HRSA
Health Resources & Services Administration

Uniform Data System (UDS) Clinical Tables Part 1: Screening and Preventive Care Measures

October 2, 2024, 2:00–3:30 p.m. ET

Elise George, MPH
Training and Technical Assistance Specialist, John Snow, Inc.
Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Opening Remarks

Alysha Darden

Data and Evaluation

Office of Quality Improvement

Bureau of Primary Health Care

Health Resources and Services Administration

Objectives of the Webinar

By the end of this webinar, participants will be able to:

- Understand reporting requirements for screening and preventive care measures.
- Identify opportunities for quality improvement.
- Access additional reporting support.

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Agenda

- Discuss Uniform Data System (UDS) reporting instructions on clinical quality measures (CQMs)
- Review UDS screening and preventive care measures reporting requirements
- Identify reporting strategies and tips for data reporting
- Review 2024 UDS training resources

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Poll

How familiar are you with the UDS CQMs?

A. I am not familiar. The basics will be helpful to learn.
B. I am not very familiar. Gaining a better understanding will be helpful.
C. I am somewhat familiar. Learning about the measures in more detail will be helpful.
D. I am very familiar with these measures. I would like to learn about any changes this year that impact UDS reporting.

UDS CQM Reporting

Key UDS Terminology in Clinical Quality Measure Reporting

Electronic Clinical Quality Improvement (eCQI) Resource Center

Key Resources

Components of Each Clinical Measure

Denominator	Numerator	Exclusions and Exceptions
• Identifies the group of patients that the measure looks at for whether they have received the service, test, or outcome. • Equal to the initial population identified in the CQM. • Reported in Column A.	• Measures whether the service, event, or outcome requirements were met. • Each patient in the denominator is assessed to determine if they meet the numerator. • Reported in Column C.	• **EXCLUSIONS:** Patients who meet exclusion criteria are not to be considered for the measure. They are removed from the denominator before determining if numerator criteria are met. • **EXCEPTIONS:** Patients who do meet denominator criteria but do not meet numerator criteria and meet any of the exceptions criteria are removed from the denominator.

Other Key Terms in UDS CQM Measurement

Specification Guidance	The Centers for Medicare & Medicaid Services (CMS) measures guidance that assists with understanding and implementing CQMs.
UDS Reporting Considerations	Additional BPHC requirements and guidance that must be applied to the specific measure and that may differ from or expand on the eCQM specifications.
CQMs	Quantified indicators used to evaluate how well the health center is achieving standards.
eCQMs	CQMs expressed and formatted to use data from electronic health record (EHR) and/or health information technology (Health IT) systems to measure health care quality, ideally data captured in structured form during the process of patient care. Most CQMs are aligned with eCQMs.
Value Sets	Lists of codes and corresponding terms from the National Library of Medicine–hosted standard clinical vocabularies (such as SNOMED CT, RxNorm, and LOINC®) that define clinical concepts.
Measurement Period	Represents Calendar Year 2024 (January 1–December 31) **unless** another time frame is specifically noted in the UDS Manual or measure specifications.
Measure Steward	An individual or organization that owns a measure and is responsible for maintaining the measure. Each eCQM has a measure steward.

Denominators: Qualifying Encounters

Clinical measure guidance for the UDS specifies that in order to be included in any given CQM denominator, patients must have:

- A **countable UDS visit** during the calendar year reported on Table 5, **and**

- A **visit that meets the qualifying encounter definitions** for that particular CQM and eCQM's measure criteria and specifications.
- Each measure defines its own qualifying encounters in its specifications.

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CQMs: Keys to Remember

To be reported *anywhere* on the UDS, a patient must have a countable visit on Table 5 during the year.

Countable visits can be in multiple service areas (medical, dental, mental health, substance use disorder, etc.) if they meet the countable visit definition.

For CQM reporting on Table 6B, patients must meet the criteria detailed in the individual measure specifications.

Eligible visit types depend on the specification defined by the particular measure steward and must be assessed for each measure individually.

It is essential to review and use the codes listed in each eCQM.

Many eCQMs will still have denominators that are limited to patients who have had at least a medical visit during the year, but in some measures, other visit types might also be included.

Understanding Eligible Visits for CQMs

- Accessing and Reading eCQMs for UDS
- Accessing Value Set Codes for CQMs

Does this mean that *all* patients with UDS countable visits are now included in the denominator for CQMs?

No! It means that those patients who meet the measure specifications are included in each measure's denominator. For some measures, this is *a lot* of visit types; in others, it's fairly narrow. Each measure steward identifies the population or denominator for the measures that they develop.

