

SFY 2023 Community Health Grants Quarter Two Report

SFY 2023 Quarter Two (July 1, 2022 - December 31, 2022)

Welcome to the Quarter Two Performance Measure Report for your organization's SFY 2023 Community Health Grant.

If you have any questions regarding the survey, please contact your grant monitor.

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- 1) Enter the FIRST and LAST NAME of the employee who compiled the performance data for this report and certifies that the performance measurements are accurate, complete and collected according to the contract terms and conditions.

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- 2) Enter the email address for the employee who compiled the performance data for this report.

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- 3) Enter the phone number for the employee who compiled the performance data for this report.

4) Grantee Organization: Pick your organization and contract number listed in the drop down box: (Select your Organization's Name from the list. Note the contract number in parentheses.)

- Advocates for Healthy Citizens dba HealthNet Gaston (44230)
- Albemarle Hospital Foundation, Inc. (44484)
- Alliance Medical Ministry, Inc. (44597)
- Bakersville Community Medical Clinic, Inc. (44424)
- Bladen Healthcare LLC dba Cape Fear Valley (44294)
- Blue Ridge Community Health Services, Inc. (44258)
- Blue Ridge Community Health Services, Inc. (44426)
- Cabarrus Health Alliance (44517)
- Camino Community Development Corporation (44506)
- Campbell University, Inc. (44473)
- Cape Fear Clinic, Inc. (44256)
- Care Ring, Inc. (44508)
- Carolina Family Health Centers, Inc. (44388)
- Coastal Horizons Center, Inc. (44308)
- Coastal Horizons Center, Inc. (44487)
- Columbus County Health Department (44282)
- Community Care Center of Forsyth County, Inc. (44550)
- Community Care Clinic of Dare (44497)
- Community Care Clinic of Rowan County (44302)
- Community Free Clinic (44510)
- Community Health Services of Union County (44321)
- County of Beaufort, Beaufort County Health Department (44596)
- County of Clay, Clay County Local Health Department (44259)
- County of Duplin, Duplin County Health Department (44576)
- County of Lee (44529)
- County of Sampson, Sampson County Local Health Department (44472)
- County of Wake, Wake County Human Services (44414)
- Davidson Medical Ministries Clinic, Inc. (44261)
- Duke University Health System, Inc. (44398)
- East Carolina University for its Department of Childrens Health in the School of Medicine (44297)
- Family Service of the Piedmont, Inc. (44343)
- FHPG, LLC (44296)
- FirstHealth of the Carolinas, Inc. (44480)
- Free Clinic of Rockingham County, Inc. (44539)
- Good Samaritan Clinic, Inc. (44425)
- Granville-Vance District Health Department (44404)
- Granville-Vance District Health Department (44560)
- Greater Hickory Cooperative Christian Ministry (44514)
- H.O.P.E. Regional Medical Center (44371)
- Healing with Caare, Inc. (44421)
- Health Reach Community Clinic, Inc. (44322)
- Helping Hands Clinic, Inc. (44260)
- Henderson County Free Medical Clinic, Inc. (44263)
- Henderson County Free Medical Clinic, Inc. (44317)
- Hyde County Health Department (44581)
- Jones County Health Department (44562)
- Kinston Community Health Center, Inc. (44540)
- Matthews Free Medical Clinic (44742)
- Medical Resource Center for Randolph County, Inc. (MERCE Family Healthcare) (44546)
- Metropolitan Community Health Services, Inc. (AGAPE) (44419)
- Moore Free and Charitable Care Clinic, Inc. (44471)
- Mountain Area Health Education Center (44428)
- Mustard Seed Community Health (44352)
- NeighborHealth Center, Inc. (44353)
- New Hope Clinic, Inc. (44281)
- Novant Health New Hanover Regional Medical Center (44312)
- Onslow Community Outreach, Inc. (44437)
- Opportunities Industrialization Center (44427)
- Pender Alliance for Teen Health (PATH) (44495)
- Piedmont Health Services, Inc. (44549)
- Presbyterian Hospital Foundation (44265)
- RAO Community Health (44292)
- Roanoke-Chowan Community Health Center, Inc. (44438)
- Roanoke-Chowan Community Health Center, Inc. (44502)
- Robeson County Department of Public Health (44278)
- Rural Health Group (44600)

