



RAPID

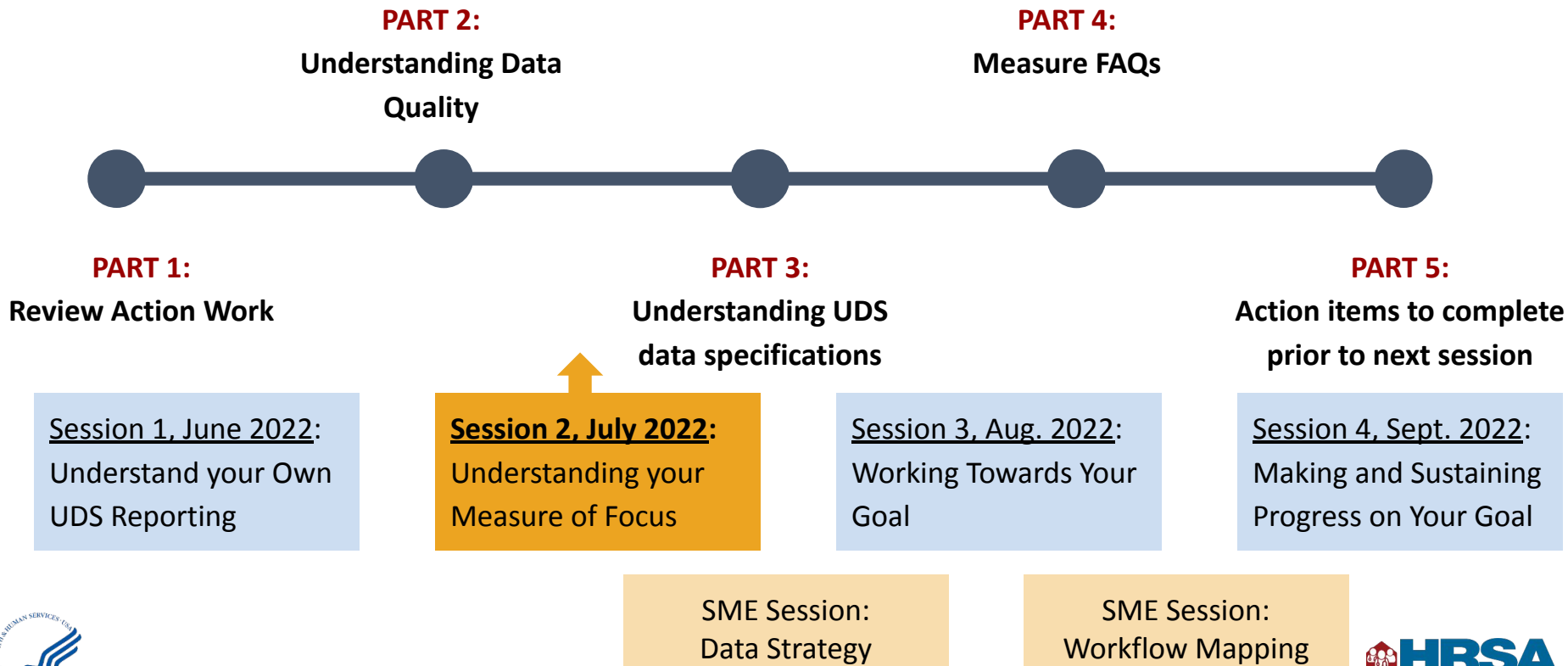
Reporting Assistance and Process
Improvement Discussion

Session 2

Vision: Healthy Communities, Healthy People

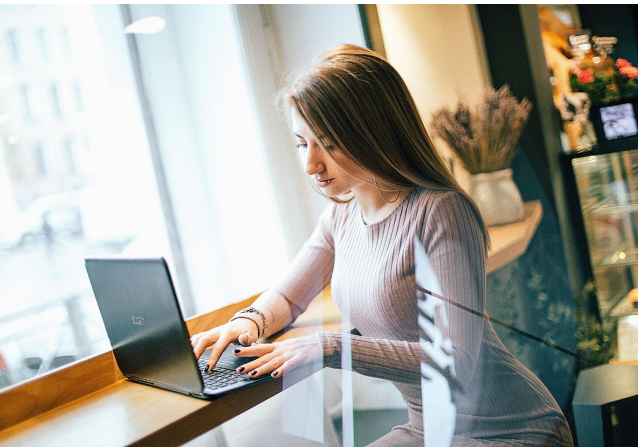


Roadmap for Today



About Us

Let's take a moment to see what each shared from last session!