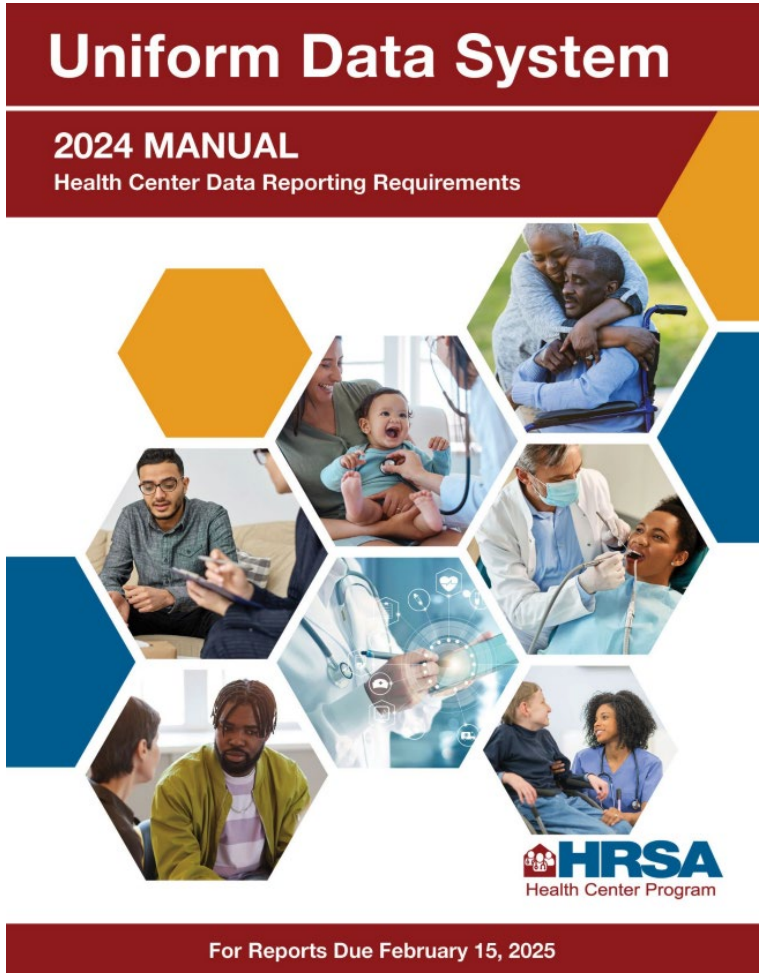
Does this mean we need to be doing pap tests or colorectal cancer screenings for our dental patients or case management patients?

Dental visit types are not specified in the denominator for cervical cancer screening or colorectal cancer screening measures. If the patient had other visits, they could be eligible. Again, the visit types/codes are specified for each measure and can be seen in the measure specifications in the eCQI Resource Center.

Getting Started with CQMs
Finding UDS Guidance

- Review the 2024 UDS Manual, which includes:
  - Definitions and instructions specific to the UDS
  - Links to all eCQMs, as well as UDS-specific considerations
  - Descriptions of additional resources to support reporting

- Review year-over-year changes via:
  - 2024 Program Assistance Letter
  - UDS Changes Webinar (held June 5, 2024)
  - Upcoming technical assistance webinars and annual UDS trainings co-hosted with Primary Care Associations



UDS+ data submission will be required for certain UDS tables. Details about the requirements for 2024 can be found on the UDS Modernization Initiative and Health Center Program Community websites.

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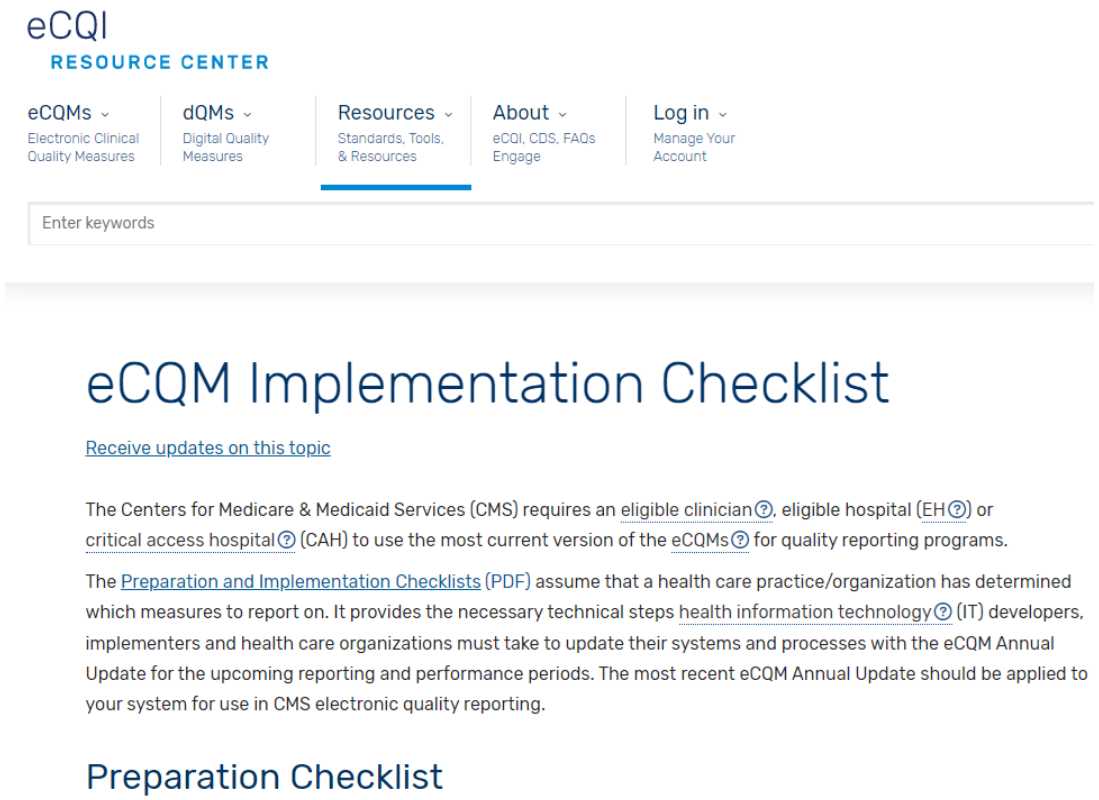
Getting Started with CQMs
eCQI Resource Center