- Samaritan Health Center, Inc. (44569)
- School Health Alliance for Forsyth County (44373)
- School Health Alliance for Forsyth County (44509)
- Scotland Community Health Clinic, Inc. (44303)
- Shepherds Care (44554)
- St. Luke's Hospital, Inc dba Fotthills Medical Associates (44305)
- St. Luke's Hospital, Inc dba Fotthills Medical Associates (44324)
- Surry County Health & Nutrition Center (44408)
- The C.W. Williams Community Health Center, Inc. (44336)
- The C.W. Williams Community Health Center, Inc. (44531)
- The Center for Rural Health Innovation (44333)
- The Center for Rural Health Innovation (44422)
- Cabarrus Health Alliance (44326)
- Cabarrus Health Alliance (44276)
- Cabarrus Health Alliance (44517)
- The Shalom Project, Inc. (44570)
- UNC Rockingham Health Care, Inc. (44561)
- UNC Rockingham Health Care, Inc. dba Rockingham County Student Health Centers (44410)
- UNC-CH Dept. of Family Medicine (44378)
- Urban Ministries of Wake County, Inc. (44575)
- Wake Forest University Health Sciences (DEAC) (44413)
- Wake Forest University Health Sciences (44415)
- Wayne Health Foundation, Inc. (WATCH) (44500)
- Wayne Initiative for School Health (WISH) (44401)
- Wayne Initiative for School Health (WISH) (44555)
- Western NC Community Health Services, Inc. (44306)
- Western NC Community Health Services, Inc. (44526)
- Wilkes County Local Health Department (44412)
- Wilkes County Local Health Department (44418)
- Wilkes County Local Health Department (44530)

Encounters

Guidance for Encounter Types

In-Clinic/In-Person Encounters Virtual/Telemedicine Encounters

Visits that occurred in-person at the clinic You can count group visits. You can count care coordination visits. Only count virtual/telemedicine visits provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient. Report virtual/telemedicine visits where: The health center provider virtually provided care to a patient who was elsewhere (i.e., not physically at their health center). The health center authorized patient services by a non-health-center provider or volunteer provider who provided care to a patient who was at the health center through telemedicine, and the health center paid for the services. (Do not report a clinic visit.) A provider who was not physically present at the health center provided care to a patient, if this is consistent with their scope of project. The provider would need access to the health center's HIT/EHR to record their activities and review the patient's record. Interactive, synchronous audio and/or video telecommunication systems permitting real-time communication between the provider and a patient were used. Do not count other modes of telemedicine services (e.g., store and forward, remote patient monitoring, mobile health) or provider-to-provider consultations. The visit is coded and charged as telehealth services, even if third-party payers may not recognize or pay for such services. Generally, these charges would be comparable to a clinic visit charge. Do not count as a virtual visit, situations in which the health center does not pay for virtual services provided by a non-health center provider (referral). Remember that Telemedicine is a growing model of care delivery. State and federal telehealth definitions and regulations regarding the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are not applicable in determining virtual visits here.

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- 1) How many virtual/telemedicine patient encounters took place during the reporting period, 07/01/2022 - 12/31/2022? Do not use commas when entering numbers.

- 2) How many in-clinic patient encounters took place during the reporting period, 07/01/2022 - 12/31/2022? Do not use commas when entering numbers.

- 3) TOTAL ENCOUNTERS REPORTED (in-clinic +virtual):

(This is the total of your virtual and in-clinic patient visits.)

