HRSA
Health Resources & Services Administration

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

October 3, 2023, 1:00–2:30 p.m. ET

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Vision: Healthy Communities, Healthy People

Opening Remarks

Lorraine Burton

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.

HRSA Health Center Program

Agenda

- Discuss 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 2023 UDS training resources

HRSA Health Center Program

Communication of UDS Reporting Changes

- Each Spring (typically in May), Centers for Medicare & Medicaid Services (CMS) communicates updates about electronic clinical quality measures (eCQM) specifications for the next reporting/performance period
  - Changes to eCQM specifications, such as logic statements, are governed and vetted by the respective measure steward
  - Most (13 of 18) of UDS clinical quality measures (CQMs) align with CMS' eCQMs for clinical quality measure reporting
  - Appendix H of the UDS Manual provides information on eCQM stewards
- 2023 UDS changes first announced via "Proposed Uniform Data System Changes for Calendar Year 2023" in Program Assistance Letter (PAL) 2022-03 dated August 12, 2022
  - Proposed 2024 UDS changes are expected to be announced this fall.
- Federal Register Notice, published October 21, 2022 and January 5, 2023, communicated proposed UDS updates and burden estimates
  - Provided opportunity for public comment

Changes described in further detail in the 2023 UDS Manual, during technical assistance webinars (fall 2023), and during annual UDS trainings co-hosted with Primary Care Associations (PCAs) (October–December 2023).

Training information will be announced this fall in the Primary Care Digest and on the UDS Training and Technical Assistance site.

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 Reporting

Electronic Clinical Quality Improvement (eCQI) Resource Center

Key Resources

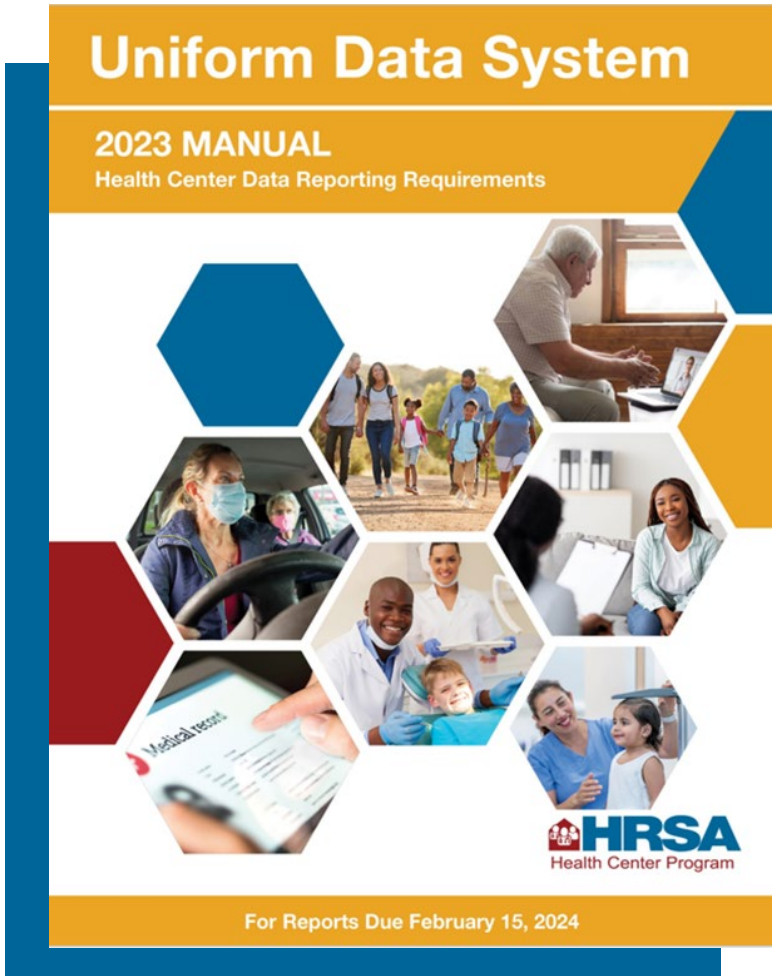
Key Terms in UDS Clinical Quality Measurement