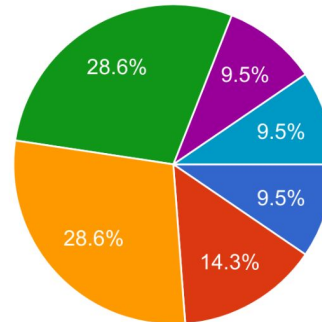
Part 1

Review Action Work

How have your cervical cancer screening rates trended for this cohort?

Some health centers have seen upward trend, but mostly down a bit.

In recent 3-5 years, has your cervical cancer screening compliance rate been trending UP or DOWN?
21 responses



- Up! Our rate has increased by more than 10% in recent years.
- Up! Our rate has increased by more than 5% but less than 10% in recent years.
- Up a bit! Our rate has increased by less than 5% in recent years
- Down a bit! Our rate has declined by between 0 and 5% in recent years.
- Down! Our rate has declined by more...
- Down! Our rate has declined by more...

Problem Statements

Here are two cervical cancer screening problem statements.

We are a FQHC that serves 20,000+ patients a year, in both rural and urban settings, serving the special populations of the unhoused, migrant/seasonal workers and public housing **trying to** increase our cervical cancer screening (CCS) rate by 3% in 2023 **but** we miss opportunities to complete CCS when patients are present for an appointment and don't capture hysterectomies consistently in a discrete data field **because** patients visits are full of other pressing medical needs, not all providers are comfortable with or like to do CCS and we lack knowledge of the best practice for documenting historical hysterectomies **which makes us feel** frustrated.

We are a health center that serves primarily low-income, uninsured, and underinsured patients in AZ, offering primary care, pediatrics, dental, pharmacy and BH services to 30000+ patients. Our goal is to improve access to cervical cancer screenings and medical care by completing care gaps, reducing no shows, increasing education, etc. Unfortunately, we have encountered difficulties reaching such goals because patients may not be able to access to care due to lack of insurance, transportation, etc. or **because** our center has limited documentation coming from external sources such as hospitals and other local providers which **makes us feel** motivated to learning new strategies and innovative alternatives.





Part 2

Understanding Data Quality

Three Layers of Data Use and Quality

External Reporting and Performance

Regulatory or Statutory Requirements (UDS, PI, P4P) | PCMH | Grants, etc.

Quality Improvement & Population Management

Registry and exception reporting | QI PDSAs | Trending and monitoring

Point of Care

Pre-visit planning | Huddle |
Care Management



Adapted from

<https://bphc.hrsa.gov/sites/default/files/bphc/qualityimprovement/clinicalquality/presentations/identifying-data-reports-for-qi-slides-ead.pdf>

Remember: Data is not an IT or clinical project, it is the **CURRENCY OF CHANGE**

Team Role	Responsibilities
Leadership/ Executive	Leadership level sponsor for project; Helps to acquire appropriate resources for program as needed
Population Management Lead	Responsible for oversight of population management and population management programs
Network/ Database Administrator	Provide access to network and EHR systems; Performance and security support
EHR/ Health IT Lead	Identify EHR templates and tables for data element capture including orders, labs, etc.; Review with clinical and QI team
QI Lead	Identify data capture workflows; complete lookup/ mapping; conduct data validation chart audits when needed
Provider and Clinical Representation	Identify data capture workflows; identify PHI data capture location and criteria; support/ provide feedback on data validation and accuracy



Adapted from

<https://bphc.hrsa.gov/sites/default/files/bphc/qualityimprovement/clinicalquality/presentations/identifying-data-reports-for-qi-slides-ead.pdf>



Targeted, Cross-Functional QI Efforts Have Better Returns



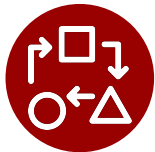
More 'bang for your buck'



