Changes to the UDS
For the 2019 Reporting Year

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June 11, 2019

Agenda

1. UDS resources and how to use them
2. Clinical Measure Changes
3. Other Changes

UDS Resources and How to Use Them

The Important Online Documents

Download the New UDS Manual and Other Resources

https://bphc.hrsa.gov/datareporting/reporting/index.html

Health Resources & Services Administration

HRSA Health Center Program

Program Requirements | Quality Improvement | Program Opportunities | Health Center Data

Home > Health Center Data > Uniform Data System (UDS) Resources

Uniform Data System (UDS) Resources

Each year, health center grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS). The UDS is a standardized reporting system that provides consistent information about health centers and look-alikes.

UDS Modernization

Learn more about UDS modernization efforts, which aim to reduce reporting burden, improve data quality and usage, and better reflect Health Center Program impact.

UDS Reporting Resources

Resources to assist health centers in collecting and submitting their data include UDS manuals, webinars, trainings, validations, crosswalks, and other technical assistance resources. Access the resources for each UDS reporting year below.

2019 UDS Resources

- 2019 UDS Tables (PDF - 885 KB)
- 2019 UDS Manual (PDF - 1.7 MB)

Download the 2019 manual and tables

- **Uniform Data System (UDS) Changes for Calendar Year (CY) 2019**
  The Program Assistance Letter (PAL) 2019-01 (PDF - 342 KB) provides an overview of approved changes to the Health Resources and Services Administration's CY 2019 UDS that is reported by Health Center Program awardees and look-alikes by February 15, 2020. Detailed information regarding these changes will be included in the 2019 UDS Manual.

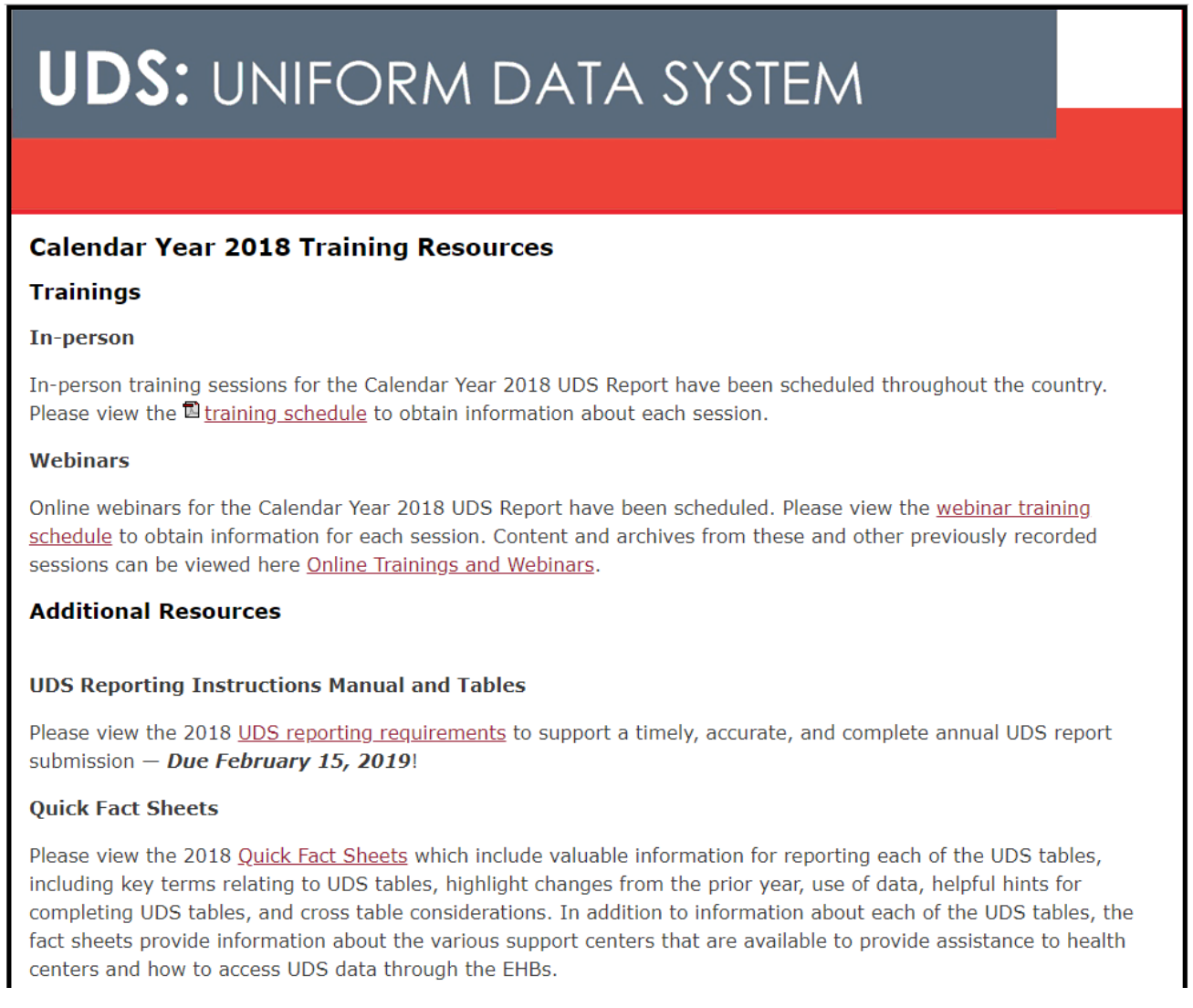
The PAL that lists the changes (we will discuss this later)

