Organization

1) Pick your organization from the drop down box. (Note that the contract number is in parentheses).

- Advance Community Health (44478)
- Bakersville Community Medical Clinic, Inc. dba Mountain Community Health Partnership (44439)
  Benson Area Medical Center, Inc. (44440)
- Black River Health Services, Inc. (44394)
- Clay Comprehensive Health Services, Inc. dba Chatuge Family Practice (44446)
- Community Care Clinic of Franklin, Inc. (44482)
- Duplin Medical Association, Inc. dba Rose Hill Medical Center (44498)
- Gaston Family Health Services, Inc. (44477)
- Grace Clinic of Yadkin Valley (44441)
- Hot Springs Health Program, Inc. (44445)
- Hugh Chatham Memorial Hospital, Inc. (44442)
- Mt. Olive Family Medicine Center, Inc. (44377)
- Richmond County Healthy Carolinians Partnership (44452)
- Scotland Memorial Hospital (44486)
- Surry Medical Ministries Foundation (44476)
- Tyrrell County Rural Health Association (44488)

2) Select the reporting period for this performance measure data collection survey.

- Q1 -- Data collected in October, covering a 3-month reporting period: 7/1/22 to 9/30/22
- Q2 -- Data collected in January, covering a 6-month reporting period: 7/1/22 to 12/31/22
- Q3 -- Data collected in April, covering a 9-month reporting period: 7/1/22 to 3/31/23
- Q4 -- Data collected in July, covering a 12-month reporting period: 7/1/22 to 6/30/23

- 7/1/22 to 9/30/22 (Q1)
- 7/1/22 to 12/31/22 (Q2)
- 7/1/22 to 3/31/23 (Q3)
- 7/1/22 to 6/30/23 (Q4)

Contact Information

1) Enter 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.
_____

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

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

4) Comments regarding the contact information for this survey. _____

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.

1) How many virtual/telemedicine patient encounters took place during the reporting period? Include all patients (MAP and non-MAP). Do not use commas when entering numbers.

_____

2) How many in-clinic patient encounters took place during the reporting period? Include all patients (MAP and non-MAP). Do not use commas when entering numbers.

_____

3) Of the [X] in-clinic patient encounters reported above, how many were MAP patient visits? Include only those visits by MAP patients. Do not use commas when entering numbers.

_____

4) TOTAL ENCOUNTERS REPORTED (in-clinic + virtual):_____
(This is the total of your virtual and in-clinic patient visits.)

5) Describe how you pulled data for patient encounters.

Encounters - Behavioral Health (answer only if your contract include Behavioral Health)

Guidance for Behavioral Health MAP Patient Encounters:

- Only include MAP encounters that are classified as Behavioral Health Encounters.
- Behavioral Health Provider examples: psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers
- You can count both In-Clinic and virtual/telemedicine visits.
- Behavioral Health Group Visits: A behavioral health provider who provides services to several patients simultaneously receives credit for a visit for each individual only if the service is documented in each patient's health record. Examples of "group visits" include family therapy or counseling sessions, group mental health counseling, and group substance use disorder counseling where several people receive services that are documented in each patient's health record. Other considerations:
    - The health center normally records applicable charges for each patient, even if another grant or contract covers the costs.
    - If only one patient is billed (for example, when a family member participates in a patient's counseling session), count only the billed individual as a patient and count the visit for only that one patient.
    - When a behavioral health provider conducts services via telemedicine, the provider can be credited with a visit only if the service is documented in the patient's health record. The session will normally be billed to the patient or a third party.
- DO NOT count group medical visits.

1) How many Behavioral Health MAP patient encounters took place during the reporting period? Include both In-Clinic and Virtual/Telemedicine visits.

_____

2) Describe how you pulled data for behavioral health patient encounters.

Patients Served

1) What is the total number of unduplicated patients served during the reporting period? 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, that patient is counted ONLY ONCE. Do not use commas when entering numbers. Cannot exceed the total number of clinic visits reported: [X]

_____

2) Describe how you pulled data for patients served:

High Blood Pressure

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 . 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.

1) What is the number of total unduplicated patients served, 18-85 years of age, during the reporting period? 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, that patient is counted only once.

Do not use commas when entering numbers. Cannot exceed the total number of unduplicated patients served: [X]

_____

2) Of the [X] patients reported in the question above, how many have a diagnosis of Essential Hypertension?

Exclude the following patients:

- 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. Cannot exceed [X].

_____

3) Of the [X] patients with hypertension reported above, how many had their blood pressure adequately controlled at the most recent visit 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 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. Cannot exceed [X].

_____

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.

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. 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? 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, that patient is counted ONLY ONCE.

Do not use commas when entering numbers. Cannot exceed the number of unduplicated patients served:
[X] _____

2) Of the [X] 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. Cannot exceed [X]

_____

3) Of the [] patients with diabetes reported in question above, how many met at least ONE of the following criteria during the reporting period:

- 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. Cannot exceed []

_____

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.

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? 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, that patient is counted ONLY ONCE.

Do not use commas when entering numbers. Cannot exceed the number of unduplicated patients served : [X] _____

2) Of those [X] patients, 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 face 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. Cannot exceed [X] _____

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.

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. 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 screen 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.

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

Do not use commas when entering numbers. Cannot exceed total patients served: [X]_____

2) Of the [X] patients reported in question above, how many were screened for tobacco use at least once within the reporting period AND meets the following criteria:

- Patient is not a tobacco user

OR

- Patient is a tobacco user and received tobacco cessation intervention

Note that 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. Cannot exceed [X] _____

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.

Community Health Workers

1) Does your practice employ any Community Health Workers (including volunteer or paid positions, full or part-time)?

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

   2a) How many unduplicated patients received a referral service from your practice's Community Health Worker as of the end of this reporting period? _____

3) How many Community Health Workers does you practice employ? Include all full-time, part-time, volunteer, or paid positions.
_____

	Paid Position	Volunteer Position	Other Position
Full-Time Employment			
Part-Time Employment			
Other (describe): _____			

Successes, Challenges and Feedback

1) Discuss any challenges or successes in meeting your contract's performance measures within the reporting period.

--End of Survey--