Mindful of people's limited bandwidth



Builds trust



Ensures that changes will actually be reflected in the measure/ reports/ data

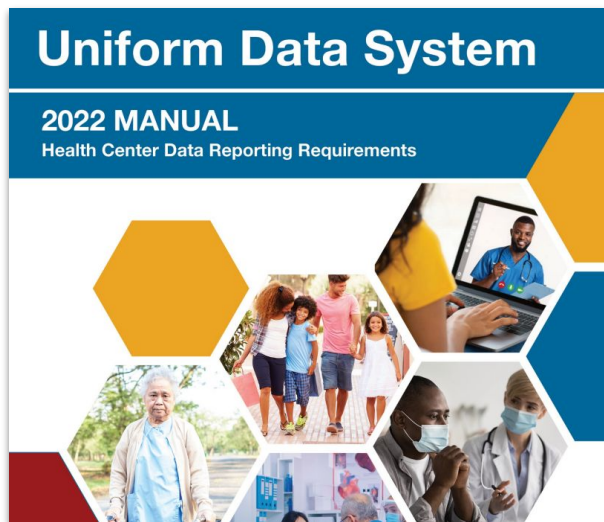


Part 3

Understanding Measure Specifications for UDS Reporting



Getting Started with Clinical Quality Measures: UDS Specific Guidance



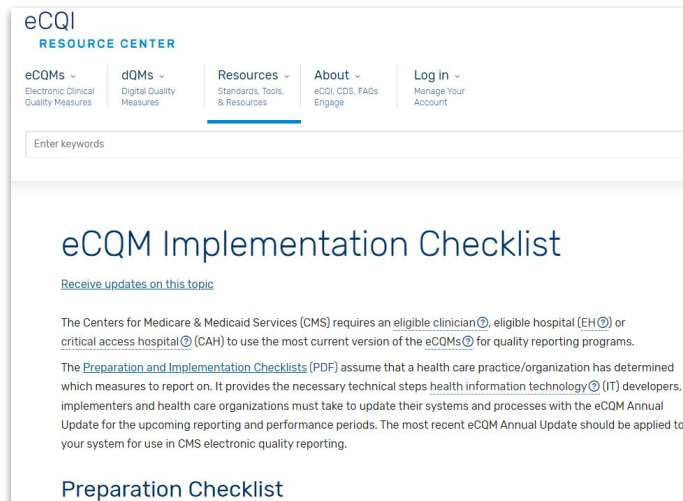
UDS Manual:

- Definitions and instructions specific to the UDS are in the [2023 UDS Manual](#).
- Clinical quality measures include links to eQIMs as well as UDS specific considerations.
- Remember that UDS measures **limit reporting to patients who had at least one UDS countable visit** during the calendar year.
 - Note that the limit to UDS medical patients has been removed for 2023; measures are now limited only by denominator specifications.

Year-over-year changes:

- [2023 Program Assistance Letter \(PAL\)](#)
- [UDS Changes Webinar](#) (Held June 6, 2023)

Getting Started with Clinical Quality Measures: eCQI Resource Center



- [eCQM Implementation Checklist](#)
 - 5 Preparation Steps
 - 7 Implementation Steps
- eCQM supports include:
 - [eCQI Resource Center](#): On the page for each measure, in the “Measure Information” tab, there is the option to “compare” -- e.g., 2022 to 2023. **This highlights changes year over year.**
 - [eCQM Flows](#): Workflows for each eCQM, updated annually and downloads as a ZIP file.
 - [Technical Release Notes: 2023 Performance Period Electronic Clinical Quality Measures \(eCQMs\)](#)
 - [eCQM value sets](#): Brings you to the VSAC site, where you can search value sets
 - Additional resources on the [EC Resources page](#)

Action Item 1

Complete the first 5 steps of the eCQM implementation checklist. Remember, UDS uses Eligible Clinician eCQMs.



<https://ecqi.healthit.gov/ecqm-implementation-checklist>



What does this look like in practice?



In the Clinic

How do you operationalize measure updates in your clinical workflows?



In the Data

How do you operationalize measure updates in your EHR/ health IT systems?

Accessing Full eCQM Specifications

Available to all at

<https://vimeo.com/635520357>



Accessing Codes for All Measures

Download all codes from the VSAC site: Once logged in, go to Download Tab → 2023 Reporting → eCQM Value Sets for Eligible Clinicians

Two download options:

- Download Excel **Sorted by CMS ID** to get the full set for each measure-- you'll match the CMS # from the Manual to the CMS # on the Tabs of the downloaded spreadsheet. There are more measures in the spreadsheet than there are in the UDS.
- Download Excel Sorted by **Value Set Name** to find codes for just certain value sets (remember, value sets are the defined components of each measure).