- **2019 Uniform Data System (UDS) Changes Webinar**
  May 9, 2019
  Presentation (PDF – 919 KB) | On Demand Webinar Recording

2019 changes presentation and webinar

UDS Training Website

http://www.bphcdata.net/html/bphctraining.html



UDS: UNIFORM DATA SYSTEM

Calendar Year 2018 Training Resources

Trainings

In-person

In-person training sessions for the Calendar Year 2018 UDS Report have been scheduled throughout the country. Please view the training schedule to obtain information about each session.

Webinars

Online webinars for the Calendar Year 2018 UDS Report have been scheduled. Please view the webinar training schedule to obtain information for each session. Content and archives from these and other previously recorded sessions can be viewed here Online Trainings and Webinars.

Additional Resources

UDS Reporting Instructions Manual and Tables

Please view the 2018 UDS reporting requirements to support a timely, accurate, and complete annual UDS report submission — ***Due February 15, 2019***!

Quick Fact Sheets

Please view the 2018 Quick Fact Sheets which include valuable information for reporting each of the UDS tables, including key terms relating to UDS tables, highlight changes from the prior year, use of data, helpful hints for completing UDS tables, and cross table considerations. In addition to information about each of the UDS tables, the fact sheets provide information about the various support centers that are available to provide assistance to health centers and how to access UDS data through the EHBs.

(Check back later…
only has 2018 info on it now)

UNIFORM DATA SYSTEM

Reporting Instructions for the 2019 Health Center Data

HRSA Health Center Program

For Reports Due by February 15, 2020

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Table 7

List of Official Changes (PAL 2019-01)

PROGRAM ASSISTANCE LETTER

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

DOCUMENT NUMBER: PAL 2019-01

DOCUMENT TITLE: Approved Uniform Data System Changes for Calendar Year 2019

DATE: March 18, 2019

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

I. Background

This Program Assistance Letter (PAL) provides an overview of approved changes to the Health Resources and Services Administration's (HRSA) calendar year (CY) 2019 Uniform Data System (UDS) to be reported by Health Center Program awardees and look-alikes in February 2020. Additional details regarding these changes will be included in the forthcoming 2019 UDS Manual.