UDS Clinical Quality Measures (CQMs)	The process and outcome measures tracked and reported by health centers as required by the Health Center Program. They include the 15 quality of care measures reported on Table 6B and the 3 health outcome and disparities measures reported on Table 7.
Electronic-Specified Clinical Quality Measures (eCQMs)	An eCQM is a clinical quality measure expressed and formatted to use data from electronic health records (EHRs) and/or health information technology (IT) systems to measure health care quality; ideally, these data are captured in structured form during the process of patient care.
Measure Steward	An individual or organization that owns a measure and is responsible for maintaining the measure. Each eCQM has a measure steward.
Measurement Period	Represents Calendar Year (CY) 2023 (January 1–December 31) **unless** another time frame is specifically noted.
Value Set	Lists of codes and corresponding terms, from National Library of Medicine–hosted standard clinical vocabularies (such as SNOMED CT®, RxNorm, and LOINC®), that define clinical concepts.

Key Terms in UDS Clinical Quality Measurement *(cont.)*

Measure Description	The quantifiable indicator to be evaluated.
Denominator	Patients who fit the detailed criteria described for inclusion in the specified measure to be evaluated.
Numerator	Records (from the denominator) that meet the criteria for the specified measure.
Exclusions	Patients not to be considered for the measure or included in the denominator.
Exceptions	Patients removed from the denominator because numerator criteria are not met.
Specification Guidance	Centers for Medicare & Medicaid Services (CMS) measure 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.

Getting Started with CQMs
UDS Guidance



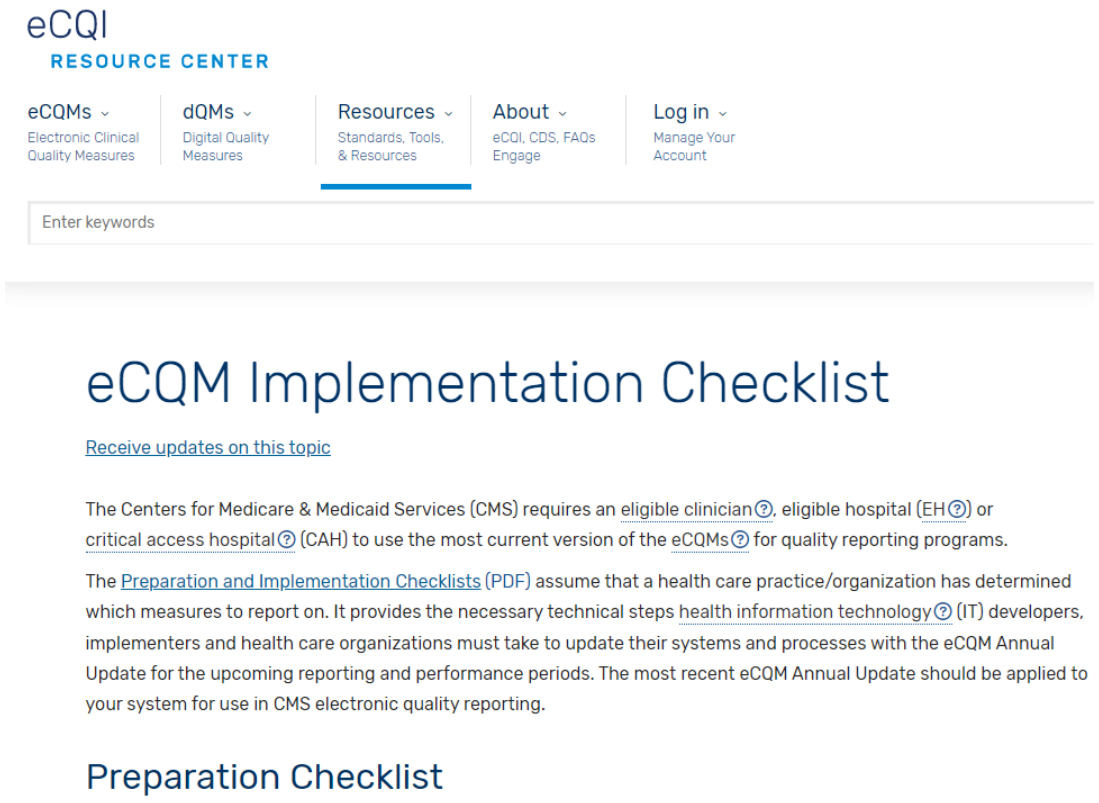
UDS Manual

- Follow the definitions and instructions in the 2023 UDS Manual.
- CQMs include links to eCQMs as well as UDS-specific considerations.
- UDS measures limit reporting to patients who had a**t least one UDS countable visit** during the calendar year.
  - Inclusion in the denominator for each measure is determined by whether the patient has a qualifying encounter, as defined by the eCQM specifications, the measure steward, and associated value sets.