-
- 4) Describe how you pulled data for patient encounters.

Patients Served

-
- 1) What is the total number of unduplicated patients served during the reporting period, 07/01/2022 - 12/31/2022? Patients are individuals who have had at least one visit during the reporting period. For example, if a patient is seen five times during the reporting period of 07/01/2022 - 12/31/2022 that patient is counted ONLY ONCE. Do not use commas when entering numbers.

Value reported cannot exceed the total number of clinic visits reported: [visits_total]

- 2) Describe how you pulled data for patients served:

Hypertension

Controlling High Blood Pressure

Definition: Percentage of patients 18-85 years old who had a diagnosis of Hypertension (HTN) overlapping the reporting period and whose most recent Blood Pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the reporting period. (For more information refer to UDS 2022 Manual pages 121-123. To access the online UDS manual click [here](#) or see attachment below. Note that ORH uses a different reporting period than the UDS.)

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension (who were diagnosed at least six months before the end of the reporting period) and had a medical visit during the reporting period.

Numerator: Patients 18-85 years old who had a diagnosis of hypertension and whose blood pressure at the most recent visit is adequately controlled during the reporting period. Adequate control is defined as systolic blood pressure lower than 140 mm Hg and diastolic blood pressure lower than 90 mm Hg. (Patients who have not had their blood pressure tested during the reporting period are not counted in the numerator.)

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. Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Exclude patients 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior. Patients who received palliative care during the measurement period

Guidance:

Note that this is a "positive" measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure. Adequate control is defined as systolic Blood Pressure lower than 140 mm Hg AND diastolic blood pressure lower than 90 mm Hg. Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis. Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit. Only blood pressure readings performed by a provider or remote monitoring device are acceptable for the numerator criteria with this measure. Blood pressure readings are acceptable if: taken in person by a clinician, measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician, or taken by a remote monitoring device and conveyed by the patient to the clinician. If no blood pressure is recorded during the reporting period, the patient's blood pressure is assumed "not controlled" and isn't counted in the numerator. If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. DO NOT include blood pressure readings: taken during an acute inpatient stay or emergency department visit; taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure (with the exception of fasting blood tests); or taken by the patient using a non-digital device, such as a manual blood pressure cuff and stethoscope.

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- 1) What is the number of total unduplicated patients served, 18-85 years of age, during the reporting period, 7/1/2022 to 12/31/2022? Value reported cannot exceed the total number of unduplicated patients served: [pts_served]

Patients are individuals who have at least one visit during the reporting period. For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022 that patient is counted ONLY ONCE. Do not use commas when entering numbers.

2) Of the [pts_18to85] patients reported in the question above, how many were diagnosed with essential hypertension?

DO NOT INCLUDE the following patients (these patients will be excluded from the performance measure):

Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Patients with a diagnosis of pregnancy during the measurement period. Patients whose hospice care overlaps the measurement period. Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Patients 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior. Patients who received palliative care during the measurement period

Do not use commas when entering numbers.

3) Of the [pts_htn_d] patients with hypertension reported above, how many had their blood pressure adequately controlled at the most recent visit during the reporting period of 7/1/2022-12/31/2022?

Adequate control is defined as systolic Blood Pressure lower than 140 mm Hg AND diastolic blood pressure lower than 90 mm Hg. Patients who have not had their blood pressure tested during the reporting period will be considered to NOT be adequately controlled (and therefore not included in this number). Note that this is a "positive" measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure.

Do not use commas when entering numbers.

4) This is the percentage you are reporting for the measure "Controlling High Blood Pressure". %

5) Discuss any challenges or successes in meeting your contract's hypertension performance measures within the reporting period (7/1/2022-12/31/2022) in the comment box below.

Diabetes

Diabetes: Hemoglobin A1c Poor Control

Definition: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the reporting period (or who had no test conducted during the reporting period).