II. Approved Changes for CY 2019 UDS Reporting

Technical Source of Measure Definitions

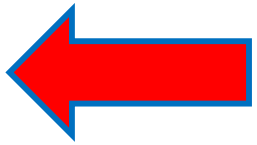
Page 1 of PAL 2019-01

"… the following clinical quality measures have been updated to align with the Center for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMS) designated for the 2019 reporting period …"

Technical Source of Measure Definitions

Page 2 of PAL 2019-01

1. Childhood Immunization Status has been revised to align with CMS117v7.
2. Cervical Cancer Screening has been revised to align with CMS124v7.
3. Tobacco Use Screening and Cessation Intervention has been revised to align with CMS138v7.
4. Use of Appropriate Medications for Asthma has been revised to align with CMS126v5.
5. Screening for Depression and Follow-Up Plan has been revised to align with CMS2v8.
6. Controlling High Blood Pressure has been revised to align with CMS165v7.
7. Diabetes: Hemoglobin A1c Poor Control has been revised to align with CMS122v7.
8. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents has been revised to align with CMS155v7.
9. Body Mass Index (BMI) Screening and Follow-Up Plan has been revised to align with CMS69v7.
10. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet has been revised to align with CMS164v7.
11. Colorectal Cancer Screening has been revised to align with CMS130v7.
12. Dental Sealants for Children Between 6 - 9 Years has been revised to align with CMS277.



Click on the blue text to go to the eCQI website

Reading the Technical Definition

eCQI RESOURCE CENTER

https://ecqi.healthit.gov/

Controlling High Blood Pressure

Last updated: May 16, 2019

CMS Measure ID:	CMS165v7
Version:	7
NQF Number:	0018
Measure Description:	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period
Initial Patient Population:	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period
Denominator Statement:	Equals Initial Population
Denominator Exclusions:	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period.
Numerator Statement:	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Numerator Exclusions:	Not Applicable

Scroll Down the Measure eCQI Webpage

Measure Steward: National Committee for Quality Assurance

Domain: Effective Clinical Care

Next Version: CMS165v8

Previous Version: CMS165v6

Measure Scoring: Proportion

Measure Type: Intermediate

Improvement Notation: Higher score indicates better quality

You can also see the definition from last year

Specifications

CMS165v7.html
CMS165v7.zip
CMS165v7_TRN.xlsx

More detail (see next slide)

Release Notes

List of changes (some impact our needs more than others)

Logic

- Removed the 'Face-To-Face Interaction' data element and added relevant SNOMED codes to the Encounter Grouping value sets to better align between the SNOMED and CPT encounter codes.

  Measure Section: Multiple Sections

  Source of Change: Measure Lead

Value Set

The VSAC is the source of truth for the value set content, please visit the VSAC for downloads of current value sets.

- Value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001): Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1264) including 7 codes.

Specifications

CMS165v7.html ← Webpage with detailed measure specifications

CMS165v7.zip

CMS165v7_TRN.xlsx

eCQM Title	**Controlling High Blood Pressure**
eCQM Identifier (Measure Authoring Tool)	165
NQF Number	0018
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	National Committee for Quality Assurance
Measure Developer	National Committee for Quality Assurance
Endorsed By	National Quality Forum
Description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Table of Contents

- Population Criteria
- Definitions
- Functions
- Terminology
- Data Criteria (QDM Data Elements)
- Supplemental Data Elements
- Risk Adjustment Variables