NIH National Library of Medicine Value Set Authority Center

Welcome Search Value Sets **Download** Q Browse

VSAC Downloadable Resources

This page contains groups of value sets designated for a particular program usage. You can search the entire repository of published VSAC value sets in the Search Value Sets

CMS eCQM & Hybrid Measure Value Sets
CMS Pre-rulemaking eCQM Value Sets
C-CDA Value Sets
CDCREC Roll-up codes

eCQMs will not be eligible for reporting to CMS unless and until they are proposed and finalized through notice, public comment, and each applicable program. For more information about eCQMs please visit the [eCQI Resource Center](#).

- 2023 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets
- 2022 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets
- May 2021 Release eCQM & Hybrid Measure Value Sets Publication Date: May 06, 2021

Expansion Version: eCQM Update 2021-05-06

Available Downloads	Sorted by CMS ID*	Sorted by Value Set Name*	Sort by Quality Measure Category
eCQM Value Sets for Eligible Hospitals Published May 06, 2021	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel
eCQM Value Sets for Eligible Professionals and Eligible Clinicians Published May 06, 2021	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel

Video demonstrating process: <https://hiteacenter.org/Resources/HITEQ-Resources/accessing-value-set-codes-for-clinical-quality-measures>



Discussion Question

What can be done with these codes once you have downloaded them?

Why is it helpful to have them?

A doctor in a white coat with a stethoscope is shown from the chest down, gesturing with both hands over a patient's arm. The background is a bright, clinical setting. The text 'eCQM Flow' is overlaid in large red font.

eCQM Flow

Each eCQM has a process flow map
which can be found in the

[eCQM resources tab of the EC eCQM home page.](#)



Part 4

Measure FAQs

Cervical Cancer Screening Measure FAQs

There appears to be a discrepancy on the age range for the cervical cancer screening measure on the HRSA website under the quality of care measures. The general description says women aged 21-64, but the numerator outlines women aged 24-64. Which is correct?

This [measure](#) looks at the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed within the last 3 years
- Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

According to the [measure specifications](#), the initial patient population being assessed for inclusion in the denominator are those who turn 24 by the end of the year (by the end of 2023). Then the specifications for numerator look back three years (back to age 21)



Cervical Cancer Screening Measure FAQs

A health center is considering offering home cervical cancer screening kits to patients. Would the results of these home tests count towards the Table 6B Cervical Cancer Screening measure?

From research, it looks like the home cervical cancer screening kits the health center is considering would be cervical HPV testing kits.

Review of [Cervical Cancer Screening \(CMS124v11\)](#) criteria and the current CMS124v11-related tickets in the ONC Issue Tracking System (OITS) JIRA project eCQM Issue Tracker system did not identify any guidance where the measure steward that specifically specifies that HPV home tests do not meet the measure criteria. To meet the numerator criteria for a HPV test, **health centers should use the related CMS124v11 CQL and value set (e.g., LOINC codes)**. Therefore, as long as the lab does the test and the relevant LOINC code is used, it could be counted.



Key Considerations to Meet Measure Requirements



- Maintain/ update the problem list regularly.
- Document onset date(s) when required, such as for diagnoses.



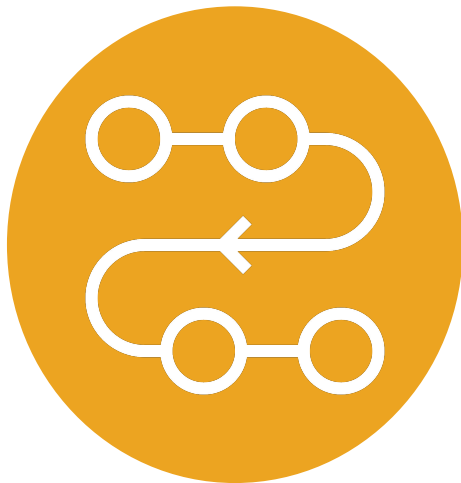
- Document surgical history (e.g., hysterectomy or mastectomy) or other history accurately in your system.



- Appropriately identify eligible visits.
 - Remember almost all measures define the specific types of visits (e.g., certain visit codes) that count toward the denominator.