Denominator: Patients 18-75 years of age with a medical visit during the reporting period who have a diagnosis of Type 1 or Type 2 diabetes. It does not matter if diabetes was treated, or is currently being treated, or when the diagnosis was made. The notation of diabetes may appear during or prior to the reporting period.

Numerator: Patients whose most recent hemoglobin A1c level during the reporting period is greater than 9.0 percent OR who had no test conducted during the reporting period OR whose test result is missing.

Exclusions: Exclude patients who were in hospice care for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior. Exclude patients who received palliative care during the measurement period.

Guidance:

Even if the treatment of the patient's diabetes has been referred to an outside provider, your organization is expected to have the current lab test results in its records. Note that this is a "negative" measure. For this measure, the lower the number of adult diabetics with poorly controlled diabetes, the better the performance on the measure. Also note that unlike the Hypertension measure, this measure calls for reporting on patients with diabetes regardless of when they were first diagnosed. Only include patients with an active diagnosis of Type 1 or Type 2 diabetes. DO NOT include patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) in the denominator. For more information refer to UDS 2022 Manual pages 123-124. To access the online UDS manual click [here](#) or see the attached file below. Note that ORH uses a different reporting period than the UDS.

- 1) What is the total number of unduplicated patients served, 18-75 years of age, during the reporting period? The reporting period is from the beginning of the contract until the end of the quarter, 7/1/2022 to 12/31/2022.

Patients are individuals who have at least one visit during the reporting period

For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022, that patient is counted ONLY ONCE. Number reported cannot exceed the number of unduplicated patients served: [pts_served] Do not use commas when entering numbers.

- 2) Of the [pts_18to75] unduplicated patients served, 18-75 years of age, reported in the question above, how many have a diagnosis of Type 1 or Type 2 diabetes?

EXCLUDE the following patients:

Patients with gestational diabetes during the reporting period. Patients with steroid-induced diabetes during the reporting period. Patients with a diagnosis of secondary diabetes due to another condition during the reporting period.

Do not use commas when entering numbers.

3) Of the [pts_diab_d] patients with diabetes reported in question above, how many met at least ONE of the following criteria during the reporting period of 7/1/2022 - 12/31/2022:

Had their most recent hemoglobin A1c level GREATER THAN 9.0 percent (HbA1c>9.0) during the reporting period
OR Had no hemoglobin A1c level test conducted during the reporting period OR

Their hemoglobin A1c level test during the reporting period was missing
Do not use commas when entering numbers.

4) This is the percentage you are reporting for the measure "Diabetes: Hemoglobin A1c Poor Control". % _____

5) Discuss any challenges or successes in meeting your contract's diabetes performance measures within the reporting period (7/1/2022-12/31/2022) in the comment box below.

Tobacco Screening

Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention

Definition: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within reporting period and received tobacco cessation intervention if identified as a tobacco user.

*For more information refer to UDS 2022 Manual pages 98-99. To access the online UDS manual click [here](#) or the attached file. Note that ORH uses a different reporting period than the UDS.

Denominator: All patients aged 18 years and older seen for at least two visits in the reporting period OR at least one preventive visit during the reporting period.

Numerator: Patients who were screened for tobacco use at least once within 12 months AND, if identified as a tobacco user, received tobacco cessation intervention. INCLUDE in the numerator those patients with a negative screening AND those patients with a positive screening who had cessation intervention if a tobacco user. Tobacco Cessation services can be utilized through telehealth services.

NOTE that the numerator is meant to include patients screened who are not tobacco users as well as those patients screened who are tobacco users that receive cessation intervention. If the screened patient is a tobacco user and did not receive cessation intervention they are not counted in the numerator.

