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RAPID

Reporting Assistance and Process Improvement Discussion

Session 2

UDS
Uniform Data System

3

Roadmap for Today

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PART 1:
Review Action Work

PART 2:
Understanding Data Quality

PART 3:
Understanding Measure Specifications for UDS Reporting

PART 4:
Measure FAQs

PART 5:
Action items to complete prior to next session

Session 1, June 2025: Understand your Own UDS Reporting

Session 2, July 2025: Understanding your Measure of Focus

Session 3, Aug. 2025: Working Towards Your Goal

Session 4, Sept. 2025: Making and Sustaining Progress on Your Goal

SME Session: Data Governance

SME Session: Workflow Mapping

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About Us

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

Instructions

Part 1

Review Action Work

Clinical Quality Measure Trends

Each health center reviewed their own data across at least three years, and then compared that to state and national trends.

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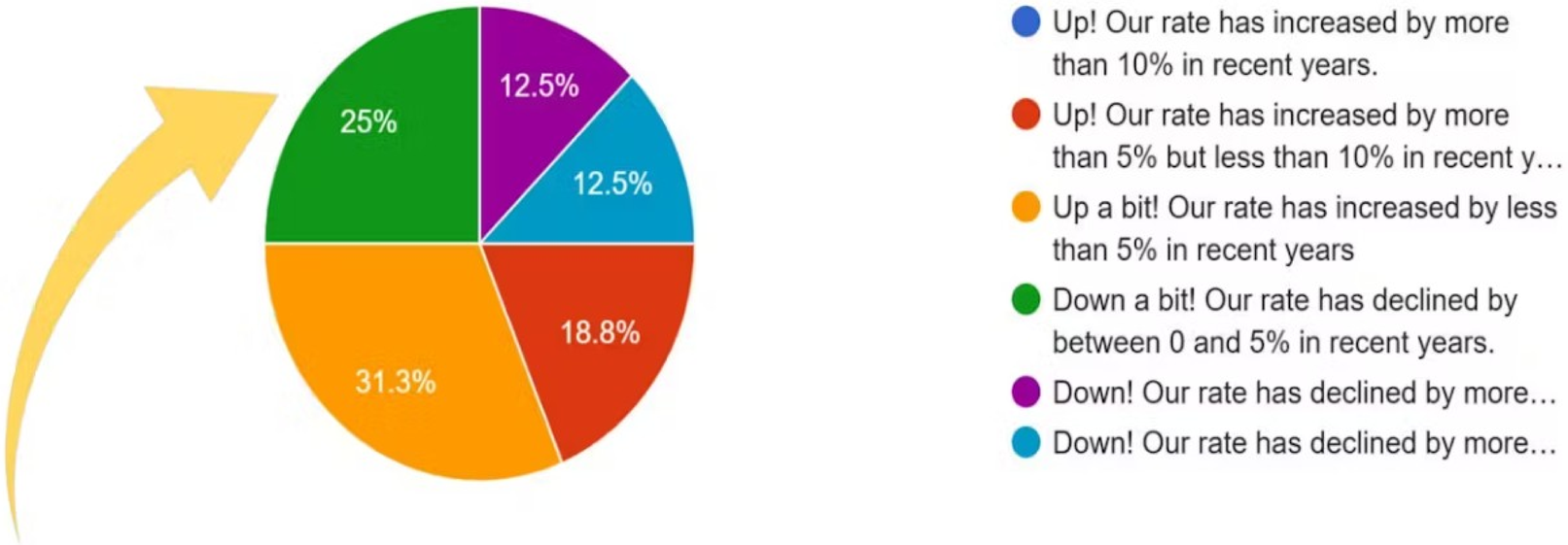
How have your cervical cancer screening rates trended for this cohort?

16 responses

Half of respondents in this cohort report their compliance rate as **BELOW** 2023 national avg.



50% of respondents have seen cervical cancer screening rates **trend DOWN** in recent years.

Five Whys Exercise

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Each health center did the Five Whys exercise with their team to better understand potential root causes of less than ideal clinical quality measure outcomes.

Cervical Cancer Screening
Initial Problems Identified

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- **Low Screening Completion:** Many responses indicate that the primary problem is the low completion rate of cervical cancer screenings.
- **Provider engagement:** Not all providers are performing cervical cancer screenings.
- **Declining Screening Rate:** Some organizations have experienced a decline in their cervical cancer screening rates.
- **Outside results:** Difficulty in obtaining screening results from outside providers.