eCQM Implementation Checklist

- Six preparation steps and seven implementation steps.

eCQM supports include:

- eCQI Resource Center: For each measure, in the "Measure Information" tab, there is the option to "compare" (e.g., 2023 to 2024). **This highlights changes year over year.**
- eCQM Flows: Workflows for each eCQM, updated annually; downloads as a ZIP file.
- Technical Release Notes: 2024 Performance Period eCQMs for Eligible Clinicians
- eCQM value sets: The Value Set Authority Center (VSAC) site allows you to search value sets.
- Additional resources are available on the Eligible Clinician eCQM Resources page.

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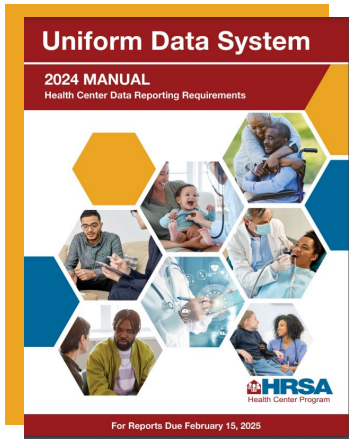
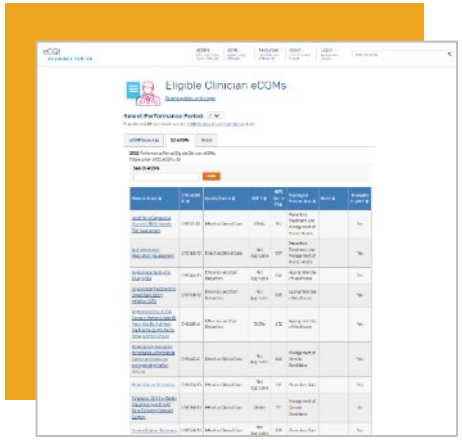
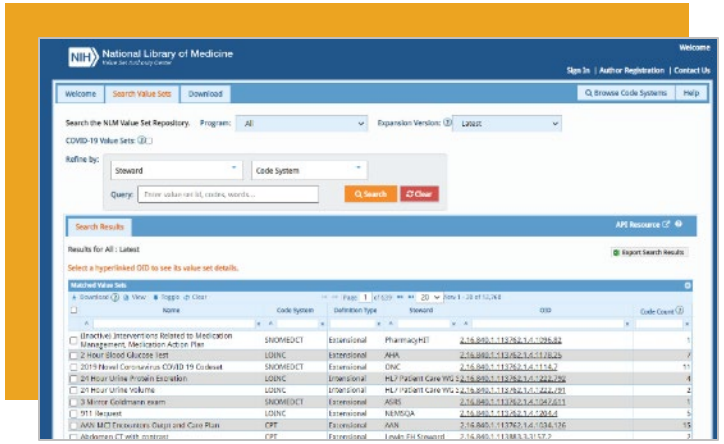
Getting Started with CQMs
Key Resources



The UDS Manual provides an overview of the UDS, covers UDS-specific considerations, and links to measure specifications.



The manual links to the eCQI Resource Center, where measure information, specifications, data elements, and value sets are found.



The codes that make up each value set within the measure specifications are available from the VSAC site.

eCQM issues that have been identified can be reviewed in the Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) Jira project eCQM Issue Tracker.

Responses to questions and guidance from the measure stewards can be found here.

Sign up for an OITS account.

Post questions in the eCQM Issue Tracker.

Knowledge Check #1

What criteria are used to determine which patients to include in a measure denominator?

A. Only patients who had at least one medical visit during the measurement period as specified in the measure.

B. Only patients who had eligible countable visit(s) (as defined by the measure steward for the selected eCQM) during the measurement period as specified in the measure.

C. Only patients who had at least one behavioral health visit at a health center site during the measurement period as specified in the measure.

D. None of the above.

Knowledge Check #1 Answer

What criteria are used to determine which patients to include in a measure denominator?

A. Only patients who had at least one medical visit during the measurement period as specified in the measure.

B. Only patients who had eligible countable visit(s) (as defined by the measure steward for the selected eCQM) during the measurement period as specified in the measure.