Exclusion (excluded from Denominator and Numerator): Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

Guidance:

The tobacco use screening and tobacco cessation intervention DO NOT need to be performed by the same provider. Include in the numerator patients with a negative screening and those with a positive screening who had cessation intervention if a tobacco user. If patients use any type of tobacco, except electronic cigarettes, (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention (counseling and/or pharmacotherapy). Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure. If a patient has multiple tobacco use screenings during the reporting period, use the most recent screening which has a documented status of tobacco user or non-user. If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers. If the patient does not meet the screening component of the numerator but has an allowable medical exception, remove the patient from the denominator. The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention data elements. If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user. Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within reporting period. Include patients who receive tobacco cessation intervention, including: Received tobacco use cessation counseling services, -OR- Received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, -OR- Are on (using) a tobacco use cessation agent.

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- 1) What is the total number of unduplicated patients, age 18 and older, that were seen for at least two visits during the reporting period OR for at least one preventive visit during the reporting period, 7/1/2022 to 12/31/2022?

Exclude patients who have a documented medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).

Value reported cannot exceed the number of unduplicated patients served: [pts_served]

Do not use commas when entering numbers.

2) Of the [pts_tobacco_d] patients reported in question above, how many were screened for tobacco use at least once in the last two years AND meet the following criteria:

Patient is not a tobacco user

OR Patient is a tobacco user and received tobacco cessation intervention Reporting period covers 07/01/2022 to 12/31/2022. This is a positive measure is meant to capture patients who are appropriately screened for tobacco use. Appropriate screening would mean offering cessation intervention to tobacco users. A tobacco user who is screened and not offered cessation intervention would not be included here.

Do not use commas when entering performance measure numbers.

3) This is the percentage you have reported for your organization's Tobacco Cessation measure: _____

4) Discuss any challenges or successes in meeting your contract's tobacco performance measures within the reporting period (07/1/2022-12/31/2022) in the comment box below.

BMI Screening

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

Definition: Percentage of patients aged 18 years and older with a visit during the reporting period with a documented BMI during the most recent visit or within the six months prior to that visit AND when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the visit.

*For more information refer to UDS 2022 Manual pages 96-97. To access the online UDS manual click [here](#). Note that ORH uses a different reporting period than the UDS.

Denominator: Patients who were 18 years of age or older with a medical visit during the reporting period.

Numerator: Patients with a documented BMI (not just height and weight) during their most recent visit or during the previous six months of the most recent visit, AND when the BMI is outside of normal parameters*, a follow-up plan is documented during the visit or during the previous six months of the current visit.

* Normal parameters: Age 18 years and older BMI greater than or equal to 18.5 and less than 25 kg/m²

Exclusions: Patients who are pregnant. Patients receiving palliative or hospice care. Patients who refuse measurement of height and/or weight. Patients with a documented Medical Reason, such as: illness or physical disability, mental illness, dementia, confusion, nutritional deficiency, such as vitamin or mineral deficiency. Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Guidance:

DO NOT use self-reported height and weight values. This performance measure cannot be completed in a telehealth visit. The only aspect that is allowable as a telehealth visit is the documented follow-up plan with the patient. Patient's self-reporting their height and weight is not acceptable. An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits. Do not use self-reported values. BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center. If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met. Document the follow-up plan based on the most recent documented BMI outside of normal parameters. Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI. Do not count as meeting the measurement standard charts or templates that display only height and weight. The fact that a HIT/EHR can calculate BMI does not replace the presence of the BMI itself.

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- 1) What is the number of total unduplicated patients served, age 18 and older, during the reporting period, 7/1/2022 to 12/31/2022? Patients are individuals who have at least one reportable visit during the reporting period.

For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022 that patient is counted ONLY ONCE. See the definition above for patients to exclude. Value reported cannot exceed the number of unduplicated patients served : [pts_served] Do not use commas when entering numbers.