Terminology

- codesystem "LOINC" using "2.16.840.1.113883.6.1 version 2.63"
- codesystem "SNOMEDCT" using "2.16.840.1.113883.6.96 version 2017-09"
- code "Diastolic blood pressure" using "LOINC version 2.63 Code (8462-4)"
- code "Discharge to healthcare facility for hospice care (procedure)" using "SNOMEDCT version 2017-09 Code (428371000124100)"
- code "Discharge to home for hospice care (procedure)" using "SNOMEDCT version 2017-09 Code (428361000124107)"
- code "Systolic blood pressure" using "LOINC version 2.63 Code (8480-6)"
- valueset "Adult Outpatient Visit" using "2.16.840.1.113883.3.464.1003.101.12.1065"
- valueset "Annual Wellness Visit" using "2.16.840.1.113883.3.526.3.1240"
- valueset "Chronic Kidney Disease, Stage 5" using "2.16.840.1.113883.3.526.3.1002" Example
- valueset "Dialysis Services" using "2.16.840.1.113883.3.464.1003.109.12.1013"
- valueset "Encounter Inpatient" using "2.16.840.1.113883.3.666.5.307"
- valueset "End Stage Renal Disease" using "2.16.840.1.113883.3.526.3.353"
- valueset "ESRD Monthly Outpatient Services" using "2.16.840.1.113883.3.464.1003.109.12.1014"
- valueset "Essential Hypertension" using "2.16.840.1.113883.3.464.1003.104.12.1011"
- valueset "Ethnicity" using "2.16.840.1.114222.4.11.837"
- valueset "Home Healthcare Services" using "2.16.840.1.113883.3.464.1003.101.12.1016"
- valueset "Hospice care ambulatory" using "2.16.840.1.113762.1.4.1108.15"
- valueset "Kidney Transplant Recipient" using "2.16.840.1.113883.3.464.1003.109.12.1029"
- valueset "Kidney Transplant" using "2.16.840.1.113883.3.464.1003.109.12.1012"
- valueset "Office Visit" using "2.16.840.1.113883.3.464.1003.101.12.1001"
- valueset "ONC Administrative Sex" using "2.16.840.1.113762.1.4.1"
- valueset "Payer" using "2.16.840.1.114222.4.11.3591"
- valueset "Pregnancy" using "2.16.840.1.113883.3.526.3.378"
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" using "2.16.840.1.113883.3.464.1003.101.12.1025"
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" using "2.16.840.1.113883.3.464.1003.101.12.1023"
- valueset "Race" using "2.16.840.1.114222.4.11.836"
- valueset "Vascular Access for Dialysis" using "2.16.840.1.113883.3.464.1003.109.12.1011"

Data Criteria (QDM Data Elements)

- "Diagnosis: Chronic Kidney Disease, Stage 5" using "Chronic Kidney Disease, Stage 5 (2.16.840.1.113883.3.526.3.1002)"
- "Diagnosis: End Stage Renal Disease" using "End Stage Renal Disease (2.16.840.1.113883.3.526.3.353)"
- "Diagnosis: Essential Hypertension" using "Essential Hypertension (2.16.840.1.113883.3.464.1003.104.12.1011)"
- "Diagnosis: Kidney Transplant Recipient" using "Kidney Transplant Recipient (2.16.840.1.113883.3.464.1003.109.12.1029)"
- "Diagnosis: Pregnancy" using "Pregnancy (2.16.840.1.113883.3.526.3.378)"
- "Encounter, Performed: Adult Outpatient Visit" using "Adult Outpatient Visit (2.16.840.1.113883.3.464.1003.101.12.1065)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: ESRD Monthly Outpatient Services" using "ESRD Monthly Outpatient Services (2.16.840.1.113883.3.464.1003.109.12.1014)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Preventive Care Services -"Preventive Care Services - Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services-"Preventive Care Services-Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Intervention, Order: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Intervention, Performed: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Procedure, Performed: Dialysis Services" using "Dialysis Services (2.16.840.1.113883.3.464.1003.109.12.1013)"
- "Procedure, Performed: Kidney Transplant" using "Kidney Transplant (2.16.840.1.113883.3.464.1003.109.12.1012)"
- "Procedure, Performed: Vascular Access for Dialysis" using "Vascular Access for Dialysis (2.16.840.1.113883.3.464.1003.109.12.1011)"
- "Physical Exam, Performed: Diastolic blood pressure" using "Diastolic blood pressure (LOINC version 2.63 Code 8462-4)"
- "Physical Exam, Performed: Systolic blood pressure" using "Systolic blood pressure (LOINC version 2.63 Code 8480-6)"

These sections define the Value Sets used by the measure

The value sets themselves are lists of codes. These codes can be programmed into reports (Relevant, BridgeIT, etc.) so standard elements are pulled consistently and correctly

The Value Set files are quite large and are not readily available (you have to set up an account at the Library of Medicine to see them)

What Do the Value Sets Look Like?