C. Only patients who had at least one behavioral health visit at a health center site during the measurement period as specified in the measure.

D. None of the above.

Table 6B CQMs

Reporting Format

Key Changes

UDS CQMs

UDS CQMs

Clinical Quality Measures Deep Dive

Recorded on September 26, 2024

Screening and Preventive Care Measures

Today's webinar

Maternal Care and Children's Health Measures

UDS Clinical Tables Part 2: October 9, 2024, 2:00–3:30 p.m. ET

Chronic Disease Management Measures

UDS Clinical Tables Part 3: October 23, 2024, 2:00–3:30 p.m. ET

Register for future UDS webinars and view past webinar recordings.

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Table 6B Reporting Format

Denominator (a)	Number of Records Reviewed [Denominator] (b)	Number of Records Meeting the Numerator Criteria [Numerator] (c)
Number of patients who fit the detailed criteria described for inclusion in the measure	Patients who fit the criteria (same as Column A), or a number equal to or greater than 80% of Column A	Number of records from Column B that meet the numerator criteria for the measure

In addition to submitting UDS Reports within the Electronic Handbooks (EHBs), UDS+ data submission will be required for certain UDS tables. Details about submission requirements for 2024 can be found on the UDS Modernization Initiative and Health Center Program Community.

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Changes to Align with eCQMs

Table 6B was updated to align with the latest CMS eCQMs. The 2024 UDS CQM Criteria handout is available to review for 2024 updates.

From Table 6B: Screening and Preventive Care Measures with Updated eCQMs

Line/Columns	Quality Care Measure	Updated eCQM
11	Cervical Cancer Screening	CMS124v12
11a	Breast Cancer Screening	CMS125v12
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v12
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v12
19	Colorectal Cancer Screening	CMS130v12
20a	HIV Screening	CMS349v6
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v13

Table 6B CQMs:
Screening and Preventive Care

General Flow of Screening and Preventive Care Measures

1. Among patients with at least one countable UDS visit during the calendar year, identify patients with at least one eligible encounter (as defined by the measure steward via value sets for the selected eCQM) during the calendar year.
2. For those who have received the specific screening or service, determine whether the service has been documented.
3. Determine whether those patients meet the other specifications for inclusion in the measure (e.g., they do not meet any exclusions or exceptions).
4. For those included, determine whether they have received the specific screening.

General Reporting Guidelines

- Performance is determined by screening results and follow-up actions.
  - Include negative screens **and** positive screens with follow-up in the numerator.
- Certain procedures cannot be completed virtually.
- Screenings and tests performed **elsewhere** may count for some measures toward performance if they are appropriately documented in the EHR and approved by a provider.
- Do not count, as meeting performance, charts that note the refusal of the patient to have the test or screening.
- For CQMs requiring the completion of screenings, tests, or procedures to meet the numerator criteria, the findings of the screenings, tests, or procedures **must be accessible** in the patient health record.

Contacts That Do Not, ALONE, Count as Visits

Screenings or Outreach	Group Visits	Tests/Ancillary Services	Dispensing/ Administering Medications	Health Status Checks
Information sessions for prospective patients	Patient education classes	Drawing blood	Dispensing medications from a pharmacy	Follow-up tests or checks (e.g., patients returning for HbA1c tests)
Health presentations to community groups	Health education classes	Laboratory or diagnostic tests	Giving injections	Wound care
Immunization drives	*Exception: behavioral health group visits*	COVID-19 tests	Providing narcotic agonists or antagonists or a mix	Taking health histories

Cervical Cancer Screening: CMS124v12

Denominator	Exclusions	Exceptions	Numerator
Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Women who had a hysterectomy with no residual cervix or a congenital absence of cervix Patients who were in hospice care for any part of the measurement period Patients who received palliative care for any part of the measurement period	Not applicable	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: • Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period. • Cervical human papillomavirus (HPV) testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

Cervical Cancer Screening: CMS124v12 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- Evaluates whether tests were performed after a woman turned 21 years of age. The youngest age in the initial population is a patient who turned 24 years old on December 31.
- Evidence of high-risk human papillomavirus (hrHPV) testing within the last 5 years also captures patients who had cotesting, therefore, additional methods to identify cotesting are not necessary.
- Include patients of all genders who have a cervix for measure assessment.
- **Screening performed elsewhere?** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.

Breast Cancer Screening: CMS125v12

Denominator	Exclusions	Exceptions	Numerator
Women 52 through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy on or before the end of the measurement period. Patients who were in hospice care for any part of the measurement period Patients aged 66 or older by the end of the measurement period • Who were living long-term in a nursing home any time on or before the end of the measurement period • With advanced illness and frailty who also meet any of these advanced illness criteria: – Advanced illness with one inpatient visit or two outpatient visits during the measurement period or the year prior; or – Taking dementia medications during the measurement period or the year prior Patients who received palliative care during the measurement period	Not applicable	Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period

Breast Cancer Screening: CMS125v12 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- The measure only evaluates whether tests were performed after a woman turned 50 years of age. The youngest age in the initial population is 52.
- Include patients according to sex assigned at birth.
- **Do not** count biopsies, breast ultrasounds, or magnetic resonance imaging, because they are not appropriate methods for *primary breast cancer screening*.
- ***Mammogram performed elsewhere?*** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.