Year-over-Year Changes

- Program Assistance Letter (PAL) 2023-03, "Final Uniform Data System Changes for Calendar Year 2023" (dated May 25, 2023)
- UDS Changes Webinar (held June 6, 2023)
- Clinical Quality Measures Deep Dive (held September 21, 2023)

Getting Started with CQMs
eCQI Resource Center



eCQM Implementation Checklist

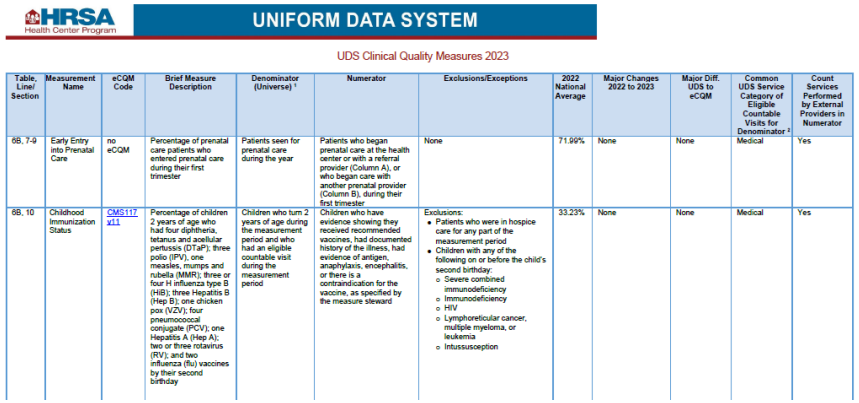
- Five preparation steps and seven implementation steps.

eCQM supports include:

- eCQI Resource Center: For each measure, in the "Measure Information" tab, there is the option to "compare" (e.g., 2022 to 2023). **This highlights changes year over year.**
- eCQM Flows: Workflows for each eCQM, updated annually; downloads as a ZIP file.
- Technical Release Notes: 2023 Performance Period Electronic Clinical Quality Measures (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.

Getting Started with CQMs
Key Resources

UDS CQM Handout (Quick Reference)



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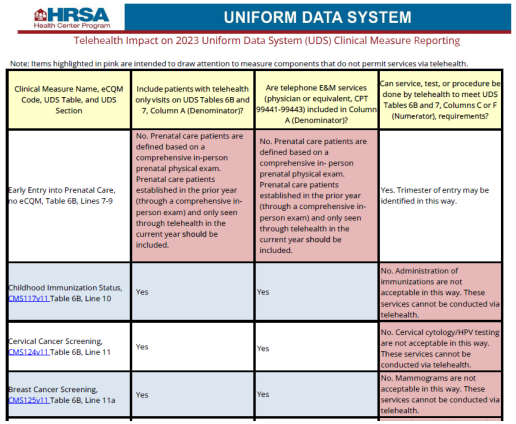
UDS Clinical Quality Measures 2023

Table, Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe) [1]	Numerator	Exclusions/Exceptions	2022 National Average	Major Changes 2022 to 2023	Major Diff. UDS to eCQM	Common UDS Service Category of Eligible Countable Visits for Denominator [2]	Count Services Performed by External Providers in Numerator
6B, 7-9	Early Entry into Prenatal Care	no eCQM	Percentage of prenatal care patients who entered prenatal care during their first trimester	Patients seen for prenatal care during the year	Patients who began prenatal care at the health center or with a referral provider (Column A), or who began care with another prenatal provider (Column B), during their first trimester	None	71.99%	None	None	Medical	Yes
6B, 10	Childhood Immunization Status	CMS117 v11	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday	Children who turn 2 years of age during the measurement period and who had an eligible countable visit during the measurement period	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had evidence of antigen, anaphylaxis, encephalitis, or there is a contraindication for the vaccine, as specified by the measure steward	Exclusions: • Patients who were in hospice care for any part of the measurement period • Children with any of the following on or before the child's second birthday: o Severe combined immunodeficiency o Immunodeficiency o HIV o Lymphoreticular cancer, multiple myeloma, or leukemia o Intussusception	33.23%	None	None	Medical	Yes

