HRSA
Health Resources & Services Administration

RAPID

Reporting Assistance and Process Improvement Discussion

Subject Matter Expert Session 2:
Process Mapping
& UDS Measure Lifecycle

SUMMER NOT OVER YET, BUT….

WHAT ARE YOU LOOKING FORWARD TO?

Starbucks' fall pumpkin spice latte is launching earlier than ever in 2024

Pumpkin cream cold brew
Iced pumpkin cream chai
Apple crisp oatmilk macchiato
Iced apple crisp oatmilk shaken espresso
Raccoon cake pop
Pumpkin cream cheese muffin

Home Depot just released its 2024 Halloween decoration collection, complete with a 7-foot skeleton dog

Jerry Lassa, MS
jerry.lassa@datamatt3rs.com

Experience

- Hospital
- 2 health centers and an HCCN
- State and national trainings
- Adjunct statistics instructor

Areas of focus

Selected content presented today was developed through the Center for Care Innovations "Building a Data Driven Culture" program and in partnership with the HITEQ Center and PCAs and HCCNs across the country.

ROADMAP

What approaches and tools help ensure sustainable change?

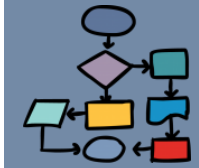
SME Session: Data Governance

SME Session: Workflow Mapping

How can we use process maps to "hard wire" RAPID measure improvements?

OBJECTIVES FOR TODAY'S SESSION

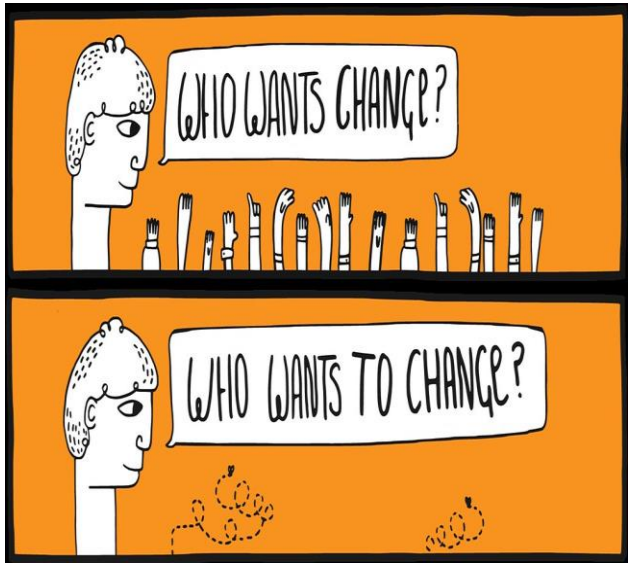
Review approaches and tools that help ensure **sustainable change** with UDS measure improvements.



Learn how to use process maps (eCQM and clinic workflows) to assess and improve UDS **measures lifecycle.**

Explore the role of data governance in **monitoring and sustaining** UDS measures lifecycle.

SUSTAINABLE CHANGE - PRINCIPLES



- Leader sponsorship, resource allocation
- Alignment with organization strategy

- Engagement of all stakeholders
- Shared understanding of current state
- Consensus on priority opportunities

- Change informed by internal opportunity and leading external practices to stretch
- Effective change process and systematizing changes to “hard wire” improvement

SUSTAINABLE CHANGE – METHODS & TOOLS

Internal assessment: strengths, weaknesses, opportunities

→ *Your RAPID work to date*

External: Evidence-based practices from the field

Degree of change

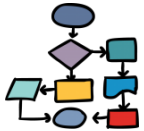
—Small, rapid changes → PDSA cycles

—Large, systemic changes → Process redesign, HIT implementation, optimization, or replacement

Documents and tools that help **systematize** change

—Policies and procedures, job descriptions, work aids

—Process and workflow diagrams

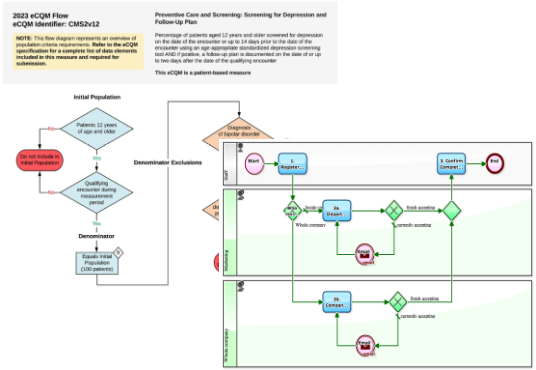


PROCESS-RELATED INFORMATION

Medical & Patient Care

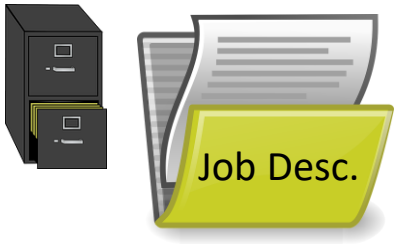
- Evidence-based clinical guidelines
- Standards of care
- Standards of practice

Processes & Workflows



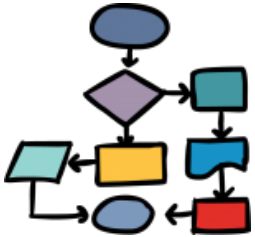
- eCQM flows, specs
- Process Maps
- Workflows

Sites, Depts, HR



- Job purpose
- Duties and responsibilities
- Qualifications

WHEN TO USE PROCESS MAPS?



- Poor process performance as measured by **clinical**, ops, financial or patient experience measures (quantitative)
- Current process not well understood and/or not being practiced consistently (qualitative)

- When implementing or optimizing a system (e.g., EHR, PHM, patient portal)
- When updating a clinical protocol or care team roles

- Valuable to maintain for all key processes and workflows

WHY USE PROCESS MAPS?

- Effective visual display that provides a “diagnostic” perspective that other tools such as policy and procedure or job description documents may not provide
- Displays chronology of how staff interact with each other, patients, and technology to achieve a goal or complete a task
- Helps to identify:
  - Bottlenecks and other sources of delay
  - Rework due to errors
  - **Role ambiguity**
  - Decision points
  - Duplicated efforts
  - Unnecessary steps
  - Sources of waste
  - **Variation**
  - Hand-offs
  - **EHR/PHM optimization needs**

PROCESS MAP TYPES

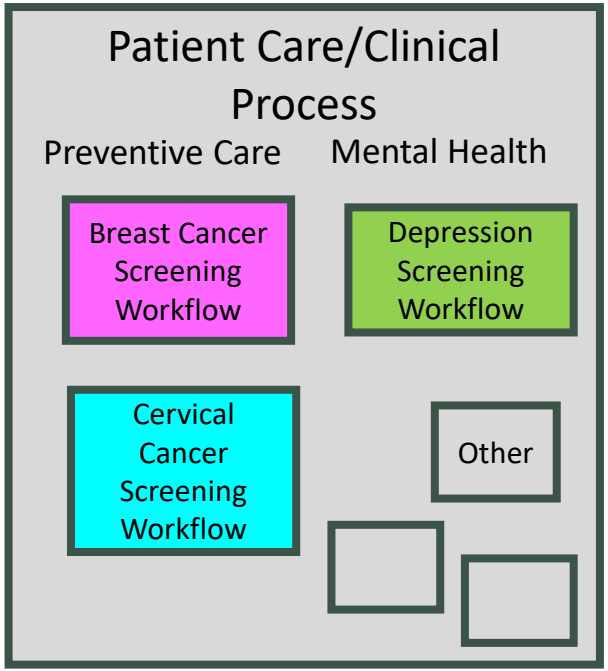
Process flows display all components to achieve a larger organization goal

Ex: Patient care process

- ✓Collect info about patient
- ✓Assess to ID problems and priorities
- ✓Create individual care plan that is evidence-based and cost-effective
- ✓Implement care plan
- ✓Monitor patient, follow-up to evaluate effectiveness of the plan and modify as needed

Workflows display activities needed to complete tasks within a process

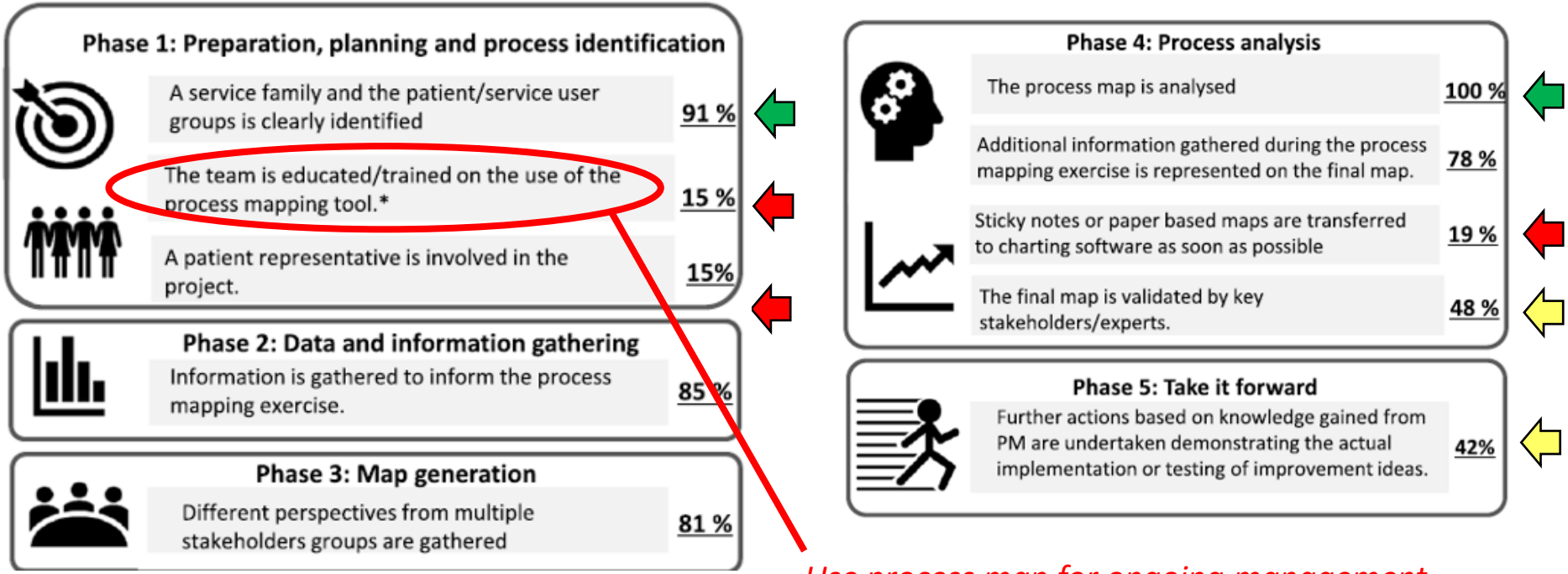
- ✓Breast Cancer Screening
- ✓Cervical Cancer Screening
- ✓Depression Screening & Follow-up



Other "flow" terms:
High level vs. detailed flowchart
Swimlane (functional) flowchart

HOW TO MAKE BEST USE OF PROCESS MAPS

Findings from a meta analysis: 105 healthcare process studies reviewed



Use process map for ongoing management.