(Adult) Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v12

Denominator	Exclusions	Exceptions	Numerator
Patients 18 years of age or older on the date of the visit with a qualifying encounter during the measurement period, as specified in the measure criteria **Do not** include patients who had only virtual visits during the year.	Patients who are pregnant at any time during the measurement period Patients receiving palliative or hospice care at any time during the measurement period	Patients who refuse measurement of height and/or weight Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan	Patients with a documented BMI (not just height and weight) during their most recent visit or during the measurement period, **and** when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the measurement period.

Conditions linked with **"and"** mean that all of the conditions must be met.

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(Adult) Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v12 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- Include in the numerator patients within normal parameters who had their BMI documented **and** patients with a BMI outside normal parameters with a follow-up plan.
- If more than one BMI is reported during the measurement period and any one of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan is to be used to determine whether performance has been met.
- BMI may be documented in the patient health record at the health center or in outside patient health records obtained by the health center.
- Height and weight are not acceptable to be self-reported or reported via a telehealth visit.
- If the only visit a patient had during the year was telehealth or telephone-only, the patient should be excluded from the measure assessment. However, development of a follow-up plan for a BMI out of range is acceptable via telehealth.
- **Do not** count as meeting the numerator criteria charts or templates that display only height and weight. The fact that health IT/EHR can calculate BMI does not replace the presence of the BMI itself.

Tobacco Use: Screening and Cessation Intervention: CMS138v12

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older at the start of the measurement period seen for at least two qualifying encounters in the measurement period **or** at least one preventive care qualifying encounter during the measurement period, as specified in the measure criteria	Patients who were in hospice care for any part of the measurement period	Not applicable	Patients who were screened for tobacco use at least once during the measurement period, **and** who received tobacco cessation intervention during the measurement period or during the six months prior to the measurement period if identified as a tobacco user

Tobacco Use: Screening and Cessation Intervention: CMS138v12 *(cont.)*

The Tobacco Screening measure **denominator changed** to include patients 12 years of age and older.

2023 Measure Denominator	2024 Measure Denominator
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period and who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user	Percentage of patients aged **12** years and older who were screened for tobacco use one or more times during the measurement period and who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user

Known Issue: The "Preventive Care Services, Initial Office Visit, 0 to 17" and "Preventive Care, Established Office Visit, 0 to 17" value sets are not currently included in the measure. (The ONC Jira tickets on this issue can be reviewed here and here.)

Solution: CMS138v12 should continue to be used to report for the 2024 UDS performance period. Clinically equivalent codes can be used for mapping. Health centers are encouraged to work with their Health Information Technology (Health IT) developers and clinical partners, as appropriate, to map the missing value sets. The missing value sets can be accessed from the Value Set Authority Center (VSAC) site.

Tobacco Use: Screening and Cessation Intervention: CMS138v12 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- The tobacco use screening and tobacco cessation intervention **do not** need to be performed by the same provider.
- If a patient has multiple tobacco use screenings during the measurement period, use the most recent screening that has a documented status of tobacco user or non-user.
- Include in the numerator patients with a negative screening **and** patients with a positive screening who had cessation intervention if a tobacco user.
- If tobacco use status of a patient is unknown, the patient **does not** meet the screening component and has not met the criteria to be counted in the numerator.
  - "Unknown" includes patients who were not screened and patients with indefinite answers.
- The measure **does** consider the use of e-cigarettes and other electronic nicotine delivery systems to be tobacco use, so patients reporting use of these devices will be included in the denominator and need to be assessed for the numerator. However, use of e-cigarettes is not considered a method of tobacco cessation for consideration of numerator compliance.

Colorectal Cancer Screening: CMS130v12

Denominator	Exclusions	Exceptions	Numerator
Patients 46 through 75 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Patients with a diagnosis of colorectal cancer or a history of total colectomy Patients who were in palliative or hospice care for any part of the measurement period Patients aged 66 or older by the end of the measurement period: • Who were living long-term in a nursing home during measurement period; **or** • With advanced illness and frailty who also meet any of these advanced illness criteria: – Advanced illness with one inpatient visit or two outpatient visits during the measurement period or the year prior; or – Taking dementia medications during the measurement period or the year prior	Not applicable	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined **by any one** of the following: • Fecal occult blood test (FOBT) during measurement period • Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT) during the measurement period or the two years prior to the measurement period • Flexible sigmoidoscopy during measurement period or the four years prior • Computerized tomography (CT) during measurement period or four years prior • Colonoscopy during measurement period or nine years prior

Colorectal Cancer Screening: CMS130v12 *(cont.)*

The Colorectal Cancer Screening measure's **numerator terminology has changed** to refer to "stool DNA (sDNA) with FIT test" in place of "FIT-DNA."