Telehealth Impact on UDS CQMs



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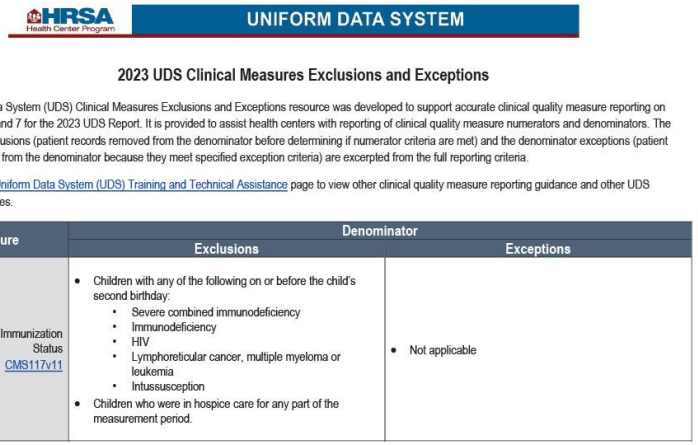
Telehealth Impact on 2023 Uniform Data System (UDS) Clinical Measure Reporting

Note: Items highlighted in pink are intended to draw attention to measure components that do not permit services via telehealth.

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?	Are telephone E&M services (physician or equivalent, CPT 99441-99443) included in Column A (Denominator)?	Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?
Early Entry into Prenatal Care, no eCQM, Table 6B, Lines 7-9	No. Prenatal care patients are defined based on a comprehensive in-person prenatal physical exam. Prenatal care patients established in the prior year (through a comprehensive in-person exam) and only seen through telehealth in the current year should be included.	No. Prenatal care patients are defined based on a comprehensive in- person prenatal physical exam. Prenatal care patients established in the prior year (through a comprehensive in-person exam) and only seen through telehealth in the current year should be included.	Yes. Trimester of entry may be identified in this way.
Childhood Immunization Status, CMS117v11,Table 6B, Line 10	Yes	Yes	No. Administration of immunizations are not acceptable in this way. These services cannot be conducted via telehealth.
Cervical Cancer Screening, CMS124v11,Table 6B, Line 11	Yes	Yes	No. Cervical cytology/HPV testing are not acceptable in this way. These services cannot be conducted via telehealth.
Breast Cancer Screening, CMS125v11,Table 6B, Line 11a	Yes	Yes	No. Mammograms are not acceptable in this way. These services cannot be conducted via telehealth.

Exclusions and Exceptions for UDS CQMs



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2023 UDS Clinical Measures Exclusions and Exceptions

The Uniform Data System (UDS) Clinical Measures Exclusions and Exceptions resource was developed to support accurate clinical quality measure reporting on UDS Tables 6B and 7 for the 2023 UDS Report. It is provided to assist health centers with reporting of clinical quality measure numerators and denominators. The denominator exclusions (patient records removed from the denominator before determining if numerator criteria are met) and the denominator exceptions (patient records removed from the denominator because they meet specified exception criteria) are excerpted from the full reporting criteria.

Please visit the Uniform Data System (UDS) Training and Technical Assistance page to view other clinical quality measure reporting guidance and other UDS reporting resources.

Measure	Denominator	
	Exclusions	Exceptions

Childhood Immunization Status CMS117v11	• Children with any of the following on or before the child's second birthday:
	  ▪ Severe combined immunodeficiency
	  ▪ Immunodeficiency
	  ▪ HIV
	  ▪ Lymphoreticular cancer, multiple myeloma or leukemia
	  ▪ Intussusception
	• Children who were in hospice care for any part of the measurement period.
		• Not applicable

All are available on HRSA's UDS Training and Technical Assistance Clinical Care webpage.