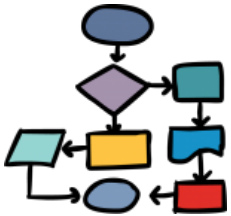
Antonacci et al, Process mapping in healthcare: a systematic review. BMC Health Services Research 2021

Poll

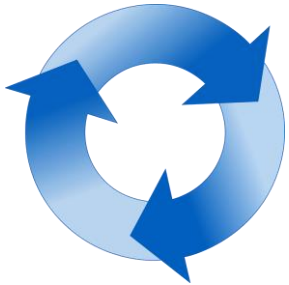
Do you regularly maintain and manage workflows for UDS measures?

- ❑ 1-2 measures
- ❑ 3-5 measures
- ❑ 6+ measures
- ❑ No
- ❑ Not sure

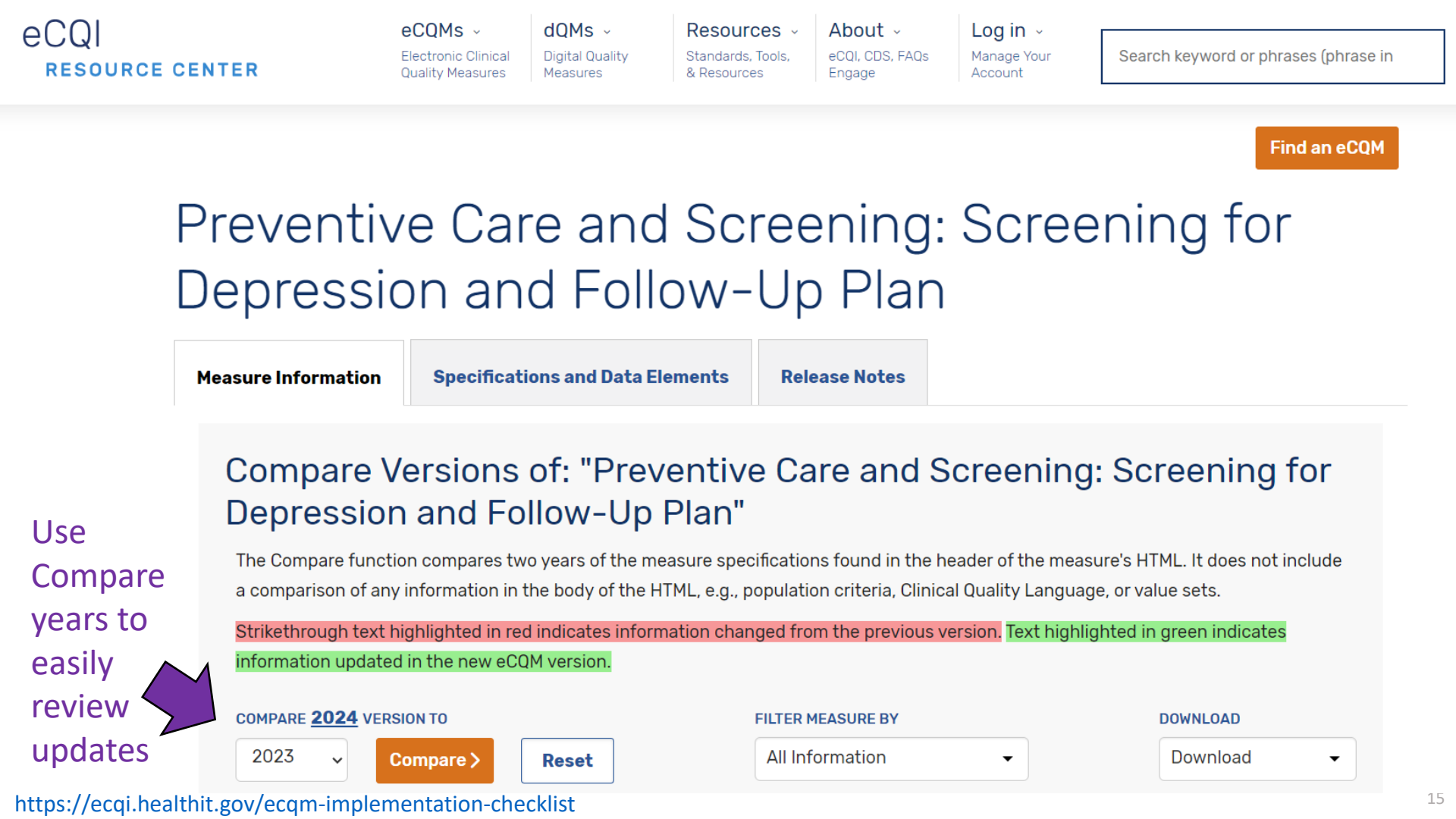
WORKFLOW EXAMPLES



- Depression Screening & Follow-up Plan (DS)
- Cervical Cancer Screening (CCS)
- Breast Cancer Screening (BCS)



- Use eCQM measure workflows to inform staff and EHR/PHM workflows



Use Compare years to easily review updates

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

Measure Information	2023 Performance Period	2024 Performance Period
Title	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CMS eCQM ID	CMS2v12	~~CMS2v12~~CMS2v13
CBE ID*	Not Applicable	Not Applicable
MIPS Quality ID	134	134
Measure Steward	Centers for Medicare & Medicaid Services (CMS)	Centers for Medicare & Medicaid Services (CMS)
Description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter
Measure Scoring	Proportion measure	Proportion measure
Measure Type	Process	Process

Review changes

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

Measure Information	2023 Performance Period	2024 Performance Period
Initial Population	All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period	All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period
Denominator	Equals Initial Population	Equals Initial Population
Denominator Exclusions	Patients who have ever been diagnosed with depression or with bipolar disorder at any time prior to the qualifying encounter	Patients who have ever been diagnosed ~~with depression or~~ with bipolar disorder at any time prior to the qualifying encounter
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter
Numerator Exclusions	Not Applicable	Not Applicable
Denominator Exceptions	Patient Reason(s)Patient refuses to participateORMedical Reason(s)Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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)	Patient Reason(s)Patient refuses to participate in or complete the depression screeningORMedical Reason(s)Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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)

Review changes

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

Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Information | **Specifications and Data Elements** | Release Notes

Specifications

Attachment	Size
CMS2v13.html	102.59 KB
CMS2v13.zip (ZIP)	94.72 KB
CMS2v13-TRN.xlsx (Excel)	22.74 KB
CMS2v13-eCQMFlow.pdf (PDF)	1.62 MB

Measure flows

There is a known issue on CMS2v13. See issue EKI-22 on the ONC eCQM Known Issues Dashboard for details.

eCQM MEASURE FLOWS

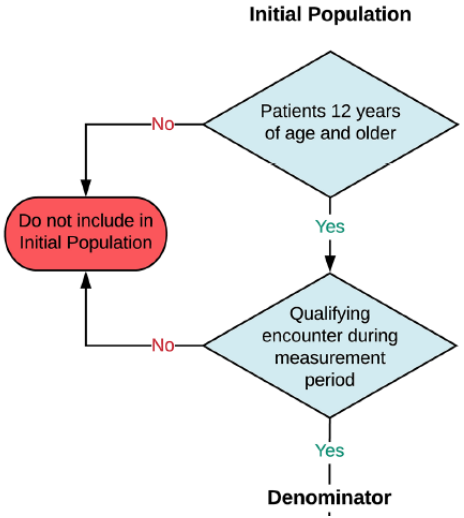
2024 eCQM Flow
eCQM Identifier: CMS2v13

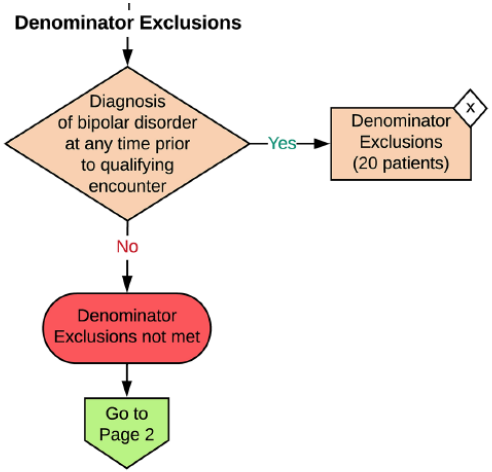
NOTE: This flow diagram represents an overview of population criteria requirements. **Refer to the eCQM specification for a complete list of data elements included in this measure and required for submission.**

Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

This eCQM is a patient-based measure





- Describes the logic for measure calculation
- A data flow for the measure
- Can help inform staff and EHR/PHM workflow

eCQM Known Issues / EKI-22

CMS2v13

To Do

Details

Type:	EP/EC	Resolution:	Unresolved
Priority:	Moderate		
Labels:	None		
Resolution:	Follow current measure logic, as specified, for CMS2v13. For patients that are advised to continue their depression care plan, clinicians can consider mapping to the following codes: SNOMED CT 410234004 (Management of mental health treatment (procedure)) or SNOMED CT 410232000 (Mental health treatment assessment (procedure)). These codes are found in the Follow Up for Adolescent Depression (2.16.840.1.113883.3.526.3.1569) and Follow Up for Adult Depression (2.16.840.1.113883.3.526.3.1568) value sets.		
Year:	2024		

Description

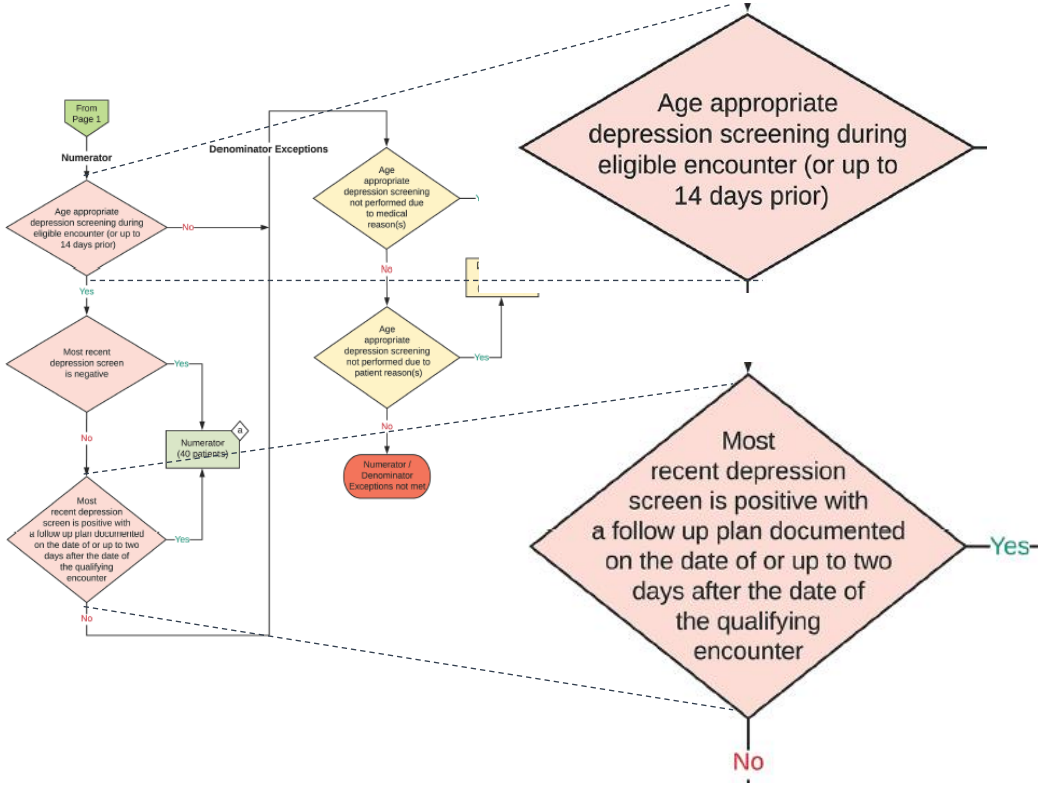
eCQMs Impacted – CMS2v13

Issue – Patients with an active diagnosis of depression who are currently receiving treatment may not meet the numerator criteria for appropriate follow-up after a positive depression screen if there are no changes to the current treatment (e.g., a clinician decides to continue a patient's antidepressant medication and does not order a refill).

eCQM Known Issues

- Provide implementation information for eCQMs with known technical issues for which a solution is under development but not yet available in a published eCQM spec.
- Includes discrepancies between eCQM narrative and logic, value sets, and/or technical, standard, or logic-related issues.
- Used by Health IT developer/vendor, implementer, measure developer/steward

DEPRESSION SCREENING & FOLLOW-UP PLAN



Your Problem Statements

- Not consistently identifying when a depression screening is due and not following established workflows when the screen is +
- Struggle with consistent implementation of workflows that capture screenings accurately
- We don't have an agreed upon standardized workflow

- Trying to capture the screenings but f/u documentation not being captured in an area that satisfies the measure

- Maintaining a consistent workflow because some providers and MAs are not on the same page
- Struggle to teach and maintain a consistent workflow across many clinical sites

- Inconsistent patient screening, documentation and coding practices due to lack of standardized EMR workflows and provider/staff training

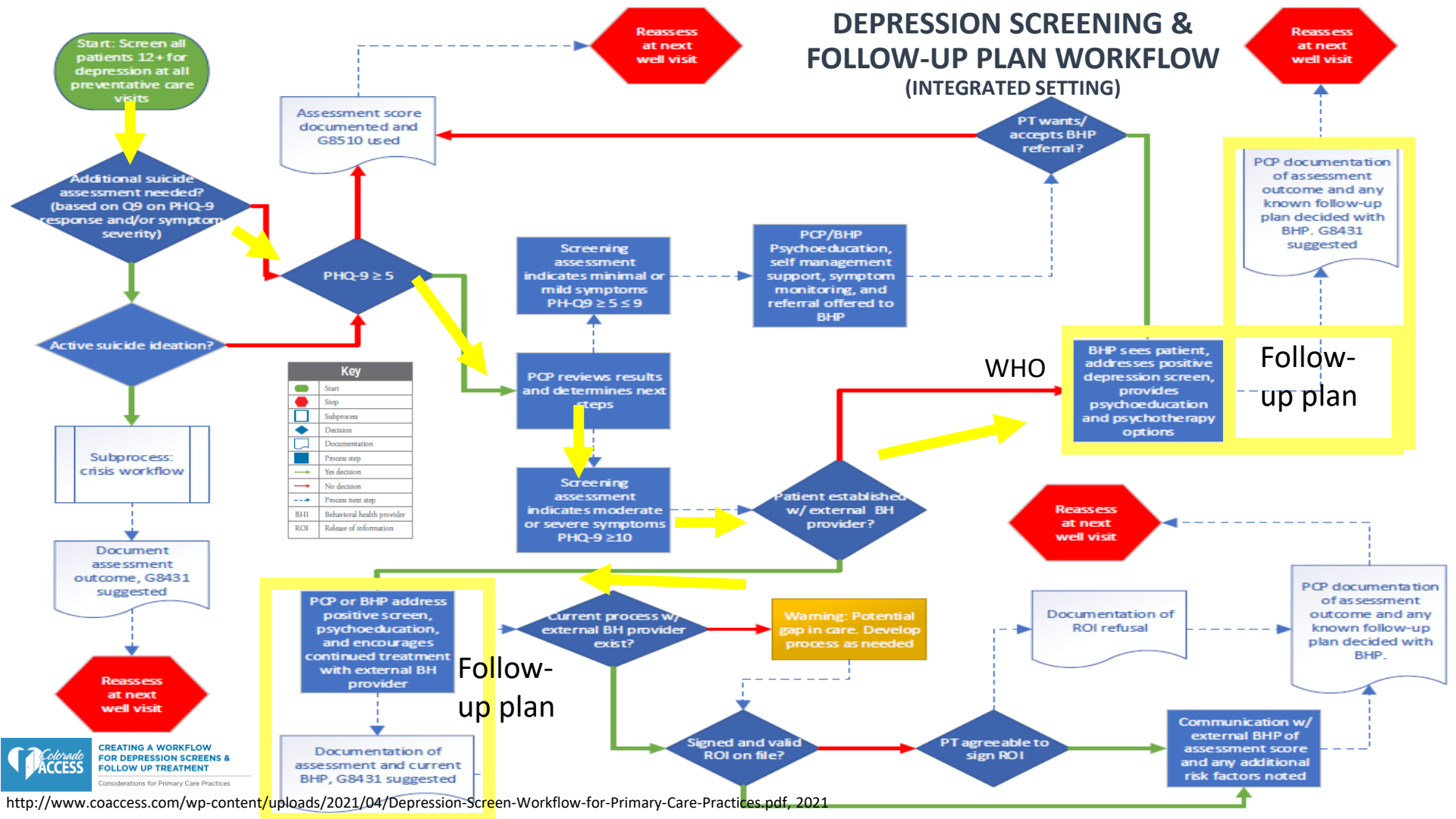
DEPRESSION SCREENING & F-U IDEAS FOR ACTION

- People
  - —Training on the measure and documentation requirements
  - —Addressing staffing and other resource issues

- Process
  - —For + screen, f-u plan must be documented on the date or up to two days after qualifying encounter
  - —Follow-up plan satisfied by:
    - Suicide risk assessment –OR-
    - New medication order (pharmacologic intervention) –OR-
    - Referral order to a provider for addt'l eval and assess, f/u plan (PsyD, LCSW, MH service/group, etc.) –OR-
    - Manually through QM/measure or billed procedure code (CPT II G8431 for +, G8510 for -)

- Technology
  - —Assess EHR workflows and structured data fields in supporting above process