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Cervical Cancer Screening
Root Causes Identified

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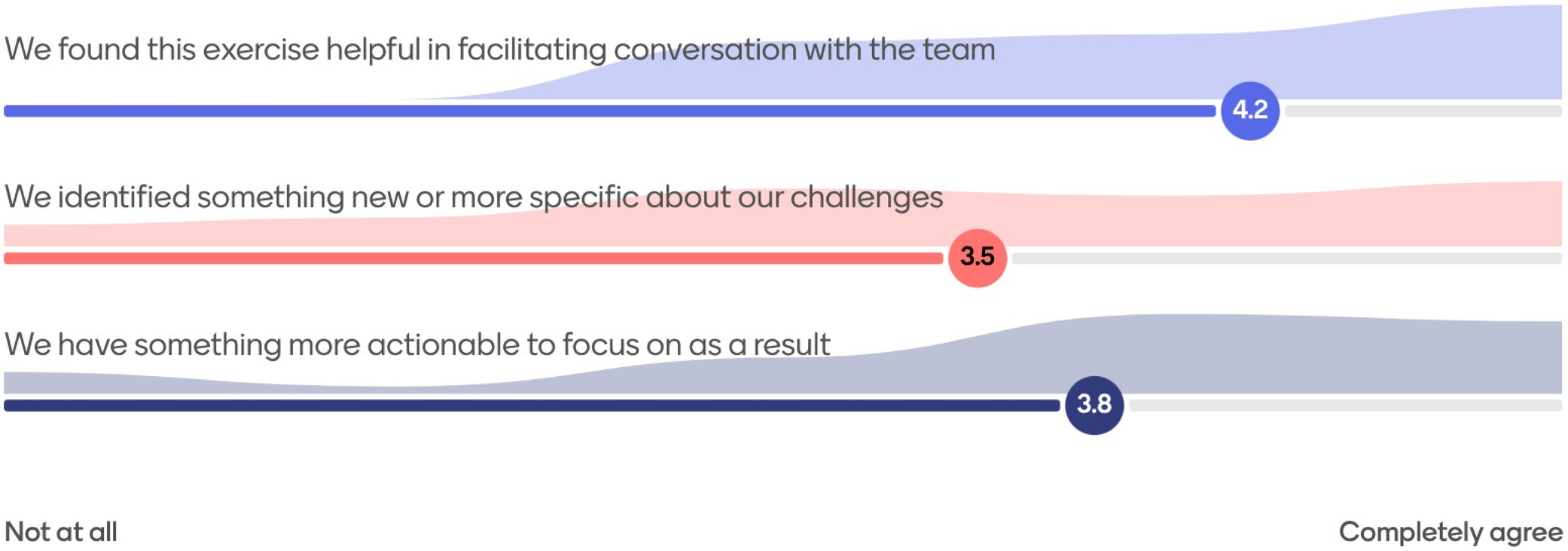
- **Patient-Related Barriers:** Patients may…
  - not understand the significance of screening
  - be reluctant to come in for an additional appointment to complete screening
  - perceive affordability as barrier
- **Systemic & Process Issues:**
  - Inability to consistently track patients due for screening
  - Challenges with documenting historical screenings
  - Lack of standardized outreach workflows
  - Staff not maximizing tools that highlight care gaps
  - Lack of integration between EHR registry tools and workflows
- **Provider Knowledge & Support:** Lack of provider competency in women's health and the need for training and support for medical teams.

Reflecting on your team's **FIVE WHYS exercise** ...



Part 2

Understanding the Scope of Data Quality

Three Layers of Data Use and Quality

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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

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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

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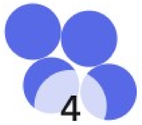
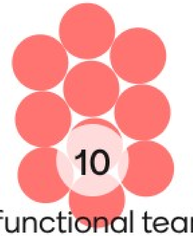
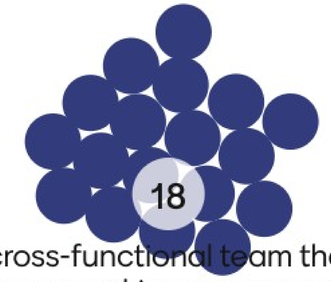
What best describes your cross functional team buy-in for UDS improvement?