2023 Measure Numerator	2024 Measure Numerator
FIT-DNA during the measurement period or the two years prior to the measurement period.	**Stool DNA (sDNA) with FIT test** during the measurement period or the two years prior to the measurement period.

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Colorectal Cancer Screening: CMS130v12 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- **Do not** count digital rectal exams (DRE) or FOBTs performed in an office setting or performed on a sample collected via DRE.
- FOBTs can be used to document meeting the numerator criteria but are required each measurement period. There are two FOBT options: the guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Screening methods performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the health center staff and the performing lab/clinician showing the results.
- **Do not** use self-reported test results.
- Procedures and diagnostic studies are not acceptable via telehealth.
- iFOBT, gFOBT, and sDNA with FIT test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.

HIV Screening: CMS349v6

Denominator	Exclusions	Exceptions	Numerator
Patients aged 15 through 65 years of age at the start of the measurement period who had at least one outpatient eligible countable visit during the measurement period, as specified in the measure criteria	Patients diagnosed with HIV prior to the start of the measurement period	Patients who died on or before the end of the measurement period	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

HIV Screening: CMS349v6 *(cont.)*

The HIV Screening measure has **added a denominator exception** for patients who died on or before the end of the measurement period.

2023 Denominator Exceptions	2024 Denominator Exceptions
Not applicable	Patients who died on or before the end of the measurement period

HIV Screening: CMS349v6 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- Documentation of the administration of the laboratory test must be present in the patient's health record.
- Patient attestation or self-report of having had an HIV test, without documentation of results, is **not** permitted to meet the measurement requirements.
- HIV tests performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.

Screening for Depression and Follow-Up Plan: CMS2v13

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria	Patients who have been diagnosed with bipolar disorder at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not	Patients: • Who refuse to participate or complete the depression screening • Who are in urgent or emergent situations • Who have a documented medical reason for not being screened for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results	Patients who: • Were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, **and** • If screened positive for depression, had a follow-up plan documented on the date of or up to 2 days after the date of the qualifying visit

Screening for Depression and Follow-Up Plan: CMS2v13 *(cont.)*

- The Depression Screening measure has removed diagnosis of depression as a denominator exclusion. This change is based on updated clinical guidance.
- Denominator exception language has been updated to include patient refusal to complete screening.

2023 Denominator Exclusions	2024 Denominator Exclusions
Patients who have been diagnosed with ~~depression or~~ bipolar disorder at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not	Patients who have been **diagnosed with bipolar disorder** at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not
2023 Denominator Exceptions	**2024 Denominator Exceptions**
Patient Reasons: Patient refuses to participate	Patient Reasons: Patient refuses to participate in **or complete the depression screening**

Known Issue: Patients with an active depression diagnosis who are currently receiving treatment might not meet numerator criteria. (See eCQM Known Issue details here.)

Solution: 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)).

Screening for Depression and Follow-Up Plan: CMS2v13 *(cont.)*

Clarifications, Tips, and Frequently Asked Questions

- The depression screening must be completed on the date of the visit **or** up to 14 days prior to the date of the visit and must be reviewed and addressed in the office of the provider on the date of the visit. Screening may occur outside of a countable visit.
- Screenings must be reviewed and addressed on the date of the visit, and if positive, follow-up must be addressed by a health center provider **or** by a provider paid by the health center, virtually or in person, on the date of the visit or up to two days after the visit.
- If a patient has had multiple screenings in the measurement period, use the most recent screening results.
- Do not exclude patients seen for routine care in urgent care centers or emergency rooms from the denominator.
- A Patient Health Questionnaire (PHQ)-9 following a PHQ-2 does not meet the numerator requirements for a follow-up plan to a positive depression screening.

Knowledge Check #2

What is the best way to receive clarification and guidance for eCQMS not already addressed with the measure specifications or CQL?

A. Sign up for an ONC Issue Tracking System account

B. Post questions to the measure stewards and review questions others have asked

C. Review known issues for implementation information for eCQMs

D. All of the above

Knowledge Check #2 Answer

What is the best way to receive clarification and guidance for eCQMS not already addressed with the measure specifications or CQL?

A. Sign up for an ONC Issue Tracking System account

B. Post questions to the measure stewards and review questions others have asked

C. Review known issues for implementation information for eCQMs

D. All of the above

Strategies for Successful Reporting

Check Data for Accuracy

- Vendor-developed reports and other reporting advancements will not replace the need for data governance and validation in your health center!
- Work with your EHR vendor to understand data output and to verify that calendar year updates have been programmed.
- Check data trends and relationships across tables: Previous-year UDS data can be compared in the EHBs with the Data Comparison tool.
- Review last year's letter from your reviewer to ensure all issues are addressed in this year's report.

