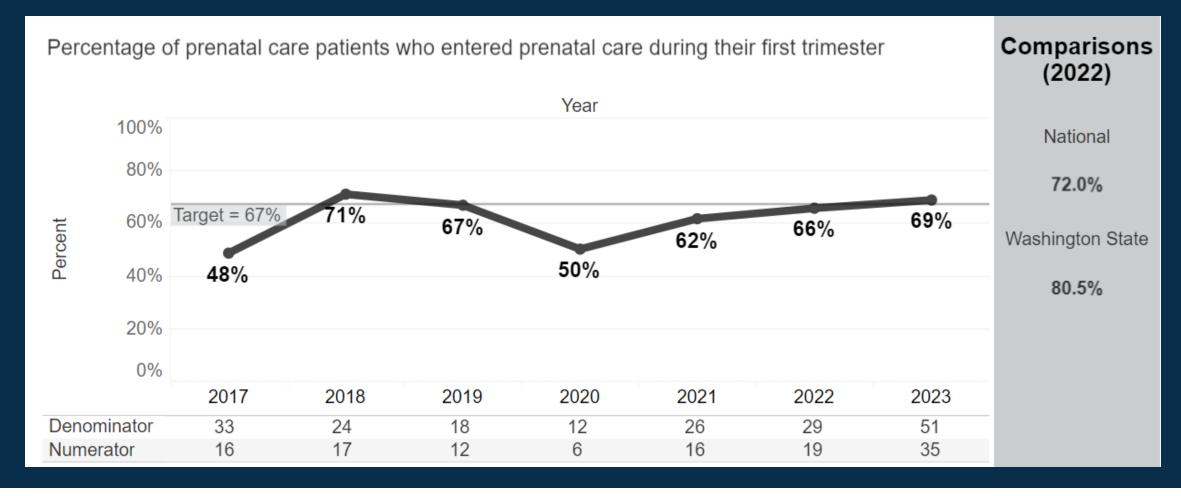


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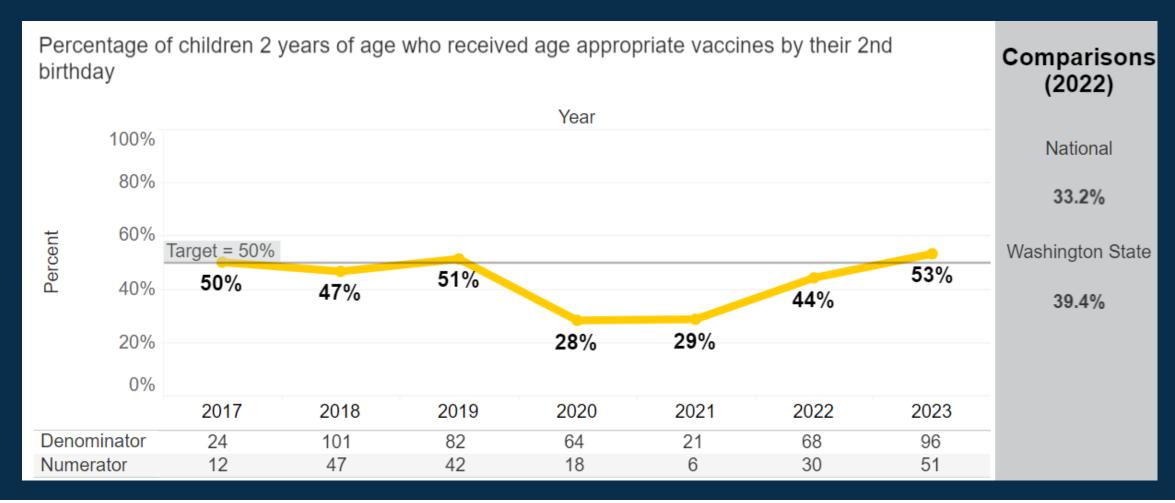
Maternal Care and Children's Health