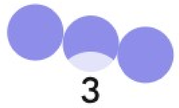
We have siloes and are not able to bring all the right people together.



We have a cross-functional team, but struggle to prioritize or make decisions.



We have a cross-functional team that works well together, and we are making some progress on change.



Our cross-functional team is strong, has leadership support and is driving data-driven change.

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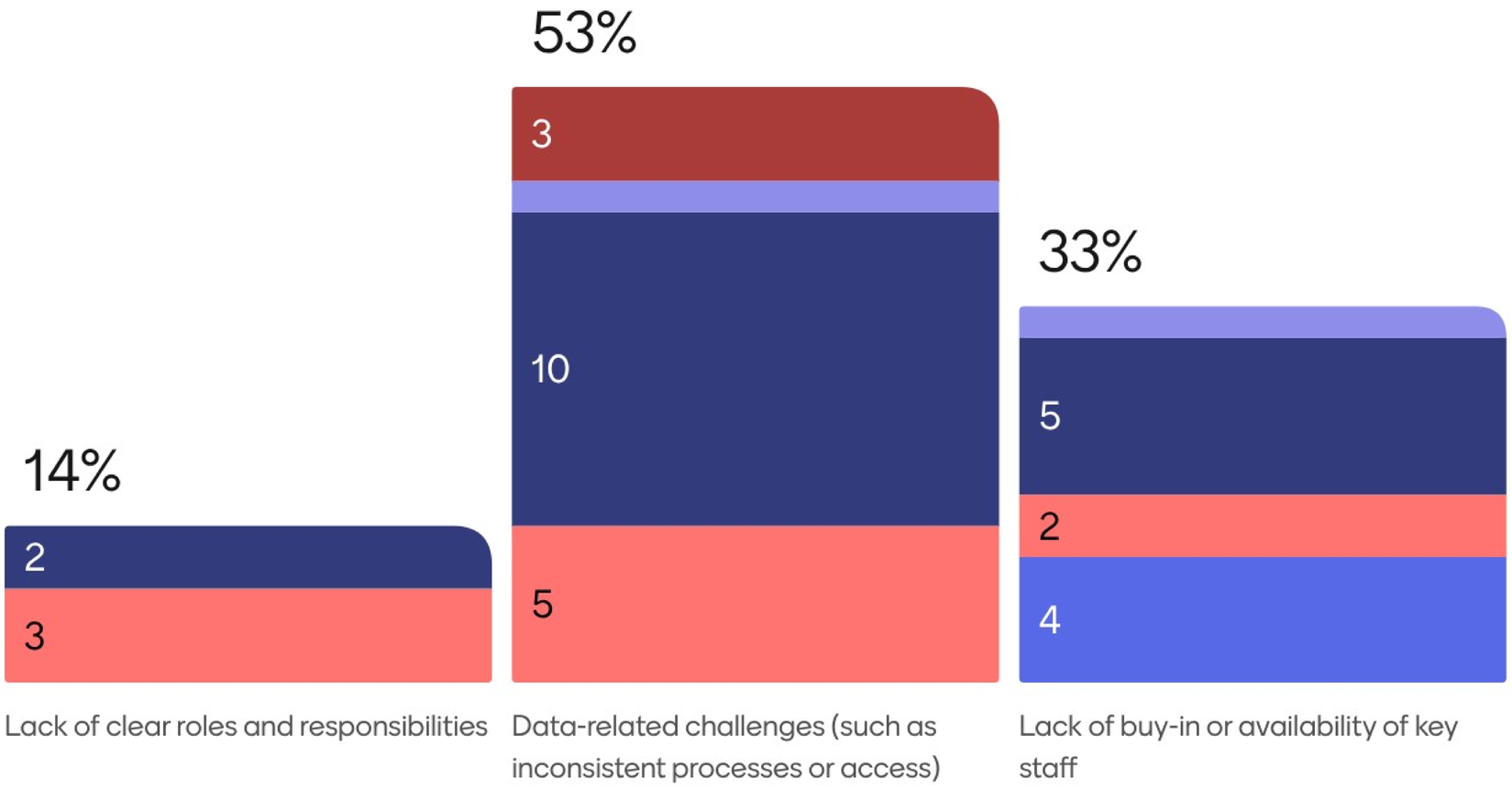
What has MOST limited progress your cross functional team's progress?