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Understanding Reported UDS Data

Tables are interrelated: Comparing data on Tables 6A and 6B

Related Measure	Measurement Period		Age	
	Table 6A	Table 6B	Table 6A	Table 6B
Cervical Cancer Screening Table 6A: Line 23, Pap test Table 6B: Line 11	Current year	Includes a look-back period	Considers a more comprehensive age range	Includes specific age range
Breast Cancer Screening Table 6A: Line 22, Mammograms Table 6B: Line 11a	Current year	Includes a look-back period	Considers a more comprehensive age range	Includes specific age range
HIV Screening Table 6A: Line 21, HIV Test Table 6B: Line 20a	Current year	Includes a look-back period	Considers a more comprehensive age range	Includes specific age range

Work as a Team

- **Tables are interrelated.**
  - Communicate early and throughout the process with your internal UDS data preparation team.
  - Review data across tables to ensure data are consistent and reasonable.
  - Review changes in performance to validate accuracy and to identify potential quality improvement initiatives.

- **Use available tools.**
  - Preliminary Reporting Environment will be available in fall 2024.
  - Use the modernized reporting features—Excel file, offline HTML file, comparison tool, and Excel mapping document—to help you prepare for UDS data reporting.

Available Resources

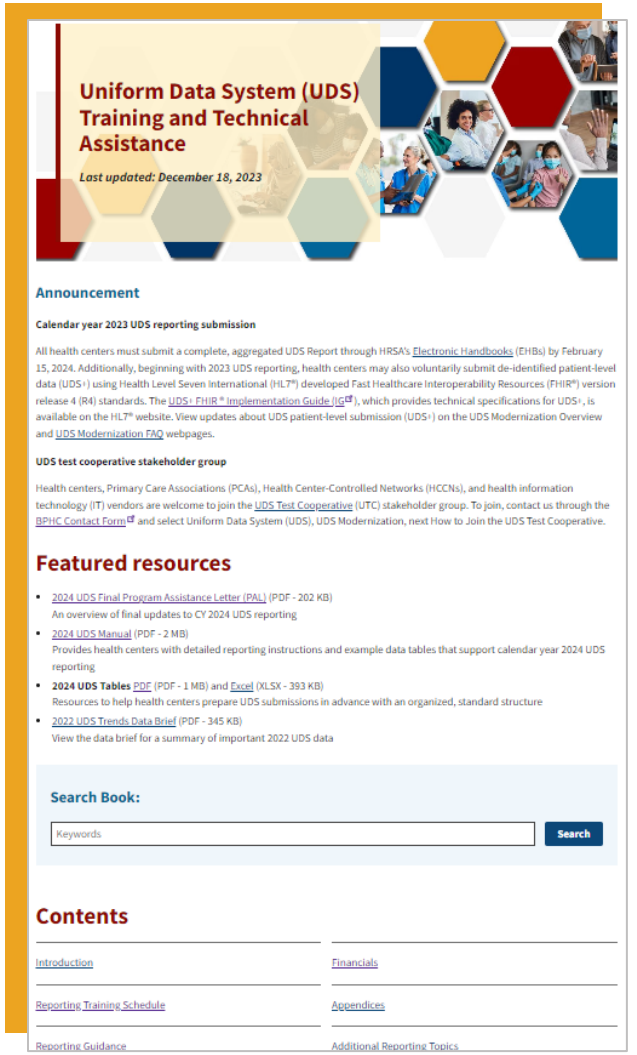
Resources are available to support your UDS reporting!

UDS Training and Technical Assistance Resources

UDS reporting resources on the BPHC website

- Introduction
- Reporting Training Schedule
- Reporting Guidance
- Patient Characteristics
- Staffing and Utilization
- Clinical Care
- Financials
- Appendices
- Additional Reporting Topics
- Technical Assistance Contacts
- UDS Data
- Archived Resources

Scan the QR code to go directly to the Training and Technical Assistance (TTA) page!



HRSA Health Center Program

UDS Reporting Webinar Series

The webinar series includes:

- **UDS Changes Technical Assistance Webinar**
- **UDS Basics:** Orientation to Terms and Resources
- **Clinical Quality Measures Deep Dive**
- **UDS Clinical Tables Part 1:** Screening and Preventive Care Measures
- **UDS Clinical Tables Part 2:** Maternal Care and Children's Health Measures
- **UDS Clinical Tables Part 3:** Chronic Disease Management Measures
- **Reporting UDS Financial and Operational Tables**
- **Successful Submission Strategies**

All webinars are archived on the Health Resources and Services Administration (HRSA) website; watch them anytime!

HRSA Health Center Program

Support Available

Description	Contact	Email or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: Uniform Data System (UDS) > UDS Reporting and > the most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical Support > EHBs Tasks/Technical Issues > EHBs Privileges	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical Support > EHBs Tasks/Technical Issues > Other EHBs Submission Types	877-464-4772
UDS+ FHIR IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: Uniform Data System (UDS) > UDS Modernization > Patient-level Submission (UDS+)	877-464-4772

FHIR IG = Fast Healthcare Interoperability Resources Implementation Guide; API = application programming interface

HRSA Health Center Program

HRSA
Health Resources & Services Administration

UDS Data Modernization and UDS Patient-Level Data (UDS+)

HRSA BPHC

Vision: Healthy Communities, Healthy People

Why Are We Modernizing UDS?