Value Set Authority Center
U.S. National Library of Medicine

CMS ID	Value Set Name	Value Set OID	Code	Description	Code System
CMS165v7	Chronic Kidney Disease, Stage 5	2.16.840.1.113883.3.526.3.1002	N18.5	Chronic kidney disease, stage 5	ICD10CM
CMS165v7	Chronic Kidney Disease, Stage 5	2.16.840.1.113883.3.526.3.1002	585.5	Chronic kidney disease, Stage V	ICD9CM
CMS165v7	Chronic Kidney Disease, Stage 5	2.16.840.1.113883.3.526.3.1002	433146000	Chronic kidney disease stage 5 (disorder)	SNOMEDCT

- The Value Set file is an Excel Workbook that contains lists of codes that can be filtered
- You can look up the value set name or OID code listed in the measure definition
- In the example above, there is one ICD-9 code, one ICD-10 code, and one SNOMEDCT code for the Value Set Chronic Kidney Disease.

Use of Value Sets

- In Relevant and BridgeIT, we use codes to define diagnosis (ICD codes), procedures (CPT codes), labs (LOINC codes) and vaccines (CVX codes).

- We would like to add medications (RXNORM codes) and medical concepts and terminology (SMOMED). However, this will take some planning because not all of these codes appear in the standard configurations of electronic health records

When Value Sets Are Not Used

There is potentially more manual work that must be done to align reports with measure definitions

For example, with medications:

1. eCW health centers must assign medications to med groups and periodically ensure the accuracy of those lists. Reports in BrigeIT/Relevant pull medications by med group.
2. NextGen health centers have medication name wild-cards built into the Relevant reports. These must be periodically reviewed.

Other Specification Items on the Measure eCQI Webpage

Copy of the webpage and also definitions that can be read by certain software

List of Header and Logic changes
(same as on the webpage)

Value Set Differences 2018 to 2019

UDS Measure (With eCQM)	CPT	ICD	LOINC	CVX
Childhood Immunization Status	Yes	Yes	No	Yes
Cervical Cancer Screening			Yes	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children	No	Yes		
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	No	Yes		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	No			
Use of Appropriate Medications for Asthma		No		
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		No	No	
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet		No		
Colorectal Cancer Screening		Yes	No	
Preventive Care and Screening: Screening for Depression and Follow-Up Plan		Yes		
Dental Sealants for Children between 6-9 Years	No			
Controlling High Blood Pressure	Yes	Yes		
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent)		No	No	

- Green shading: measure uses Value Set for the codes in the column heading
- “Yes” means there was a change from 2018 to 2019
- “No” means no change

Impact of Value Set Changes to Relevant Reports

- Transformers or Importers for the 2019 Relevant Quality Measures should link directly to the Value Set file, where applicable
- For example, SELECT diagnosis codes FROM the patient problem list WHERE the diagnosis code on the Problem List = the Value Set diagnosis codes for Essential Hypertension
- Therefore, each year, the Value Set file is replaced, instead of going through all the Transformers or Importers and replacing individual codes in the SQL itself
- Value Set changes generally do not impact the measure percentage greatly. Nonetheless, we should ensure accuracy as much as possible by always using the most current Value Set

Clinical Measure Changes

One Clinical Change to the 2019 UDS,

Not Including Changes to Value Sets

2019 Clinical Measure List

eCQM	Measure Name	Comment
--	Early Entry into Prenatal Care	no eCQM
CMS117v7	Childhood Immunization Status	
CMS124v7	Cervical Cancer Screening	
CMS155v7	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	
CMS69v7	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	
CMS138v7	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	
CMS126v5	Use of Appropriate Medications for Asthma	2018 Version
CMS347v2	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	New
CMS164v7	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	
CMS130v7	Colorectal Cancer Screening	
--	HIV Linkage to Care	no eCQM
CMS2v8	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	
CMS277v0	Dental Sealants for Children between 6-9 Years	2018 Version
--	Low Birth Weight	no eCQM
CMS165v7	Controlling High Blood Pressure	
CMS122v7	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent)	

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

- The old measure, “Coronary Artery Disease (CAD): Lipid Therapy (Line 17)” is no longer reported. There was no eCQM for it.
- For those health centers that are part of the ACO, this new measure is the same as the ACO statin therapy measure (PREV-13)

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			

CVD Statins: Denominator Definition

The denominator is composed of three populations:

1. Patients aged 21 years or older with a diagnosis of arteriosclerotic cardiovascular disease (ASCVD).
2. Patients aged 21 years or older with a diagnosis of hypercholesterolemia or an LDL-C lab value equal to or greater than of 190 mg/dL ever in the past.
3. Patients aged 40 through 75 years with a diagnosis of diabetes and the highest LDL-C lab value in the past three years between 70–189 mg/dL.