References for Measure FAQs

ONC Project Tracking Jira



eCQM Known Issues Tracker (part of ONC tracking)



UDS Changes Webinar and Helplines



Access each with these links: <https://oncprojecttracking.healthit.gov/support/projects/CQM/summary>;
<https://oncprojecttracking.healthit.gov/support/projects/EKI/summary>; and
<https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance/technical-assistance-contacts>

We understand!

All of this
information is a lot
to wade through
and to translate
to your clinic's
processes!

Hard

- Extra work for staff
- Often having to chase after information
- EHRs often are not terribly conducive to some of the details.

Why else?

Important

- It's the only way to truly know who has or has not gotten the needed screenings or outcomes.
- Ensures better accuracy
- Numbers reported accurately reflect both your work and your patients

Why else?

Achieving our goals!



Part 5

Action Items before Next Session

Closing the Gap from Where We Are

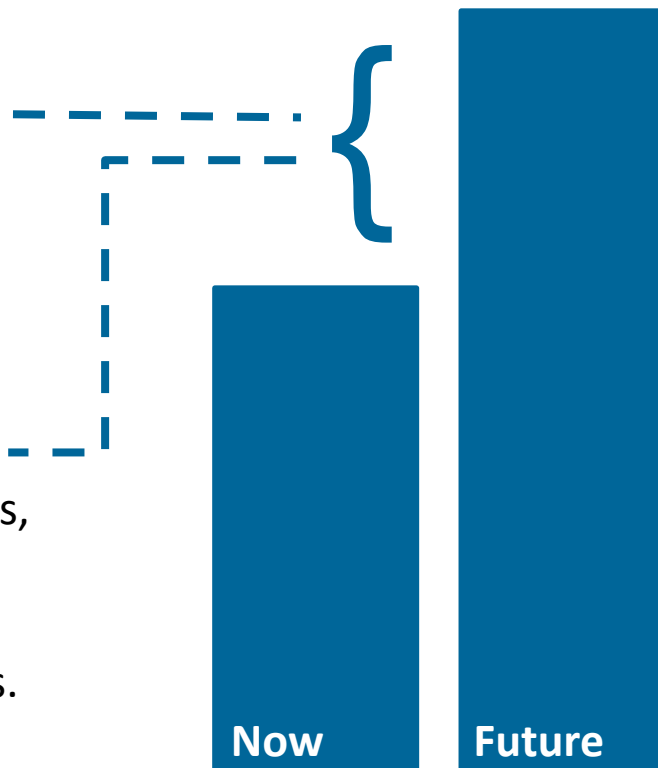
And Where We Want to Be



Some portion may be addressed through patient-facing changes or improvement in care.



Some portion may be addressed through addressing other issues, such as understanding and implementing measure specifications.



Action items before next session

After completing the first steps in the implementation checklist, access specifications and codes for the measure.

Conduct review of your own processes and documentation compared to measure specifications we've looked at.

Identify **one specific component where patient records ARE meeting the measure specifications** (where you can say, this is definitely not a problem that is impacting performance on the measure).

Identify **one specific component where the patient records are NOT meeting the measure specifications** (where you can say, this probably IS a problem that is impacting performance on the measure)

Note: You don't need to solve this or even describe how you are going to solve this yet!



Peer Learning Session with Subject Matter Expert: Data Governance | July 13th



Provide overview on the fundamentals of data governance and how to apply them in the improvement efforts.



Ensure the respective RAPID measure work is sustained via data governance prioritization, oversight, and resource allocation to “hard wire” improvements

Next Cohort Session:

Session 3 Working Towards Your Goal



Review the insights you found from your review of your processes.



Analyzing the broader environment driving your clinical quality measure performance.



Establishing a SMARTIE goal based on problem statement and opportunity for improvement.

Assistance Available

UDS Support Center

- Assistance with UDS reporting content questions
- 866-UDS-HELP (866-837-4357)
- udshelp330@bphcdata.net

HRSA Call Center

- Assistance with EHBs account and user access questions
- 877-Go4-HRSA (877-464-4772), Option 3
- <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

Health Center Program Support

- Assistance with EHBs electronic reporting or EHB account issues
- 877-464-4772, Option 1
- <http://www.hrsa.gov/about/contact/bphc.aspx>

UDS Mapper

- Assistance with the online service area mapping tool
- <http://www.udsmapper.org/contact-us.cfm>