2) Of those [pts_bmi_d] patients who are eligible to receive a BMI screening, reported in question above, how many met at least ONE of the following criteria:

a documented BMI (not just height or weight) during their most recent visit (or during the previous six months of the most recent visit) that is within normal parameters OR

a documented BMI (not just height or weight) during their most recent visit (or during the previous six months of the most recent visit) that is outside of normal parameters AND a documented follow-up plan

Normal parameters:

Age 18-64 years and BMI was greater than or equal to 18.5 and less than 25

Age 65 years and older and BMI was greater than or equal to 23 and less than 30

Documentation: Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must normally display BMI. do not count as meeting the measurement standard, charts or templates which display only height and weight. The fact that an HIT/EHR is capable of calculating BMI does not replace the presence of the BMI itself.

Do not use commas when entering numbers.

3) This is the percentage you are reporting for the measure "BMI Screening and Follow up". %

4) Discuss any challenges or successes in meeting your contract's BMI performance measures within the reporting period (7/1/2022-12/31/2022) in the comment box below.

School Based Health Center

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Definition: Percentage of patients 3-18* years of age who had an outpatient medical visit and who had evidence, height, weight, and body mass index (BMI) percentile documentation AND who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the reporting period.

*UDS definition uses 17 years of age as their cutoff, ORH has extended this age to 18.

*For more information refer to UDS 2022 Manual pages 95-96. To access the online UDS manual click [here](#). Note that ORH uses a different reporting period than the UDS.

Denominator: Patients 3-18 years of age with at least one outpatient visit with a medical provider during the measurement period.

Exclusions: Patients who have a diagnosis of pregnancy during the reporting period. Exclude patients whose hospice care overlaps the reporting period.

Numerator: Children and adolescents who have had a height, weight and body mass index (BMI) percentile recorded during the reporting period and who had counseling for nutrition during the reporting period and who had counseling for physical activity during the reporting period.

Guidance:

Visits can be performed by any medical provider not just a PCP or OB/GYN (for example, include patients who had a visit with an NP). Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile, rather than an absolute BMI value, is assessed. Values that are self reported by patient are not acceptable.

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- 1) What is the number of total unduplicated patients served, ages 3-18 during the reporting period, 7/1/2022 to 12/31/2022? Value reported cannot exceed the total number of unduplicated patients served: [pts_served]

Patients are individuals who have at least one visit during the reporting period. For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022 that patient is counted ONLY ONCE. Do not use commas when entering numbers.

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- 2) Of the [sbhc_bmi_d] patients reported in the question above, how many met ALL of the following criteria:

Had a documented BMI (not just height and weight) during the reporting period, 07/1/2022 to 12/31/2022. AND

Had documentation of counseling for nutrition AND

Had documentation of counseling for physical activity during the reporting period.

Do not use commas when entering numbers.

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- 3) This is the percentage you are reporting for the measure "Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ". % _____
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- 4) Discuss any challenges or successes in meeting your contract's Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents performance measures within the reporting period (7/1/2022-12/31/2022) in the comment box below.
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Tobacco Use and Help with Quitting Among Adolescents

Definition: Percentage of adolescents 12 to 20 years of age with a primary care visit during the reporting year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.

Denominator: Adolescents who turn 12 through 20 years of age during the reporting period.

Numerator: Patients who were screened for tobacco use at least once within 18 months and who received tobacco cessation intervention if identified as a tobacco user.

Guidance:

Tobacco Cessation services can be utilized through telehealth services. Include those adolescents who use tobacco and are offered help with quitting but who refuse to accept help.

- 5) What is the number of total unduplicated patients served, ages 12-20, during the reporting period, 7/1/2022 to 12/31/2022? Value reported cannot exceed the total number of unduplicated patients served: [pts_served]

Patients are individuals who have at least one visit during the reporting period. For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022 that patient is counted ONLY ONCE. Do not use commas when entering numbers.

- 6) Of the [sbhc_tobacco_d] patients reported in the question above, how many met ALL of the following criteria:

Screened for tobacco use at least once within the past 18 months AND

Received tobacco cessation intervention IF identified as a tobacco user

Do not use commas when entering numbers.