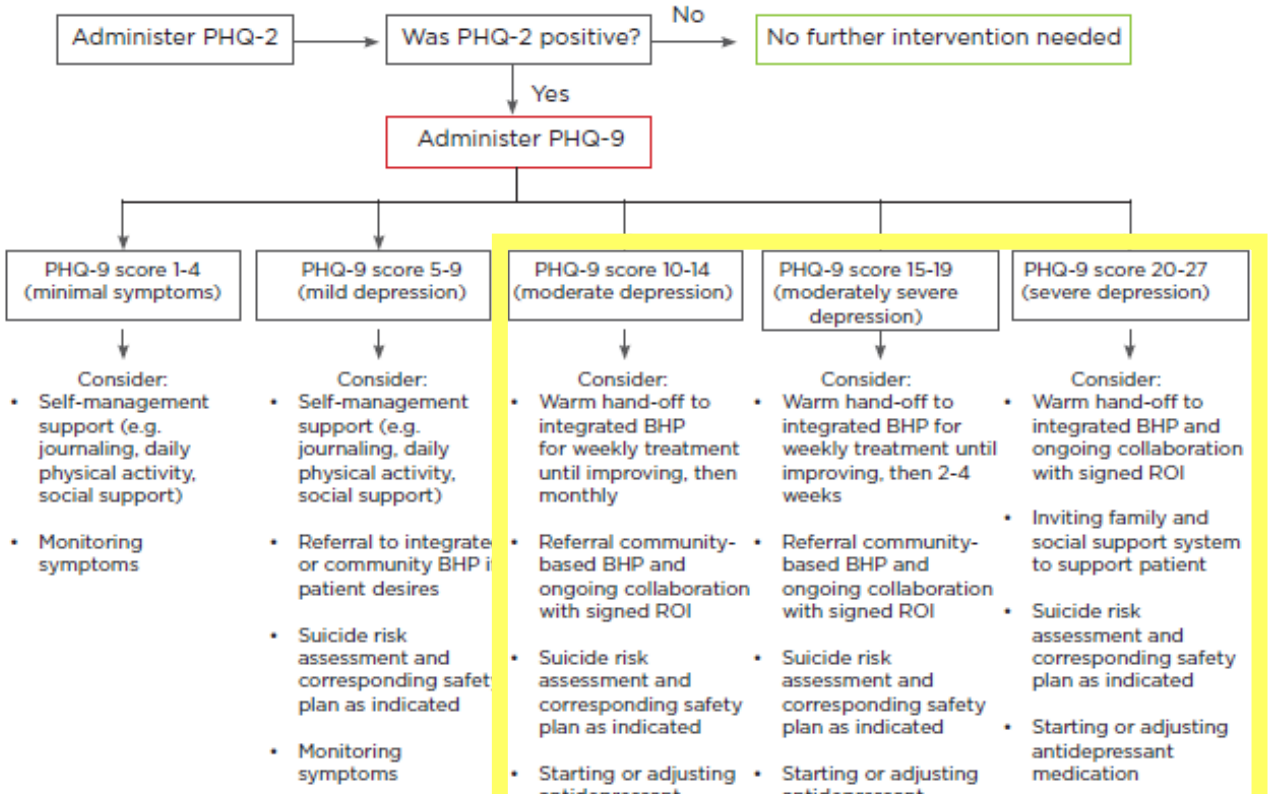
DEPRESSION SCREENING & FOLLOW-UP PLAN WORKFLOW
(INTEGRATED SETTING)



Colorado ACCESS
CREATING A WORKFLOW FOR DEPRESSION SCREENS & FOLLOW UP TREATMENT
Considerations for Primary Care Practices

http://www.coaccess.com/wp-content/uploads/2021/04/Depression-Screen-Workflow-for-Primary-Care-Practices.pdf, 2021

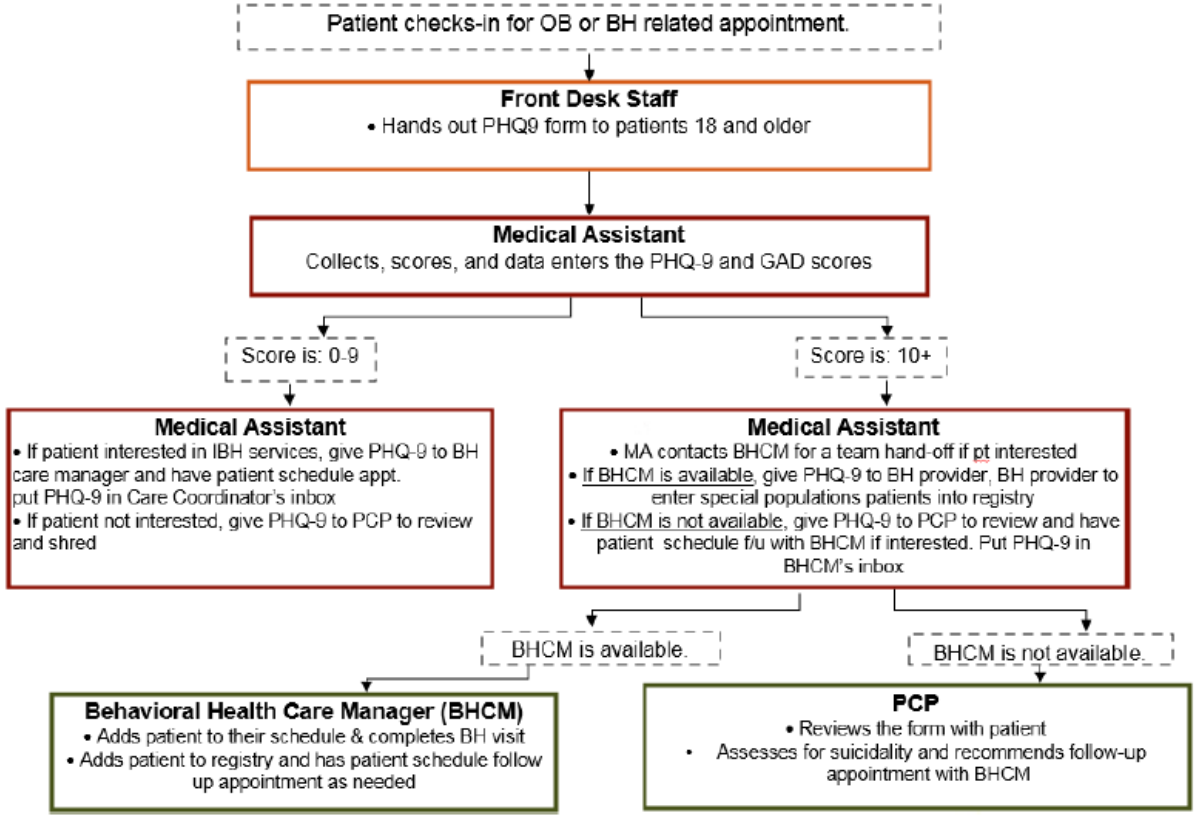
SAMPLE FOLLOW-UP PLANS BASED ON PHQ-9 SCORE



Options for follow-up plan in list format

http://www.coaccess.com/wp-content/uploads/2021/04/Depression-Screen-Workflow-for-Primary-Care-Practices.pdf, 202

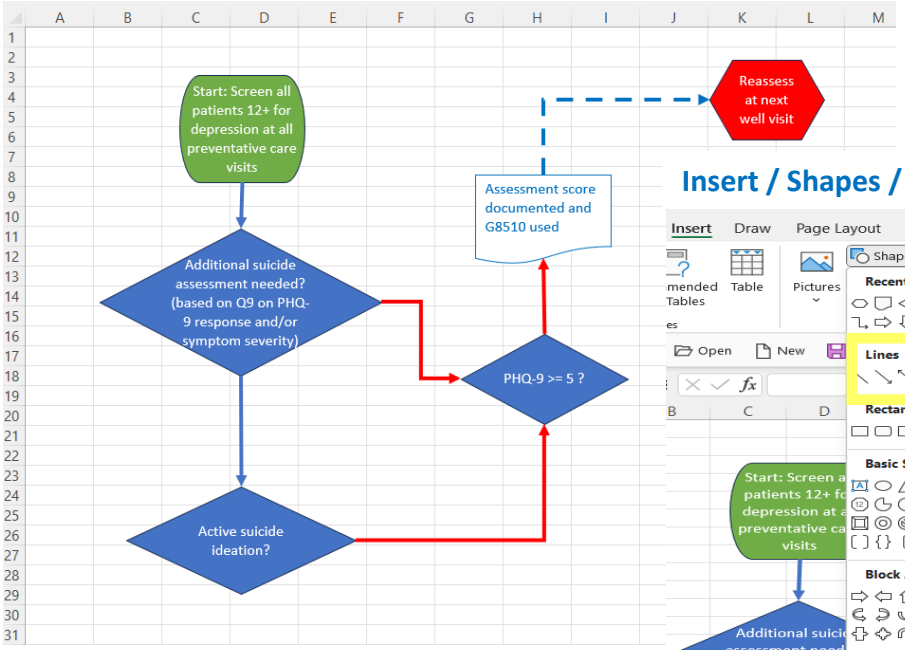
DEPRESSION SCREENING WORKFLOW EXAMPLE



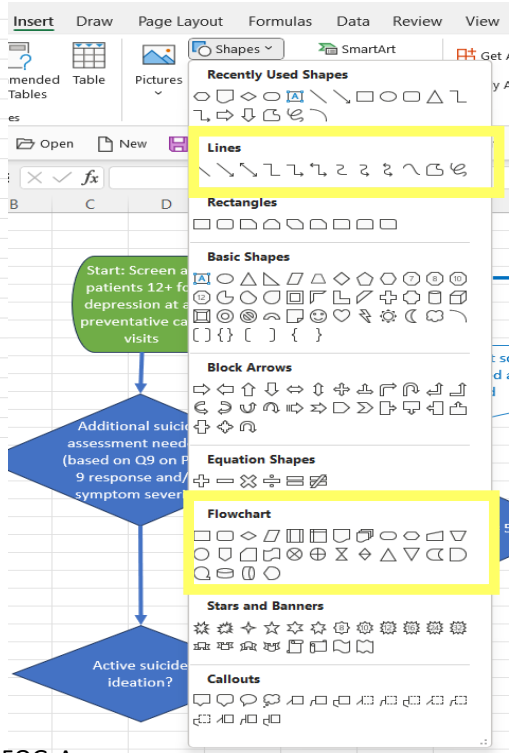
- Another formatting option
- Flow diagram with decision criteria
- Team member roles and responsibilities identified

HealthPoint CHC example from "Depression Screening and Case-Finding: Training Tools for Primary Care Teams", AIMS Center, University of WA, 2019
https://aims.uw.edu/wastate/sites/default/files/Screening%20and%20Case-finding%20Toolkit_Final.pdf