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Table 6B Clinical Quality Measures (CQMs)

Reporting Format

Key Changes

UDS CQMs

UDS CQMs

Clinical Quality Measures Deep Dive

Recorded on September 21, 2023

Screening and Preventive Care Measures

Today's webinar

Maternal Care and Children's Health Measures

UDS Clinical Tables Part 2: October 11, 2023, 1:00–2:30 p.m. ET

Chronic Disease Management Measures

UDS Clinical Tables Part 3: October 26, 2023, 1:00–2:30 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), health centers may voluntarily submit certain de-identified patient-level report data for Tables 6B and 7 using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

Modification to Table 6B

- Age “as of” for several CQMs has been revised to align with Clinical Quality Language (CQL) criteria: Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening.
- Patients **with eligible visits, as defined by the measure steward for each selected measure**, are to be considered for the denominator.

2022 UDS Guidance	NEW 2023 UDS Guidance
Include and evaluate patients for the denominator who had **at least one medical visit** during the measurement period as specified in the measure (dental visits are used for the dental sealant measure), even though some eCQMs may specify a broader range of service codes.	Include and evaluate patients for the denominator who had **at least one eligible countable visit (as defined by the measure steward for the selected eCQM)** during the measurement period as specified in the measure.

Changes to Align with eCQMs

Table 6B was updated to align with the latest CMS eCQMs. The 2023 UDS Clinical Quality Measures (CQM) Criteria handout is available to review for 2023 updates.

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

Line/Columns	Quality Care Measure	Updated eCQM
11	Cervical Cancer Screening	CMS124v11
11a	Breast Cancer Screening	CMS125v11
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v11
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v11
19	Colorectal Cancer Screening	CMS130v11
20a	HIV Screening	CMS349v5
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v12

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

Table 6B: Preventive Care and Screening Measures

Line/Columns	Quality Care Measure	Updated eCQM
11	Cervical Cancer Screening	CMS124v11
11a	Breast Cancer Screening	CMS125v11
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v11
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v11
19	Colorectal Cancer Screening	CMS130v11
20a	HIV Screening	CMS349v5
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v12

General Reporting Guidelines

- Performance is determined by screening results and follow-up actions.
  - Screening and tests alone **do not** count as UDS countable visits.
  - 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: CMS124v11

Denominator	Exclusions	Exceptions	Numerator
Women 24 through 64 years of age by the end of the measurement period with an eligible countable visit 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 who are at least 21 years old at the time of the test. • Cervical 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: CMS124v11 *(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.
- Include patients of all genders who have a cervix for measure assessment.
- Cervical cytology/HPV testing are not acceptable via telehealth. These services cannot be conducted via telehealth.
- **Screening performed elsewhere?** Include documentation in the patient health record including 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: CMS125v11

Denominator	Exclusions	Exceptions	Numerator
Women 52 through 74 years of age by the end of the measurement period with an eligible countable visit 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 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 an institution for more than 90 consecutive days during the measurement period or • With frailty for any part of the measurement period: advanced illness 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: CMS125v11 *(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*.
- Mammograms are not acceptable through telehealth. These services cannot be conducted via telehealth.
- ***Mammogram performed elsewhere?*** Include documentation in the patient health record including 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.

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(Adult) Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v11

Denominator	Exclusions	Exceptions	Numerator
Patients 18 years of age or older on the date of the visit with at least one eligible countable visit during the measurement period, as specified in the measure criteria **Do not** include patients who had only virtual visits during the year in the assessment.	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	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 during the measurement period

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

(Adult) Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v11 *(cont.)*

The Body Mass Index (BMI) Screening and Follow-Up Plan measure **numerator changed**:

- From a 12-month requirement for the documented BMI to a requirement during the measurement period.
- To allow for the follow-up plan to be documented **during the measurement period**, rather than on or after the most recent documented BMI.

2022 Measure Numerator	2023 Measure Numerator
Patients with a documented BMI **during the most recent visit or during the 12 months preceding that visit**, and when the BMI is outside of normal parameters, a **follow-up plan is documented on or after the most recent documented BMI**	Patients with a documented BMI **during the most recent visit or during the measurement period**, and when the BMI is outside of normal parameters, a **follow-up plan is documented during the measurement period**

(Adult) Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v11 *(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: CMS138v11

Denominator	Exclusions	Exceptions	Numerator
Patients aged 18 years and older seen for at least two eligible countable visits in the measurement period **or** at least one preventive eligible countable visit 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 6 months prior to the measurement period if identified as a tobacco user

Tobacco Use: Screening and Cessation Intervention: CMS138v11

- The Tobacco Screening measure **numerator changed** to allow for tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if the patient is identified as a tobacco user.
- Use of e-cigarettes and other electronic nicotine delivery systems is now **considered to be tobacco use**. Patients who report use of these devices are considered a positive screen for tobacco use and need to be assessed for tobacco cessation intervention for the numerator.
- Hospice care has been **added as a denominator exclusion**.
- Denominator exceptions have been **removed** (i.e., documented medical reasons for not screening or providing cessation intervention).