- 7) This is the percentage you are reporting for the measure "Tobacco Use and Help with Quitting Among Adolescents ". % _____
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- 8) Discuss any challenges or successes in meeting your contract's Tobacco Use and Help with Quitting Among Adolescents performance measure within the reporting period (7/1/2022-12/31/2022) in the comment box below.
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Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Definition: Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if screening was positive, had a follow-up plan documented on the date of the visit.

Denominator: All patients aged 12 years and older with at least one medical visit during the reporting period.

Exclusions: Patients with an active diagnosis for depression or a diagnosis of bipolar disorder. Patient refuses to participate. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. Situations where the patient's cognitive capacity, functional or motivational may impact the accuracy of results.

Numerator: Patients screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool AND if screened positive for depression, had a follow-up plan documented on the date of the visit.

*For more information refer to UDS 2022 Manual pages 105-107. To access the online UDS manual click [here](#). Note that ORH uses a different reporting period than the UDS.

Guidance:

Use the most recent screening results. The follow-up plan must be related to a positive depression screening. Documentation of a follow-up plan "on the date of the visit" can refer to any countable visit, NOT only a medical visit. The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit. If the screening result is positive, a follow-up plan must be documented on the date of the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions. Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. Follow-up for a positive depression screening must include one or more of the following: 1) Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment. 2) Referral to a provider for further evaluation for depression. Or 3) Pharmacological interventions, when appropriate. DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen. DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator criteria for a follow-up plan to a positive depression screening. A suicide risk assessment does not qualify for the numerator as a follow-up plan.

-
- 9) What is the number of total unduplicated patients served, age 12 years and older during the reporting period, 7/1/2022 to 12/31/2022? Value reported cannot exceed the total number of unduplicated patients served: [pts_served]

Patients are individuals who have at least one visit during the reporting period. For example, if a patient is seen five times during the reporting period of 7/1/2022 to 12/31/2022 that patient is counted ONLY ONCE. Do not use commas when entering numbers.

-
- 10) Of the [sbhc_depression_d] patients reported in the question above, how many met ALL of the following criteria:

Screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool AND

If screening was positive for depression, a follow-up plan documented on the date of the visit Note: Patients who are already participating in ongoing treatment for depression will not included in the universe count.

Do not use commas when entering numbers.

11) This is the percentage you are reporting for the measure "Screening for Clinical Depression and Follow-Up Plan ". %

12) Discuss any challenges or successes in meeting your contract's Screening for Clinical Depression and Follow-Up plan performance measure within the reporting period (7/1/2022-12/31/2022) in the comment box below.

Community Health Workers

Does your practice employ a Community Health Worker?

- Yes
- No

Does your practice track the number of patient referrals who are initiated for the patient by the Community Health Worker?

- Yes
- No

How many unduplicated patients received a referral service from your practice's Community Health Worker as of the end of this reporting period?

How many CHW's does your practice employ (full-time, part-time, volunteer, or paid positions)?

Number of CHWs employed

Full-time employment (≥ 32 hours/week) _____

Part-time employment (< 32 hours/week) _____

Full-time volunteer (≥ 32 hours/week) _____

Part-time volunteer (< 32 hours/week) _____

Other (describe): _____

Community Health Workers

Does your practice employ a Community Health Worker?

- Yes
- No

Does your practice track the number of patient referrals who are initiated for the patient by the Community Health Worker?

- Yes
- No

How many unduplicated patients received a referral service from your practice's Community Health Worker as of the end of this reporting period?

How many CHW's does your practice employ (full-time, part-time, volunteer, or paid positions)?

Number of CHWs employed

Full-time employment (\geq 32 hours/week) _____

Part-time employment ($<$ 32 hours/week) _____

Full-time volunteer (\geq 32 hours/week) _____

Part-time volunteer ($<$ 32 hours/week) _____

Other (describe): _____