Maternal Care and Children's Health Early Entry into Prenatal Care

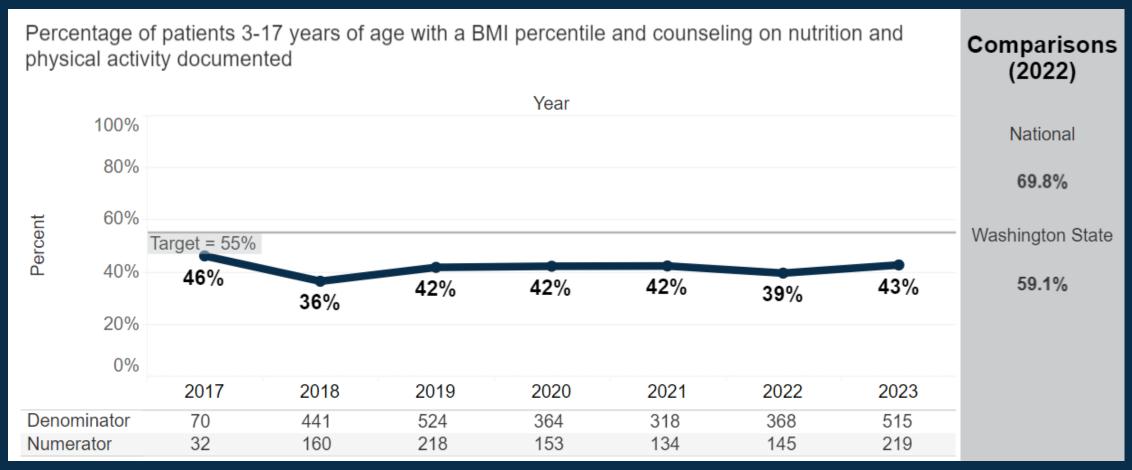


Maternal Care and Children's Health Childhood Immunization Status



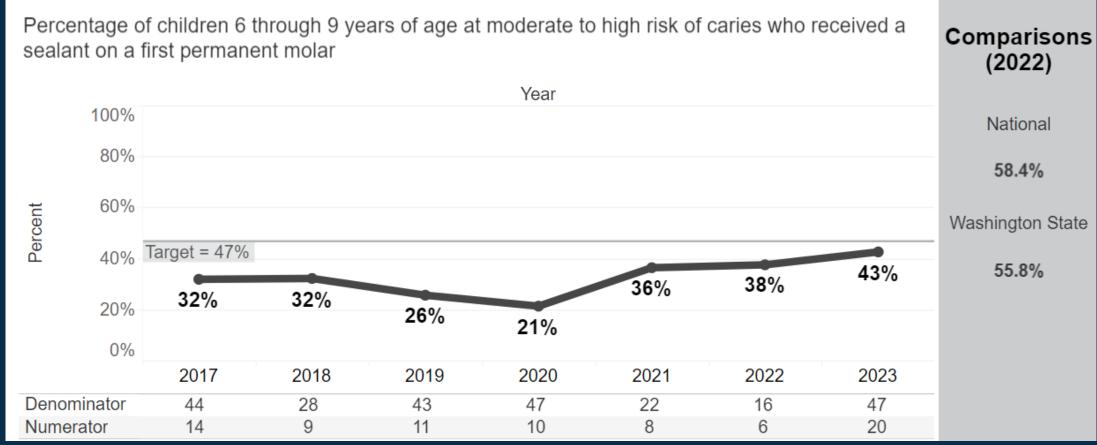


Maternal Care and Children's Health Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents



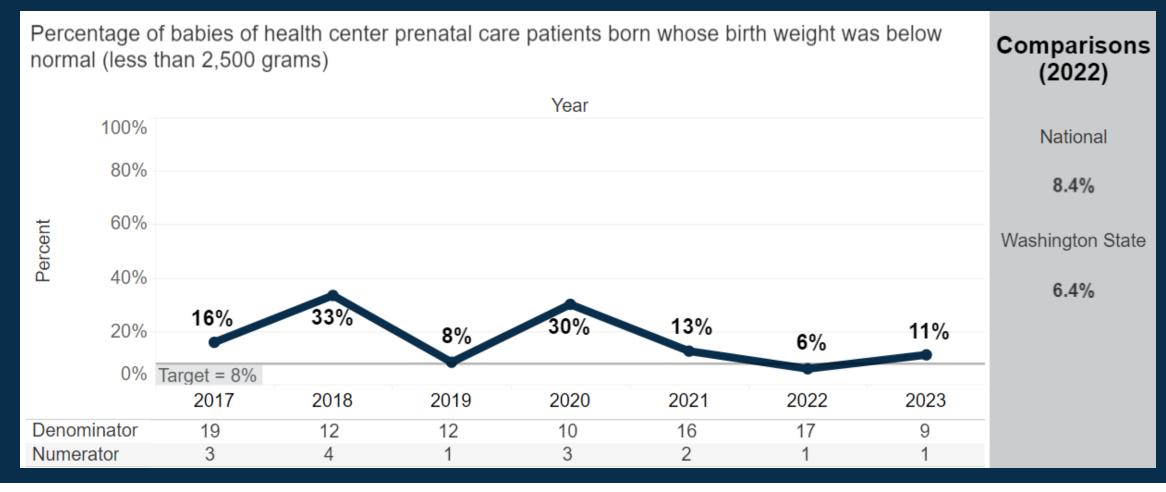


Maternal Care and Children's Health Dental Sealants for Children between 6 9 Years