CREATE BASIC WORKFLOWS IN EXCEL



Insert / Shapes / Flowchart & Lines



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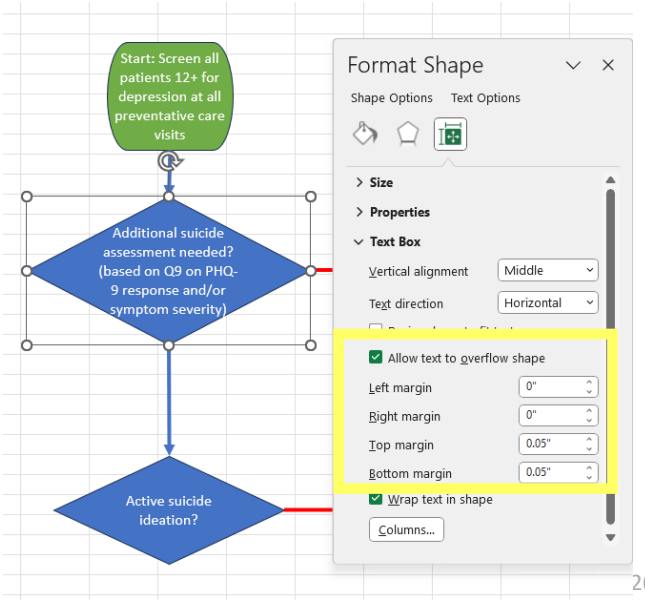
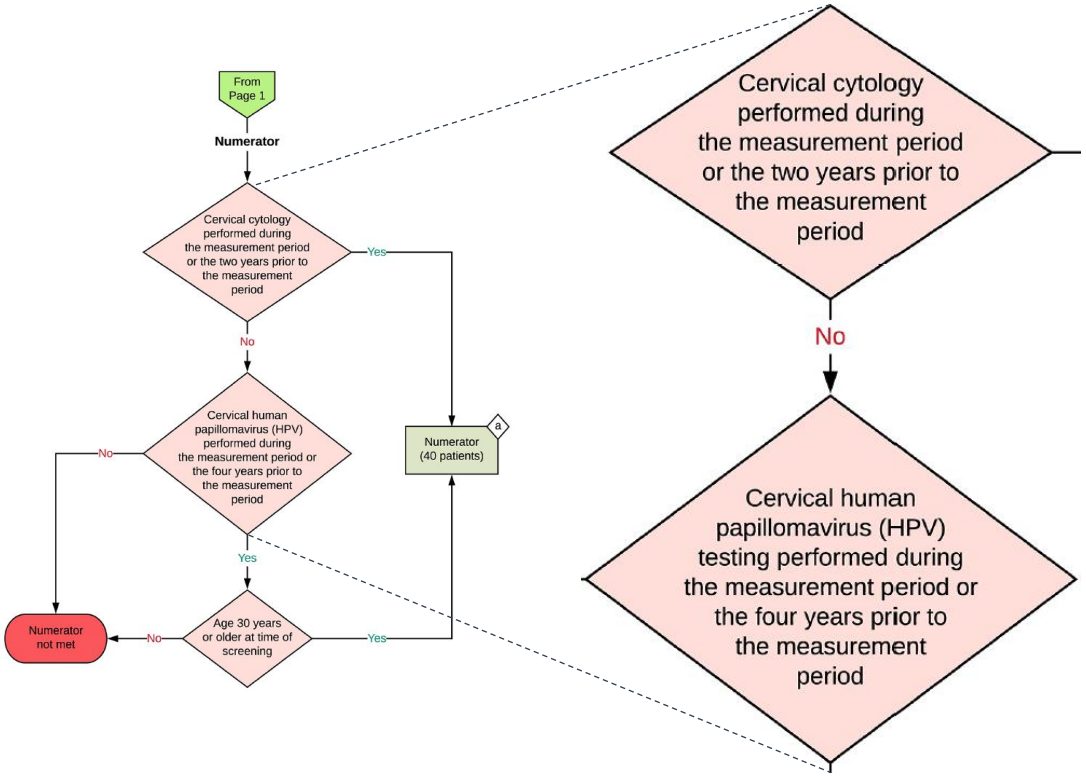


Your process mapping tool?

Other process mapping tool options:
https://miro.com/templates/flowcharts/
https://mural.co/use-case/flowchart
Visio free trial: https://www.youtube.com/watch?v=XGNSQDFQGrA

CERVICAL CANCER SCREENING



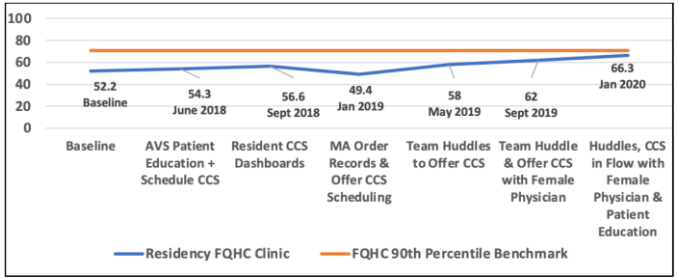
Your Problem Statements

- Many of our patients receive screening outside of health center
- Rarely receive historical or specialty records/results
- Screenings are not always documented the same way
- Getting resulted labs for PAPs inputted into structured data within our EMR because many patients receive screening at outside facilities and results are provided via fax

- Not able to capture screenings that occur outside of health center unless a lab/pap was directly ordered by one of our PCPs because EMR only considers reports with corresponding order in the chart
- Data sharing problems … use of multiple systems that cannot interface electronically with each other
- Trying to obtain reports from external hospital systems
- Do not have reliable documentation of external results in system.. lack standardized workflow identifying roles and responsibilities
- Lack of standardized workflows and facilities/hospitals to refer patients to

IMPROVING CCS RATES AT AN FQHC (URBAN)

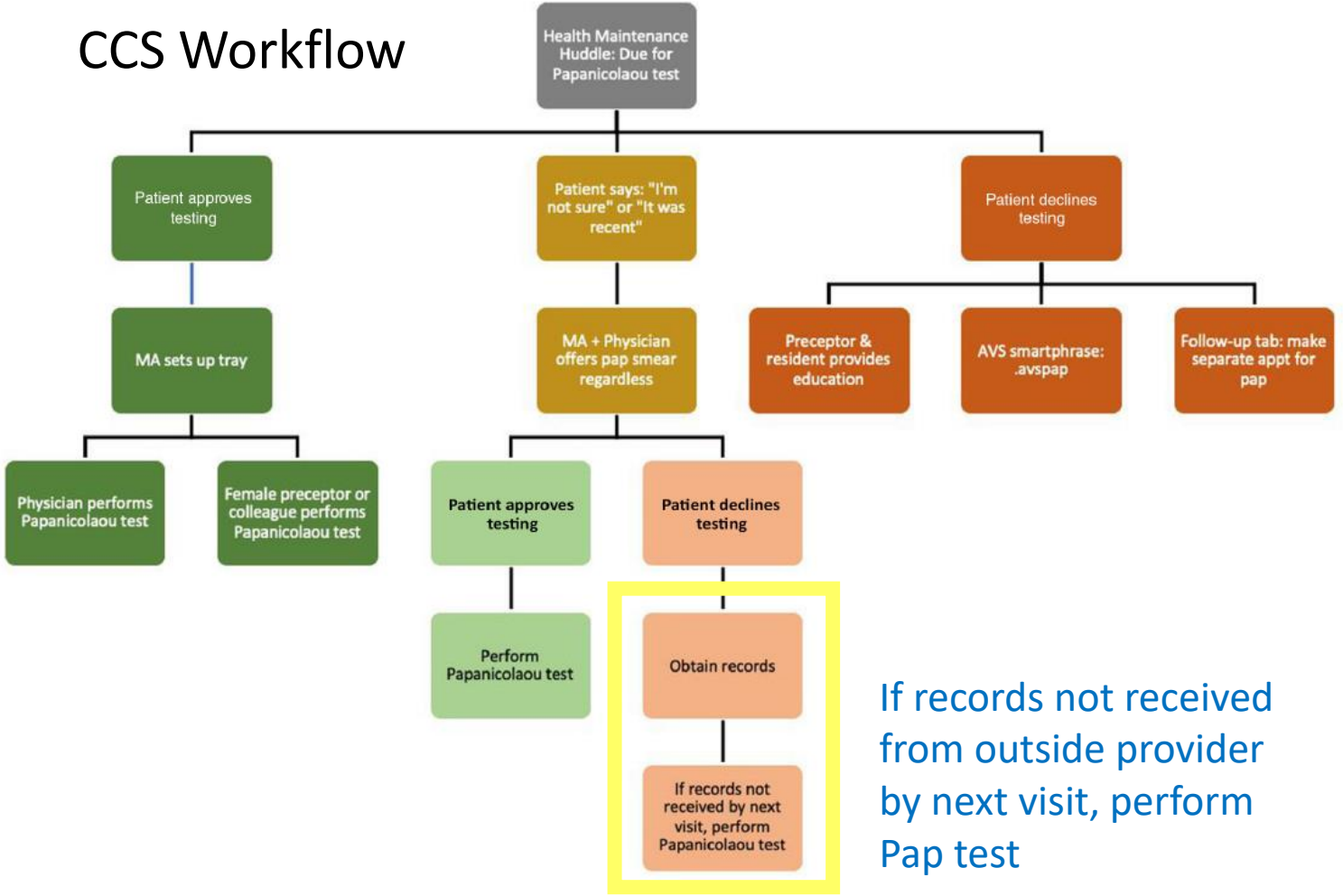
- Method
  - A series of resident-run, team-based QI projects were conducted to iteratively improve CCS rates.
  - CCS processes at the FQHC were critically analyzed using root cause analysis, process flow, and run charts after each PDSA intervention.
- Results
  - CCS rates improved from **52%** to **66%** through 6 QI projects (UDS National 2022 is 54%)