- Leverage developments in health IT over the last decade that allow us to advance health equity efforts while reducing reporting burden
- Standardize data collection using Fast Healthcare Interoperability Resources (FHIR) resources to automate and reduce the technical burden for health centers
- Improve the fidelity and integrity of data and enable more robust analyses to improve equitable access to high-quality, cost-effective care for our patients
- Drive quality improvement for vulnerable and historically underserved population groups
- Allow HRSA to better administer the Health Center Program and better serve its patients

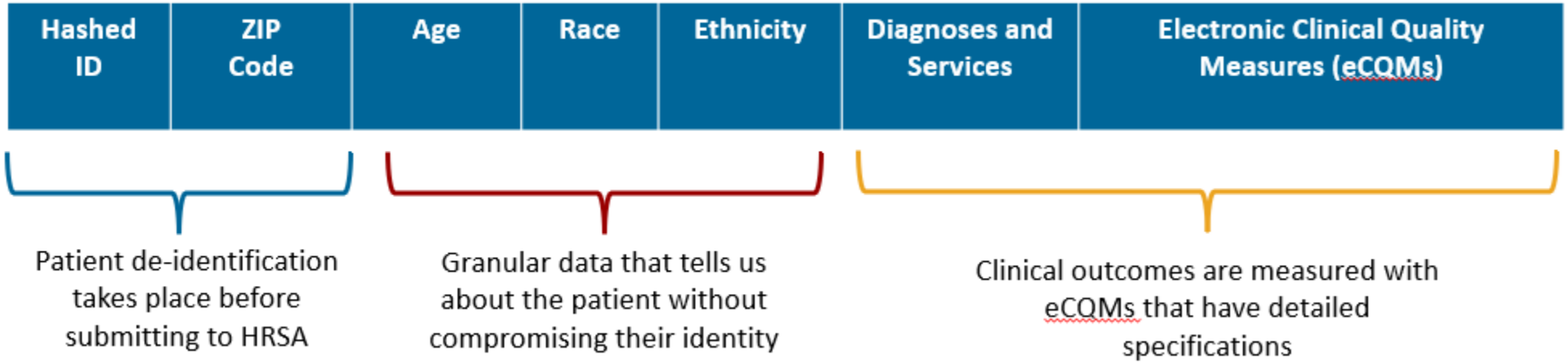
UDS Patient-Level Submission (UDS+)

UDS+ is...

- De-identified patient-level data
- Applicable to UDS Tables Patients By ZIP Code, 3A, 3B, 4, 6A, 6B, and 7
- Submitted via FHIR

UDS+ is not...

- Full copies of data directly from patients' electronic medical records



For more information, visit: UDS Modernization Initiative

HRSA Health Center Program

UDS+ 2024 Reporting Year: Submission Requirements

2024 UDS+ Submissions Due by April 30, 2025

1. Submit data for your ***medical*** patients.

2. Submit ***all*** the demographic tables data:
   - **Table:** Patients by ZIP Code
   - **Table 3A:** Patients by Age and by Sex Assigned at Birth
   - **Table 3B:** Demographic Characteristics
   - **Table 4:** Selected Patient Characteristics

3. Submit ***one eCQM*** from the measures listed below:
   - **Table 6B:** Quality of Care Measures
     - Breast Cancer Screening
     - Cervical Cancer Screening
     - Colorectal Cancer Screening
   - **Table 7:** Health Outcomes and Disparities
     - **Controlling High Blood Pressure***
     - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

   ** Recommended measure*

HRSA Health Center Program

2024 Calendar Year: UDS and UDS+ Reporting

All health centers are **required** to submit **aggregated** UDS data by **February 15, 2025**.

- Submit aggregated UDS data through EHBs, using the traditional submission method.
- Include all UDS tables and appendices.
- This will be the official submission of record.

All health centers will be required to submit a minimum amount of **patient-level data (UDS+) by April 30, 2025**.

- Submit UDS+ data via FHIR.
- Include, at a minimum, only demographic data and one eCQM for medical patients.
- UDS+ submission supports system capacity building and progress toward full implementation.

EHBs will remain the submission of record.

HRSA Health Center Program

How Can Health Centers Prepare for UDS+?

UDS TEST COOPERATIVE (UTC)

Join the UTC for continued UDS+ updates and resources.

HL7® FHIR®

Review:

- HL7.org
- HL7® FHIR® resources page
- UDS+ FHIR IG

ENGAGEMENT

Visit the UDS Modernization Initiative webpage for up-to-date UDS+ information.

Encourage your health IT vendors to join the UTC and participate in UDS+ testing before 2025.

Submit questions through the BPHC Contact Form by selecting **Uniform Data System (UDS) > UDS Modernization > Patient-Level Submission (UDS+).**

HRSA Health Center Program

Questions and Answers

Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net ***or*** BPHC Contact Form

1-866-837-4357

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