Segment

What best describes your cross functional team buy-in for UDS improvement?

- We have siloes and are not able to bring all the right people together.
- We have a cross-functional team, but struggle to prioritize or make decisions.
- We have a cross-functional team that works well together, and we are making some progress on change.
- Our cross-functional team is strong, has leadership support and is driving data-driven change.
- Unknown

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What has supported building your cross-functional team?

our organization invested in expanding our quality department and connecting to EMR management

seeking participation at individual clinic locations who all feel that they experience challenges unique to their locations

Special sauce: Have clearly defined roles for each team member, set clear deadlines for deliverables.

The first UDS we did together felt like a trial by fire. We learned to work together and have been determined to make the process better each year.

Educating the why behind the reason.

Developing new standardized solutions that reduce workload for providers

Incorporating a wider variety of job roles and departments into our quality improvement committee

Organizational buy in in terms of protected time for clinicians

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What has supported building your cross-functional team?

well-defined roles and responsibilities; also, continuous open dialogues/ommunication

Joint meetings between IT and QA. Regular QA meetings at clinic locations. Tying improvements to increased PVP efforts

a dedicated person/team to manage data and program monitoring cohesive team with strong provider champions -- give people a voice and they will use it

Use of a pre-visit planning form to identify gaps or opportunities to address with the patients.

Make sure you set aside a regularly scheduled time to come together to keep the conversations going and open, so they do not get lost in the day-to-day business.

Potential loss of Select Status for insurance companies brought leaders across all departments to the table for early disc.

Including individuals across departments involved in patient care, data, and quality who act as liaisons between data and clinical.

Two way communication. Allows for buy in and everyone feels a part of the team.

What has supported building your cross-functional team?

checking egos at the door when huddling with care team

Understanding the reason and getting the buy in from the leadership

Pairing together people from different aspects that are willing to work together tightly, have a weekly touch base on progress, and collaborate equally in specific goals. Discussing goals monthly.

Staff education and continuously providing up-to-date data. If they saw the big picture and understood they are more likely to be engaged. Also creating an open dialogue!

improved transparency and communication - - allowing information to not just be top down

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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 2025 UDS Manual.
- Clinical quality measures include links to eCQMs as well as UDS specific considerations.
- Remember that UDS clinical quality measures **include patients who had at least one UDS countable visit** during the calendar year ***and*** **met the denominator specifications** for the measure.
    - Note that the limit to UDS *medical* patients was removed in 2023; measures are reported according to eCQM denominator specifications. This was noted as challenge in the Five Whys!

Year-over-year changes:

- 2025 Program Assistance Letter (PAL)
- UDS Changes Webinar (Held June 26, 2025)

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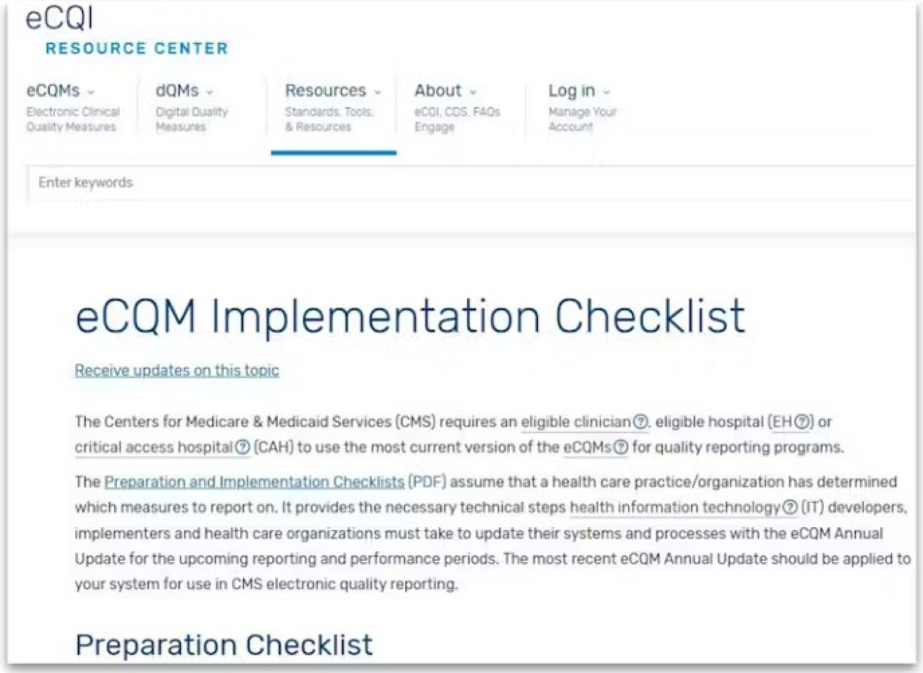
Getting Started with Clinical Quality Measures: **eCQI Resource Center**