- Lessons Learned
  - **Need to slowly refine clinical processes and workflows** to support screening and involve all staff and providers as change agents. It took 6 PDSA cycles for the team to sustain and maintain changes.
  - The most practical and useful interventions were:
    - **Providing early CCS to all eligible women if outside records not immediately available**
    - Having CCS planned and offered in advance to reduce clinic cycle time
    - Having a female physician available if requested by a patient
    - Providing adequate patient education
  - Poor understanding of CC by patient and fear or embarrassment about the exam are two of the greatest barriers to CCS

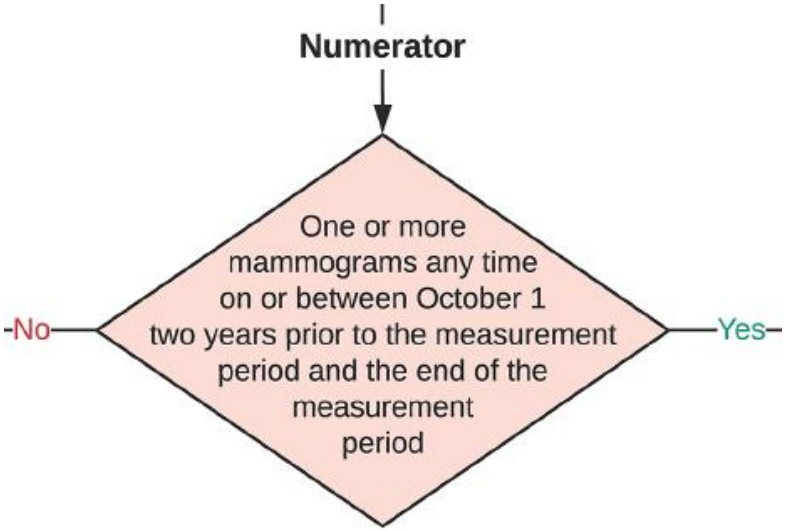
Improving Cervical Cancer Screening Rates at an Urban FQHC Family Medicine Residency Clinic, The Permanente Journal, 2022

CCS Workflow



If records not received from outside provider by next visit, perform Pap test

BREAST CANCER SCREENING



Your Problem Statements

- Trying to improve the accuracy of documented screening provided to our patients, but lack consistently followed screening workflows across clinic sites because of ambiguous EHR click paths

- Receiving the report from the mammogram facility to ensure the proper referral will be offered to the patient
- Getting back the results in EHR; employee time to follow-up with patients and reach out to them to confirm if the mammogram is completed or scheduled an appointment
- Hard time receiving reports from the facility because we do not have a good follow-up process implemented

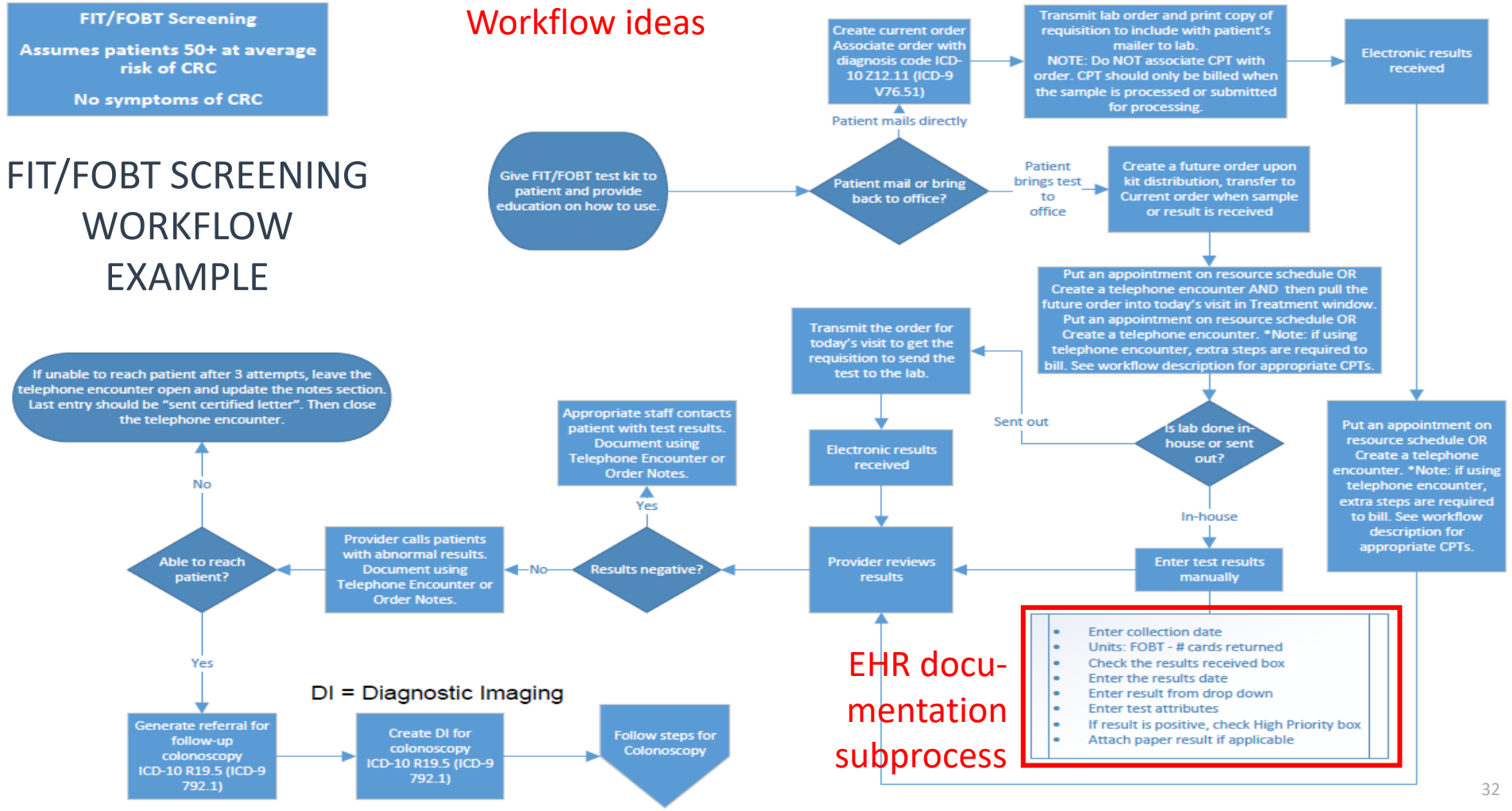
FIT/FOBT Screening

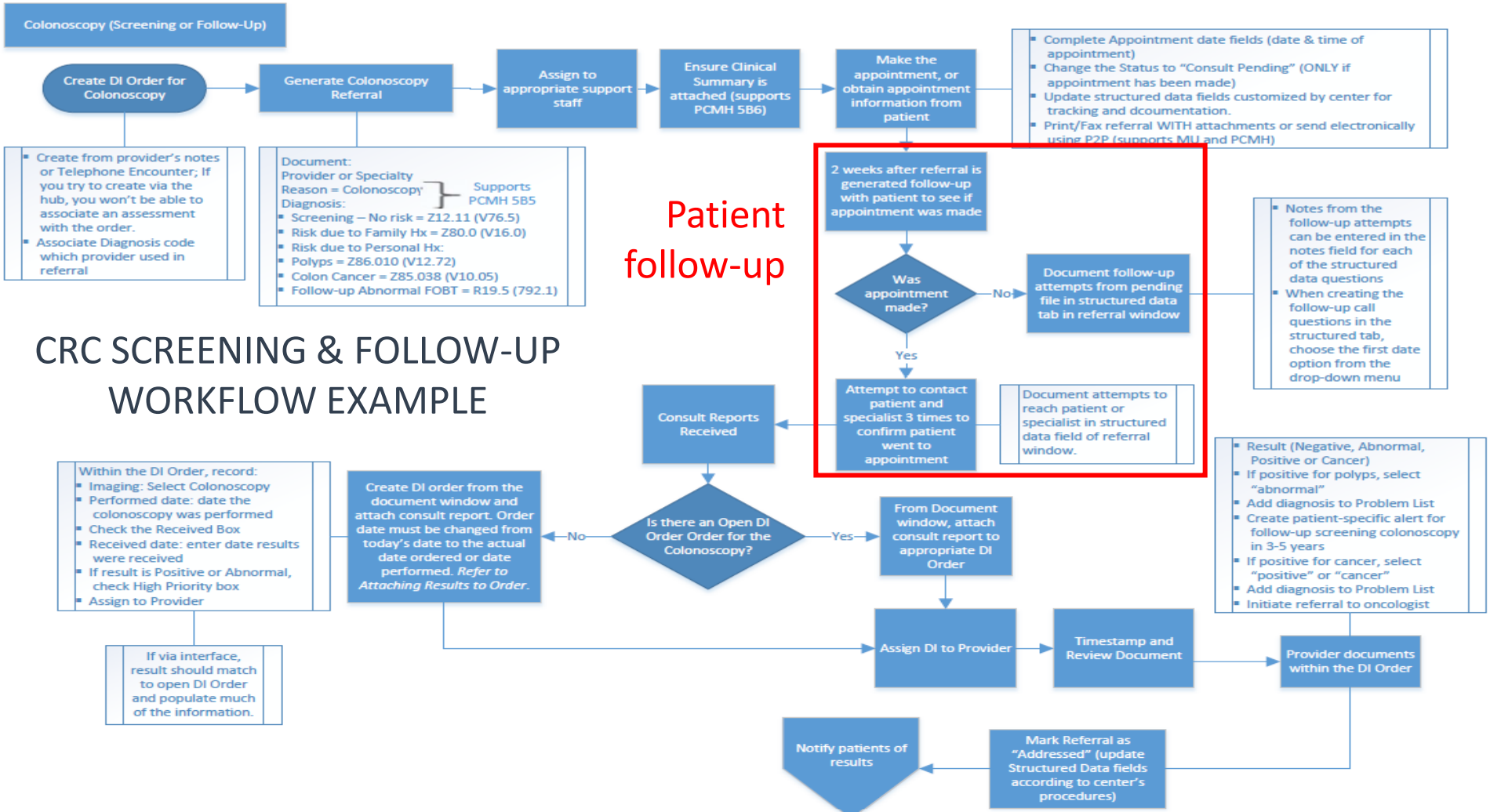
Assumes patients 50+ at average risk of CRC