CVD Statins: Denominator Exclusions

Patients are excluded from the measure if they:

- Had a medical reason for not taking statins (pregnant, breastfeeding or an allergy to the medication)
- Had diabetes and age 40 to 75 years, with a low LDL value (under 70 mg/dL) as the most recent value
- Had a diagnosis of rhabdomyolysis, active liver disease, hepatic disease or insufficiency (including hepatitis A or B), end-stage renal disease (ESRD), or receiving palliative care.

CVD Statins: Numerator Definition

Denominator patients using a statin medication in the past year

Other Changes

Non-Clinical Changes to the 2019 UDS

Table 4, Homeless Section (330H Health Centers Only)

Table 4: Selected Patient Characteristics (continued)

Reporting Period: January 1, 2019, through December 31, 2019

Line	Special Populations	Number of Patients (a)
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21a	Permanent Supportive Housing (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report this line)	

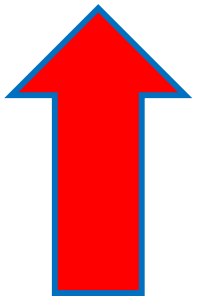
New row

Table 5: Addition of Virtual Visits Column

Table 5: Staffing and Utilization

Reporting Period: January 1, 2019, through December 31, 2019

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)



New Column

Definition: “Virtual visits must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.”

Addendum to Table 5

Table 5: Selected Service Detail Addendum

Reporting Period: January 1, 2019, through December 31, 2019

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Addendum to Table 5

Two parts:

1. A break-out of mental health services by medical providers
2. A break-out of substance abuse services by medical providers and mental health providers

Addendum to Table 5

- The lines on Table 5 continue to be reported as in other years. The addendum is an additional table.
- The addendum displays services (personnel, visits and patients) that are NOT reported in the mental health and substance abuse lines of the main Table 5 (lines 20a through 21).
- This is because the mental health and substance abuse services were performed by other providers. Therefore, the services in the addendum are already counted on other lines of the main Table 5.
- There will be duplication because one patient with one visit could have medical, mental health and substance abuse issues. The addendum allows for duplication.

Addendum to Table 5: Breakouts

To define the services for each Major Service Category, refer to the diagnosis codes on Table 6A

Mental Health Service Detail (lines 20a through 20d) for medical providers. Use codes from Table 6A lines:

- Line 20a: Depression and other mood disorders
- Line 20b: Anxiety disorders, including post-traumatic stress disorder (PTSD)
- Line 20c: Attention deficit and disruptive behavior disorders
- Line 20d: Other mental disorders, excluding drug or alcohol dependence

Addendum to Table 5: Breakouts

Substance Use Disorder Service Detail (lines 18 through 19a) for medical providers and mental health providers. Use codes from Table 6A lines:

- Line 18: Alcohol-related disorders
- Line 19: Other substance-related disorders
- Line 19a: Tobacco use disorder

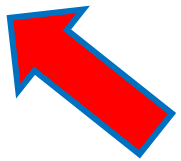
NOTE on Table 6A Diagnostic and Procedure Codes

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2019, through December 31, 2019

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		
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		



These codes are sometimes updated. There will be a new version of the manual later in the year, if necessary

Table Removed: Table 5A, Tenure for Health Center Staff

Table 5A: Tenure for Health Center Staff

Reporting Period: January 1, 2018, through December 31, 2018

Line	Health Center Staff	Full- and Part-Time		Locum, On-Call, etc.	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)

Appendix D: Health Center Health Information Technology (HIT) Capabilities

- Some questions added or revised
- 2018: 9 questions
- 2019: 12 questions

New Appendix F: Workforce

- Six questions
- Questions and a table on the health center's role in the health professional education/training process
- Questions on the implementation of satisfaction surveys about providers and general staff

Questions?