- **eCQM Implementation Checklist**
  - 6 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., 2024 to 2025. **This highlights changes year over year.**
  - eCQM Flows: Workflows for each eCQM, updated annually and downloads as a ZIP file.
  - eCQM value sets: Brings you to the VSAC site, where you can search and download value sets.
  - Additional resources on the EC Resources page

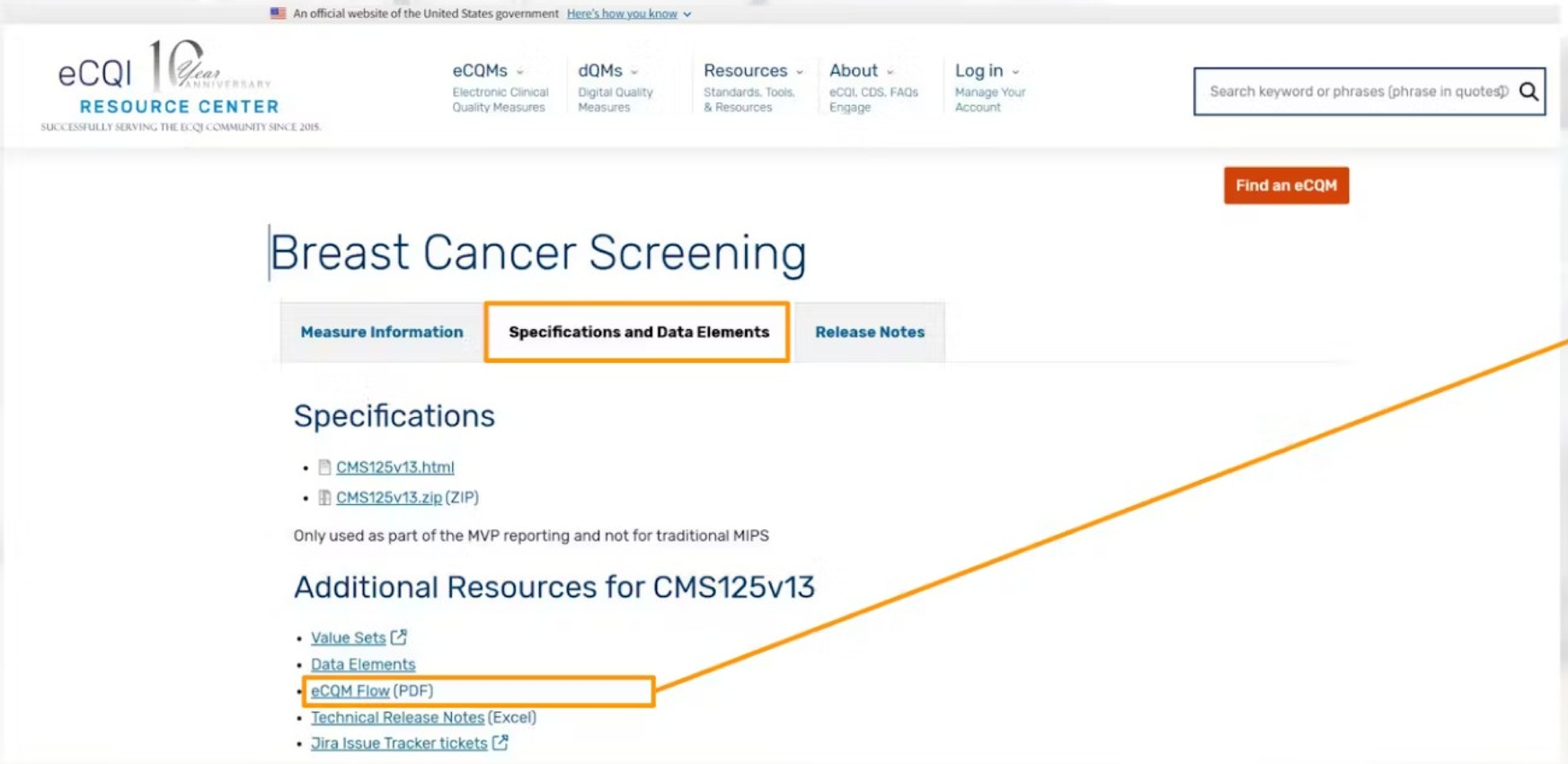
Action Item 1

Review the first 5 steps of the eCQM implementation checklist.

Remember, UDS uses Eligible *Clinician* eCQMs.

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

eCQM Flow



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Each eCQM has a process flow map which can be found in the *Specifications and Data Elements* tab, under the *Additional Resources…* heading.