No symptoms of CRC

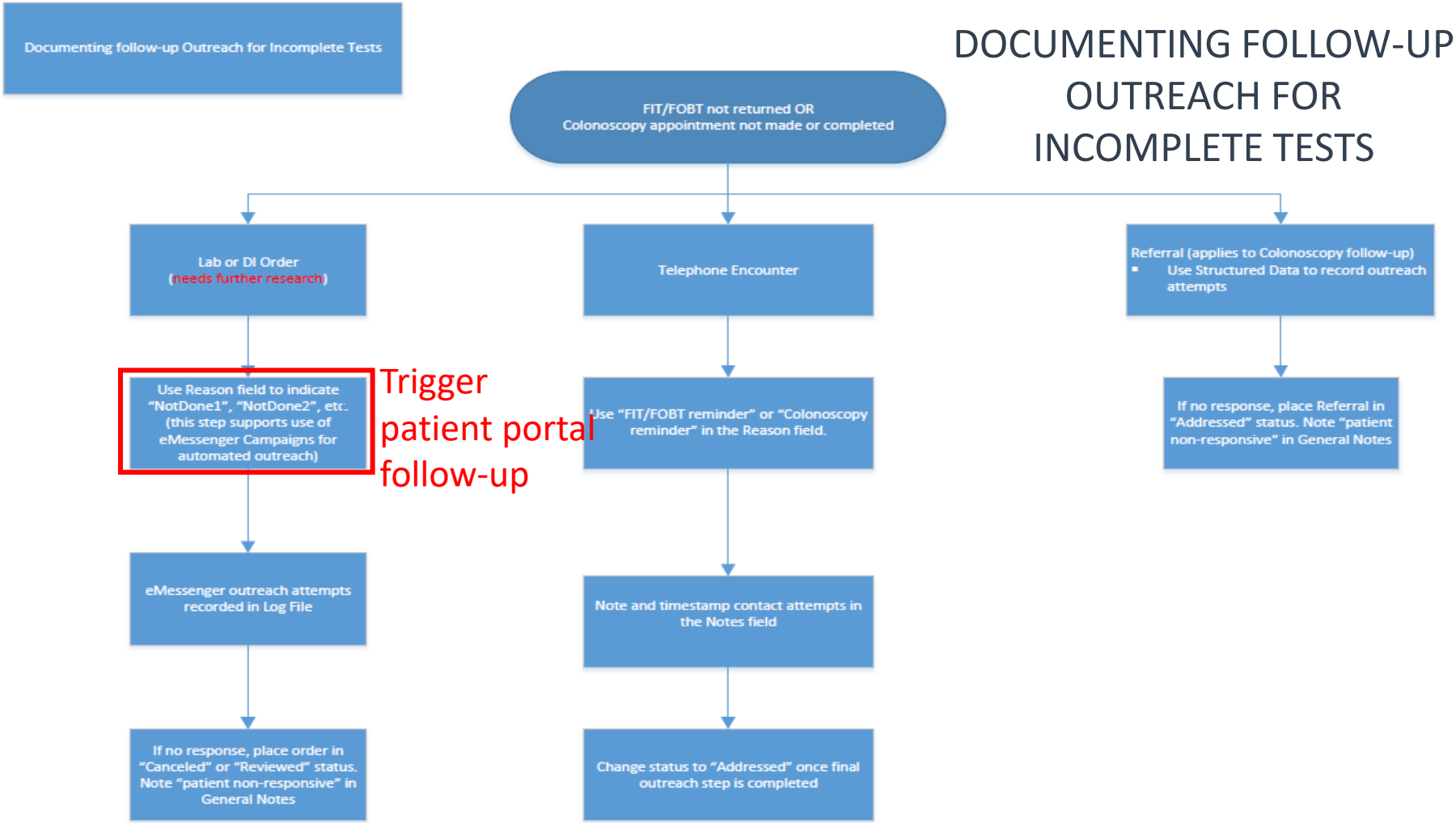
FIT/FOBT SCREENING WORKFLOW EXAMPLE

Workflow ideas




Colonoscopy (Screening or Follow-Up)
Create DI Order for Colonoscopy
Generate Colonoscopy Referral
Assign to appropriate support staff
Ensure Clinical Summary is attached (supports PCMH 5B6)
Make the appointment, or obtain appointment information from patient
Complete Appointment date fields (date & time of appointment)
Change the Status to "Consult Pending" (ONLY if appointment has been made)
Update structured data fields customized by center for tracking and dcoumentation.
Print/Fax referral WITH attachments or send electronically using P2P (supports MU and PCMH)
Create from provider's notes or Telephone Encounter; If you try to create via the hub, you won't be able to associate an assessment with the order.
Associate Diagnosis code which provider used in referral
Document:
Provider or Specialty
Reason = Colonoscopy
Diagnosis:
Supports PCMH 5B5
Screening – No risk = Z12.11 (V76.5)
Risk due to Family Hx = Z80.0 (V16.0)
Risk due to Personal Hx:
Polyps = Z86.010 (V12.72)
Colon Cancer = Z85.038 (V10.05)
Follow-up Abnormal FOBT = R19.5 (792.1)
Patient follow-up
2 weeks after referral is generated follow-up with patient to see if appointment was made
Was appointment made?
No
Document follow-up attempts from pending file in structured data tab in referral window
Notes from the follow-up attempts can be entered in the notes field for each of the structured data questions
When creating the follow-up call questions in the structured tab, choose the first date option from the drop-down menu
Yes
Attempt to contact patient and specialist 3 times to confirm patient went to appointment
Document attempts to reach patient or specialist in structured data field of referral window.
Consult Reports Received
CRC SCREENING & FOLLOW-UP WORKFLOW EXAMPLE
Within the DI Order, record:
Imaging: Select Colonoscopy
Performed date: date the colonoscopy was performed
Check the Received Box
Received date: enter date results were received
If result is Positive or Abnormal, check High Priority box
Assign to Provider
If via interface, result should match to open DI Order and populate much of the information.
Create DI order from the document window and attach consult report. Order date must be changed from today's date to the actual date ordered or date performed. Refer to Attaching Results to Order.
No
Is there an Open DI Order Order for the Colonoscopy?
Yes
From Document window, attach consult report to appropriate DI Order
Result (Negative, Abnormal, Positive or Cancer)
If positive for polyps, select "abnormal"
Add diagnosis to Problem List
Create patient-specific alert for follow-up screening colonoscopy in 3-5 years
If positive for cancer, select "positive" or "cancer"
Add diagnosis to Problem List
Initiate referral to oncologist
Assign DI to Provider
Timestamp and Review Document
Provider documents within the DI Order
Notify patients of results
Mark Referral as "Addressed" (update Structured Data fields according to center's procedures)

DOCUMENTING FOLLOW-UP OUTREACH FOR INCOMPLETE TESTS



IDEAS WITH EQUITY FOCUS

Breast Cancer Screening

- Study evaluated feasibility of individualized breast cancer risk assessment in primary care practice as an intervention to increase mammography rate among Black and Hispanic women at increased breast cancer risk
- Custom software application implemented with validated risk assessment tools to be implemented at time of woman's encounter with PC clinician at screening mammogram appointment
- Cohort study of 114 women at FQHC in underserved, racial and ethnic minority communities; **Mammography uptake found to be significantly higher (51% vs 37%)** after receiving individualized breast cancer risk information (UDS Nat'l 2022 is 50%)

JAMA Network Open 2021;4(9):e2124535.doi:10.1001/jamanetworkopen.2021.24535

- Rural population, IN and OH; DVD mailed to women that interactively assessed and provided messages on health beliefs, risk of developing targeted cancers, benefits, self-efficacy
- Patient Navigators (PN) f-u up with non-response and counseled on barriers to obtaining screenings
- Of 963 women, **DVD group 2X likely as usual care group to obtain all needed screenings, and nearly 6X for DVD/PN**

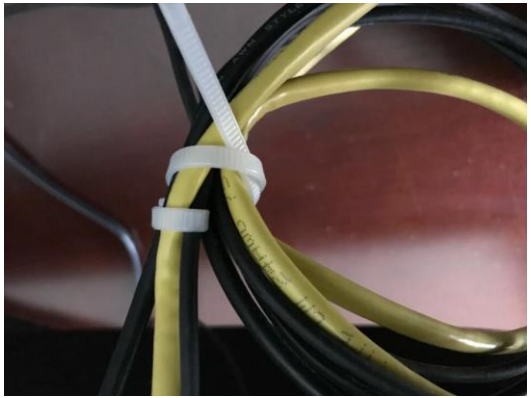
JAMA Network Open 2023;6(4):e2311004. doi:10.1001/jamanetworkopen.2023.11004

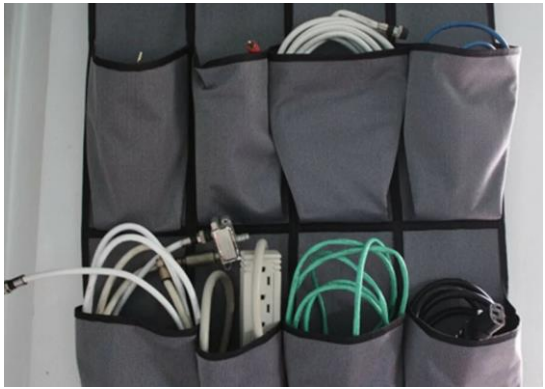
Poll

Participation in RAPID measure workflow improvement work? (check all that apply)