2022 Measure Numerator	2023 Measure Numerator
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 if identified as a tobacco user**	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**

Tobacco Use: Screening and Cessation Intervention: CMS138v11 *(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 12-month 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.

Knowledge Check #2

If a patient only had a telehealth visit during the year, how should they be reported on Table 6B's CQMs?

A. If the only visit is a virtual visit, the patient will be excluded from Table 6B.
B. If the only visit is a virtual visit, the patient should still be included in all Table 6B measures.
C. Each measure should be considered individually, per instruction, for inclusion in Table 6B.

Knowledge Check #2 Answer

If a patient only had a telehealth visit during the year, how should they be reported on Table 6B's CQMs?

A. If the only visit is a virtual visit, the patient will be excluded from Table 6B.

B. If the only visit is a virtual visit, the patient should still be included in all Table 6B measures.

C. Each measure should be considered individually, per instruction, for inclusion in Table 6B.

Colorectal Cancer Screening: CMS130v11

Denominator	Exclusions	Exceptions	Numerator
Patients 46 through 75 years of age by the end of the measurement period with an eligible countable visit 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: • Who were living long-term in an institution for more than 90 consecutive days 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 • Fecal immunochemical test-deoxyribonucleic acid (FIT-DNA) test during measurement period or 2 years prior to measurement period • Flexible sigmoidoscopy during measurement period or the 4 years prior • Computerized tomography (CT) during measurement period or 4 years prior • Colonoscopy during measurement period or 9 years prior

Colorectal Cancer Screening: CMS130v11

The Colorectal Cancer Screening measure **denominator changed** the age from 50–75 to 45–75.

2022 Measure Denominator	2023 Measure Denominator
Percentage of adults **50–75 years of age** who had appropriate screening for colorectal cancer	Percentage of adults **45*–75 years of age** who had appropriate screening for colorectal cancer

*Use 46 on or after December 31 as the initial age to include in assessment.

Colorectal Cancer Screening: CMS130v11 *(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 FIT-DNA test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.

HIV Screening: CMS349v5

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	Not applicable	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

HIV Screening: CMS349v5 *(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: CMS2v12

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older at the beginning of the measurement period with at least one eligible countable visit during the measurement period, as specified in the measure criteria	Patients who have been diagnosed with depression or bipolar disorder at any time prior to the qualifying visit, regardless of whether the diagnosis is active or not	Patients: • Who refuse to participate • Who are in urgent or emergent situations • Who have a documented medical reason for not screening the patient 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: CMS2v12 *(cont.)*

The Depression Screening **measure changed** from follow-up, if needed, on the date of the visit to follow-up on the date of or up to 2 days after the date of the visit.

The **denominator exclusions were updated** for patients diagnosed with depression or bipolar disorder to include diagnosis of depression or bipolar disorder at any time prior to the qualifying visit, regardless of whether the diagnosis is active or not.

2022 Measure	2023 Measure
Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if screening was positive, had a follow-up plan documented **on the date of the visit**	Percentage of patients aged 12 years and older 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 depression screening tool and, if screening was positive, a follow-up plan is documented **on the date of or up to two days after the date of the qualifying visit**

Screening for Depression and Follow-Up Plan: CMS2v12 *(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 (but does not have to be a medical visit).
- Screenings must be reviewed and addressed on the date of the visit, and if positive, follow-up must be addressed in the office of 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 2 days after the visit.
- If a patient has had multiple screenings in the measurement period, use the most recent screening results.
- Screening may occur outside of a countable visit.
- 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.

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.

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

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.

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 (PRE) will be available in fall 2023.
  - Use the modernized reporting features—Excel file, offline HTML file, comparison tool, and Excel mapping document—to help you prepare for UDS data reporting.
  - Assess whether your health center has capacity to report UDS+ (patient-level) data and inform BPHC of your health center's intent to report this data."