There are many UDS Clinical Care TA resources available!

Available on clinical care page of TA Site; they are updated annually. Most will be updated in summer/fall.

These include:

- UDS Clinical Measures Exclusions and Exceptions
- UDS Clinical Quality Measures and Healthy People 2030 Objectives and Benchmarks
- UDS Clinical Quality Measures (CQM) Criteria
- eCQM Encounter Code Guide

Note that these **summarize information from the specifications**--they are not separate information!

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What does this look like in practice?

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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

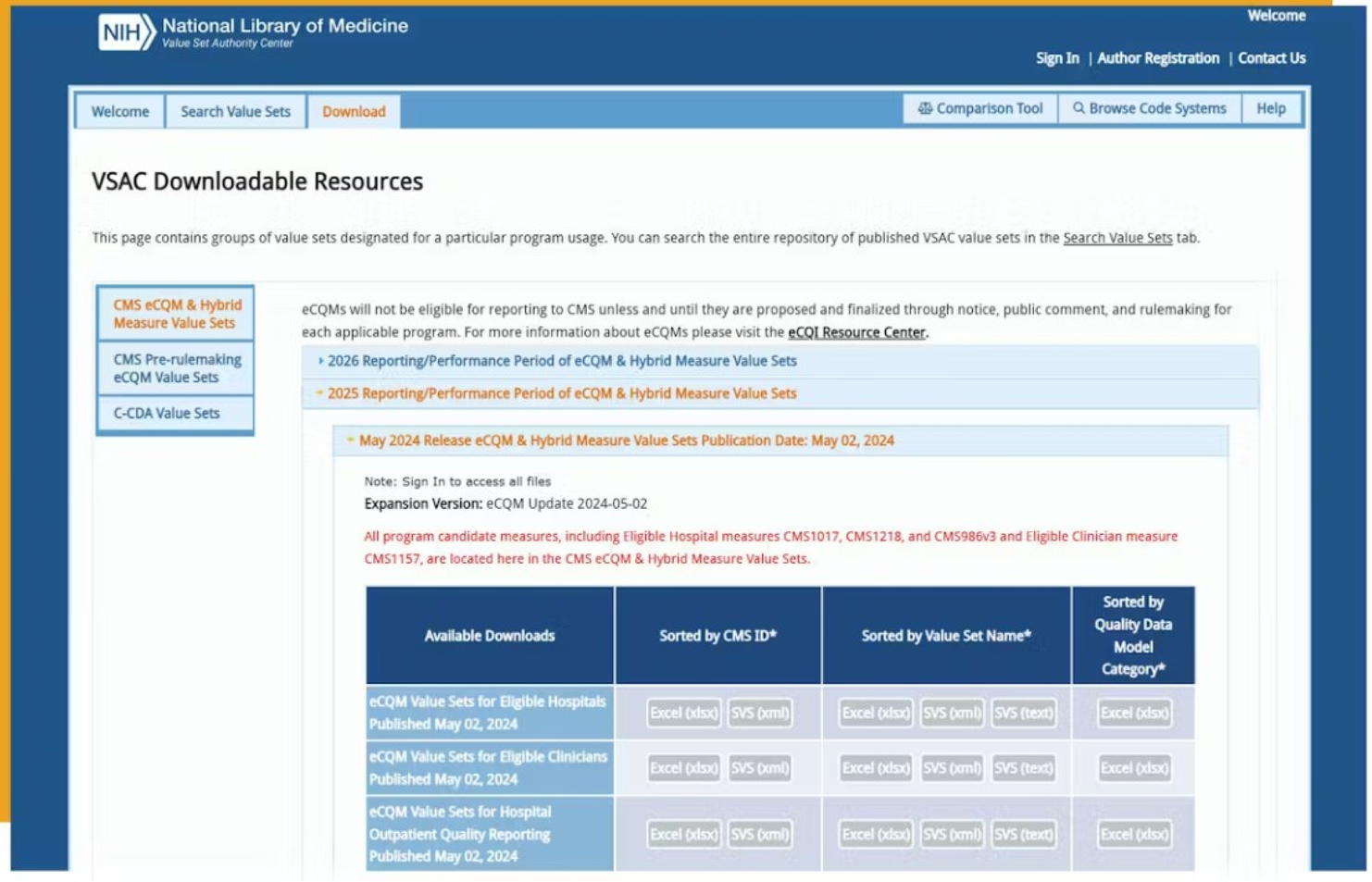
Available to all at
https://vimeo.com/635520357