- ❑ Local expert(s) or passionate staff on care team
- ❑ QI, HIT, DG or management committee
- ❑ Senior leadership

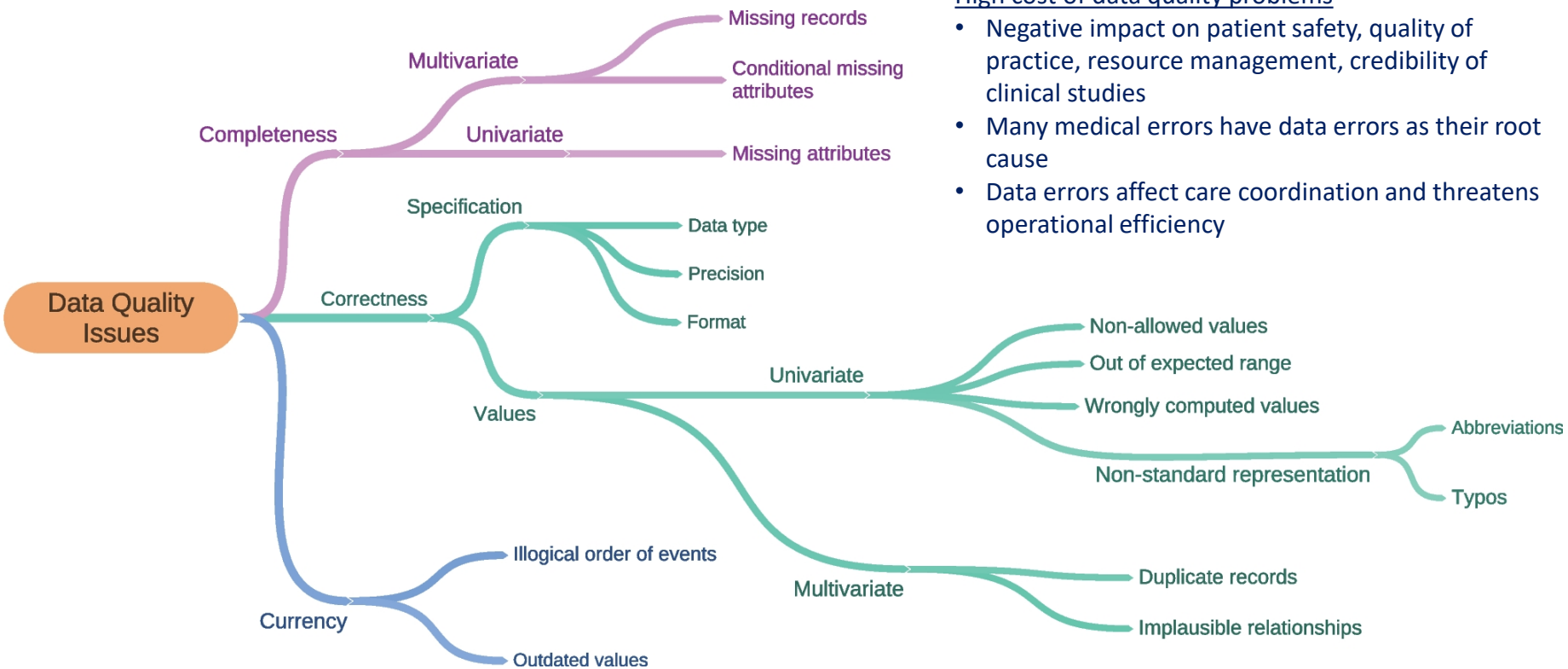
HOW TO “HARD WIRE” UDS RAPID MEASURE IMPROVEMENT?





PC Mag, Clean Up Your Messy Cables, 2024, Jill Duffy

WHY: DATA QUALITY



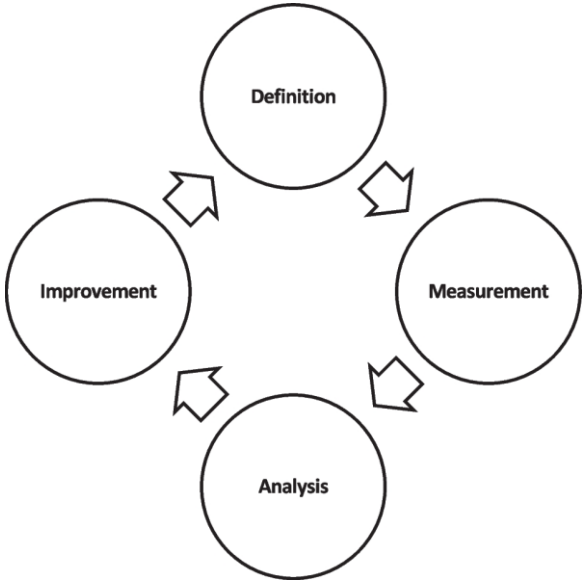
High cost of data quality problems

- Negative impact on patient safety, quality of practice, resource management, credibility of clinical studies
- Many medical errors have data errors as their root cause
- Data errors affect care coordination and threatens operational efficiency

Ozonze, O., Scott, P.J. & Hopgood, A.A. Automating Electronic Health Record Data Quality Assessment. J Med Syst 47, 23 (2023). https://doi.org/10.1007/s10916-022-01892-2

HOW: MANAGE UDS MEASURE LIFECYCLE

Typical Cycle
DQ Assessment



→ UDS measures lifecycle

Ways to improve EHR data quality

- **Preventive interventions**
  - Continuous training on use of EHR
  - Enforce standards to curb variations in documentation practice
  - More focus on data elements commonly needed for secondary use
  - Give patients more access to their data (portal)
  - Provide tangible incentives to encourage accurate documentation

- **Better usability in EHR design**
  - Tailor workflows to match clinical processes
  - Intuitive interfaces and documentation support (tooltips, input masks) to guide users when in doubt and promote best practices

WHO: DATA GOVERNANCE & DATA STEWARDS

Data Governance Function Role

- Train data stewards on how to support their measure lifecycle
- Recommend measure documentation to have and maintain
- Define measure lifecycle assessment criteria
- Receive measure lifecycle updates, help prioritize measures of focus, sponsor efforts and allocate resources

Measure Lifecycle Assessment Criteria

- Measure performance
- Data quality, literacy and use
- Workflow integrity

Actions

- Prioritize measure focus (including equity focus)
- Advise on ideas for action (people, process, technology)

MONITORING MEASURES LIFECYCLE

		Health Center vs. State								Equity Focus		Data Hygiene / Data Quality				
		Health Center				State				R/E		Last		Actions		
#	Quality of Care Measures	2020	2021	2022	Trend	2020	2021	2022	Trend	Low-High	Actions	Audit	Findings	People	Process	Technology
	Perinatal Health															
1	Early Entry into Prenatal Care (1st visit in 1s	82%	86%	84%		77%	77%	76%								
2	% L&VL Birth Weight (lower is better)	6.5%	7.2%	7.0%		6.8%	7.3%	7.1%								
	Preventive Health Screening & Services															
3	Cervical Cancer Screening	56%	58%	60%		52%	55%	58%								
4	Breast Cancer Screening	41%	40%	42%		47%	49%	52%								
5	Wt Assess, Counseling, Child/Adol	62%	70%	67%		60%	66%	65%								
6	BMI Screening and Follow-Up Plan	69%	59%	45%		61%	58%	59%								
7	Adults Screen Tobacco Use, Rec Cess Int	86%	78%	86%		84%	83%	86%								
8	Colorectal Cancer Screening	24%	28%	29%		37%	40%	42%								
9	Childhood IZ Status	44%	42%	34%		40%	39%	34%								
10	Screening Depression and F-U Plan	69%	70%	69%		59%	65%	67%								
11	Depression Remission at Twelve Months	15%	19%	16%		11%	14%	15%								
12	Dental Sealants Children 6-9 Years	79%	79%	79%		44%	55%	57%								
13	HIV Screening	62%	64%	64%		38%	44%	52%								
	Chronic Disease Management															
14	Statin Ther., Prev. & Tx Cardiovasc. Disease	73%	74%	71%		69%	70%	73%								
15	IVD: Use of Aspirin or Another Antiplatelet	70%	78%	74%		77%	76%	74%								
16	Controlling High Blood Pressure	56%	53%	61%		56%	57%	61%								
17	Diabetes: Hgb A1c Poor Control (lower is b	41%	42%	41%		37%	35%	33%								
18	% Pts seen for F-U w/i 30 days of 1st ever H	55%	93%	100%		81%	84%	80%								
		Better than State														
		Within 3%														
		Worse than 3%														

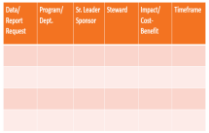
Assess disparities and equitable care

Ensure data quality

Take action

What measures need help?

BECOMING DATA DRIVEN



Data Stewardship

- Experts (or passionate staff) within a clinic site and/or department are assigned as data stewards for key UDS and other measures of focus
- Measure responsibilities are defined for data quality, data literacy and data use
- Stewards are supported by giving them authority and allocating time

Data Governance

- A forum is designated where decisions are made, priorities set, and resources allocated to improve data management and use for UDS and other priority measures
  - This may be an existing committee or management forum, ideally multi-disciplinary
  - Or start small (or from where you are at), add value, engage senior leaders, and grow from there

Data Services

- UDS and other measure data/report requests are prioritized by the staff or team that analyzes data for the organization
  - This may be a QI, IT or data analyst function
- Data and reports are accessible to relevant staff, presented in ways that are meaningful to their role, and are actionable

GOOD LUCK WITH WORKFLOWS AND UDS MEASURE LIFECYCLE!

Unlike the holiday season, you can never start too soon.

Most people think holiday season starts too early — 'Christmas fatigue' is real: survey

QUESTIONS

Send to:
jerry.lassa@datamatt3rs.com

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