Maternal Care and Children's Health Low Birth Weight





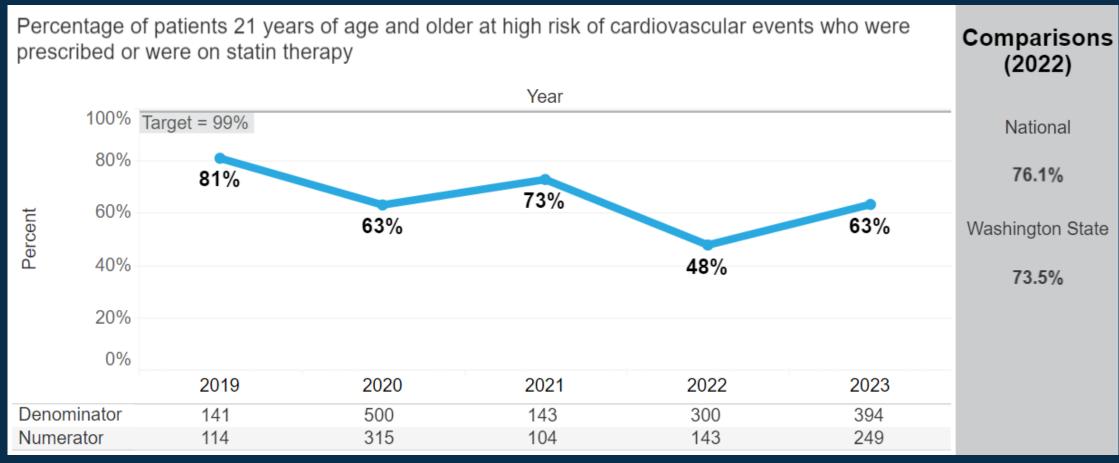
Appendix: UDS Clinical Measures

Disease Management



Disease Management

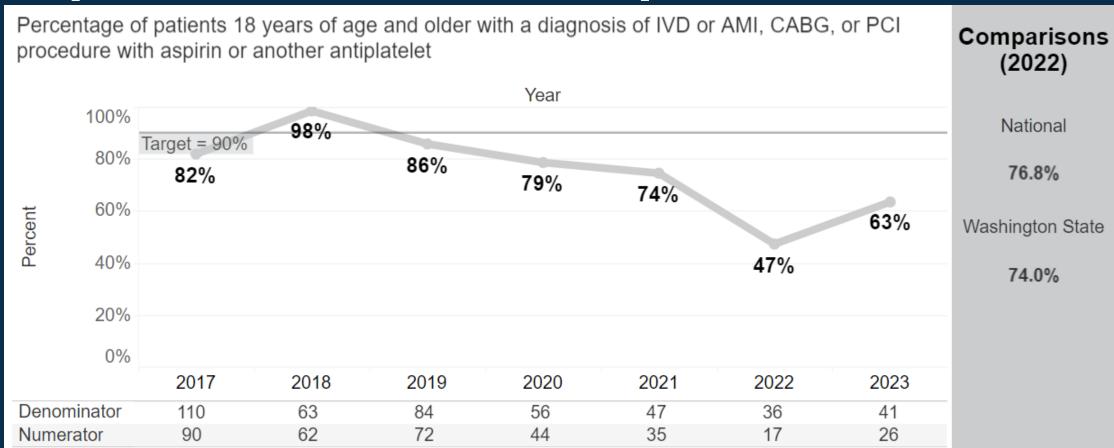
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease





Disease Management

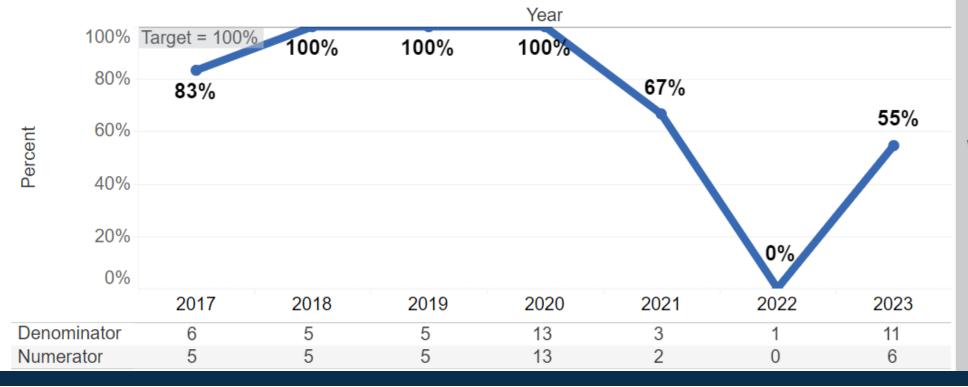
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet





Disease Management HIV Linkage to Care

Percentage of patients whose first-ever HIV diagnosis was made by health center staff between December 1 of the prior year and November 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis



Comparisons (2022)

National

82.2%

Washington State

71.5%



Disease Management Depression Remission at Twelve Months