Accessing Codes for All Measures

Download all codes from the VSAC site: Once logged in, go to Download Tab → 2025 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 then 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).



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

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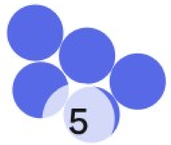
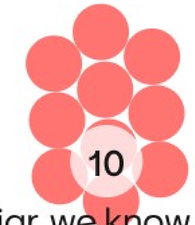
How familiar are you with the sites to access measure specifications?

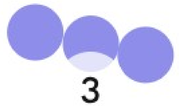


Very familiar, we access this information every year



Somewhat familiar, we know it exists and have accessed the information at least once.

We are aware of it, but haven't accessed the specifications in depth.



I am newly learning about these!

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Action Item 2

Access the measure specifications from the eCQI Resource Center and download the codes from the VSAC site for this measure (or get as far in that process as you can!)

Part 4

Measure FAQs

Cervical Cancer FAQs: Question 1

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If a patient has an HPV screening at 29 years, can that patient still be counted in the numerator when they turn 30?

No, an HPV screening performed when the patient is 29 years old cannot be counted for the Cervical Cancer Screening measure, even if they turn 30 in the period.

The measure numerator specifications say: Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women *who are 30 years or older at the time of the test*.

Cervical Cancer FAQs: Question 2

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Does self-swab testing count towards the numerator for this measure?

The method of collection is not specified in the eCQM specifications. HPV tests that are documented using the codes specified in the value set meet the numerator criteria. This question was captured in Jira here in February 2025, and received guidance that "Self-reporting is acceptable given that HPV Test report is documented in an EHR, approved for entry by the provider, using any of the codes found in the value set "HPV Test" (OID: 2.16.840.1.113883.3.464.1003.110.12.1059), has a non-null result, and is performed within the required timeframe."

Key Considerations to Meet Measure

- Ensure that screenings are attached to relevant visits.
- 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.

References for Measure FAQs

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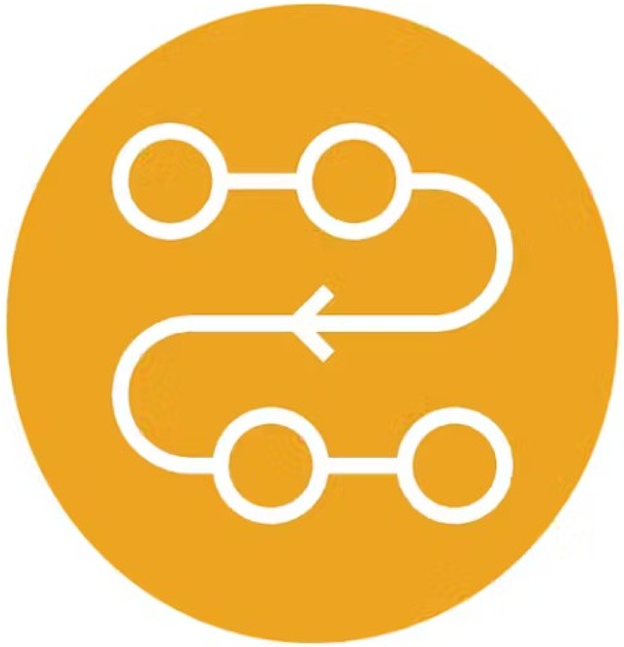
ONC Project Tracking Jira



eCQM Known Issues Tracker (part of ONC tracking)

UDS Changes Webinar and Helplines

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

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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?

Achieving our goals!

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?

Part 5

Action Items Before Next Session

Closing the Gap from Where We Are
And Where We Want to Be

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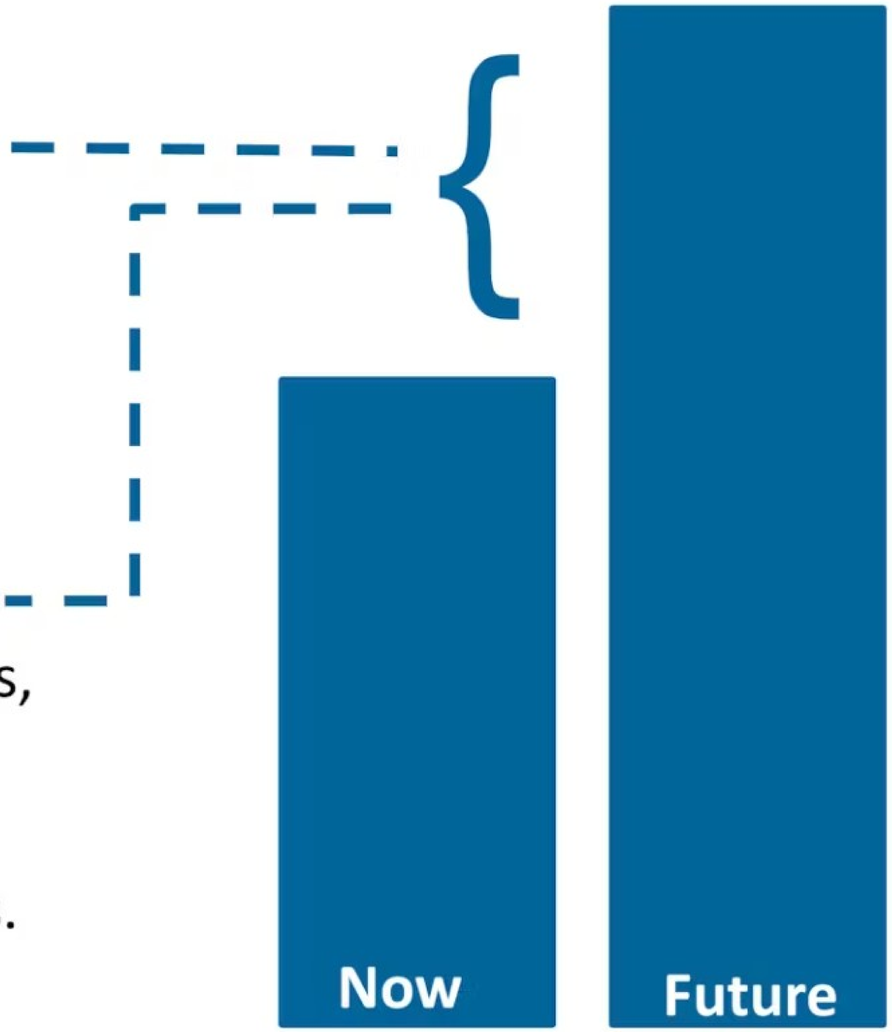
Some portion may be addressed through patient-facing changes or improvement in care processes.

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



Action items before next session

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After doing the first five steps in the eCQM implementation checklist, access specifications and codes for the measure.

Review that measure information and consider it in relation to the **root cause you identified** in your Five Whys exercise.

Identify **one specific area or component that could be improved to address the root cause you identified**, that aligns with the measure specifications.

Identify **one action step for your health center to move that specific improvement forward.** No need to do it yet!

Peer Learning Session with Subject Matter Expert:

Data Governance | July 30th | 2-3pm ET

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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

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

Analyzing the broader environment driving your clinical quality measure performance.

Establishing a SMART goal based on five whys, root cause, specifications, and opportunity for improvement.

Assistance Available

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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

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Thank You!

Contact:

udshelp330@bphcdata.net or BPHC Contact Form

1-866-837-4357

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