Resources Are Available to Support Your UDS Reporting

UDS Training and Technical Assistance (TTA)

- Central, user-friendly hub for health centers to access UDS reporting TTA.
- Organized by UDS topic areas, such as:
  - Patient characteristics
  - Staffing and utilization
  - Clinical care
  - Financials

Visit
UDS TTA

UDS Webinars

- Upcoming technical assistance clinical webinars:
  - UDS Clinical Tables Part 2: Maternal Care and Children's Health Measures: October 11, 2023, 1:00–2:30 p.m. ET
  - UDS Clinical Tables Part 3: Chronic Disease Management Measures: October 26, 2023, 1:00–2:30 p.m. ET
- Register for future UDS webinars and view past webinar recordings and presentations on the UDS TTA site.

Follow UDS Guidance

- Thoroughly read definitions and instructions in the 2023 UDS Manual.
- See other available guidance:
  - PAL 2023–03
  - eCQI Resource Center
  - VSAC

Support Available

Description	Contact	E-mail or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: UDS Reporting and 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 R4 IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: UDS Modernization	877-464-4772

*The phone line is available year-round from 8:30 a.m. to 5:00 p.m. ET.

HRSA Health Center Program

UDS Modernization Updates

UDS Modernization Initiative

Reduce Reporting Burden

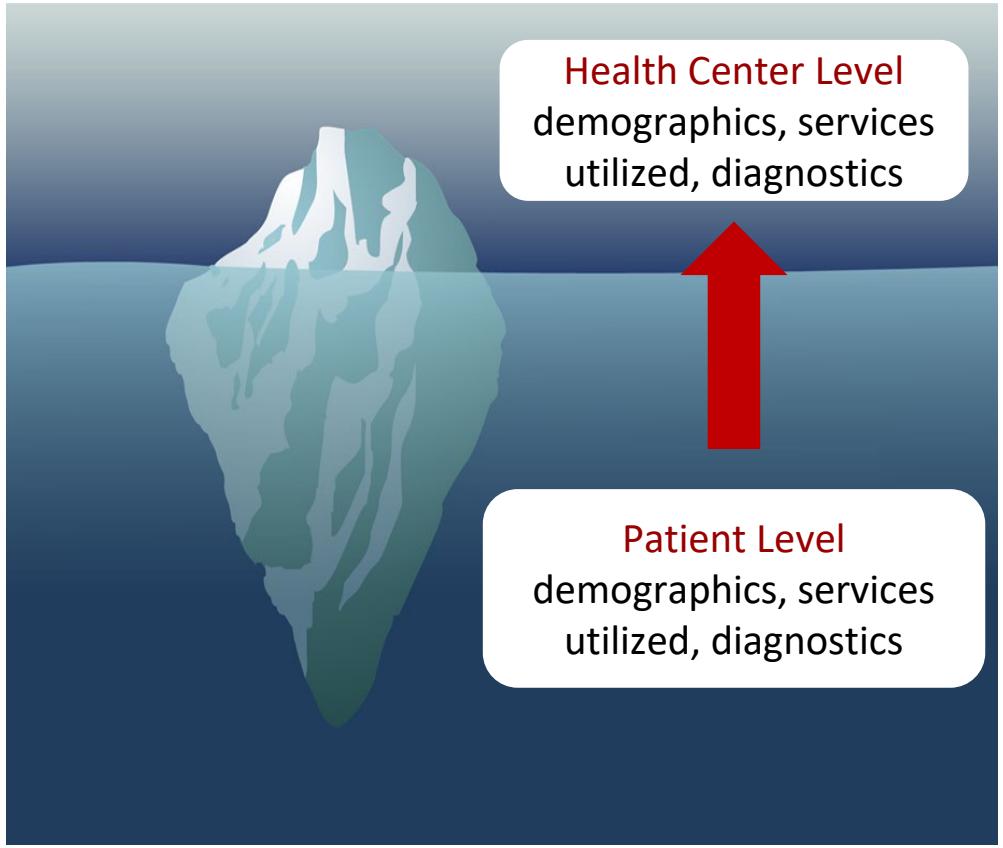
Automate data submission, provide enhanced UDS reporting capabilities, promote transparency, and integrate stakeholder feedback.

Better Measure Impact

Improve the quality of UDS data to reflect improvements in patient-centered care and an evolving primary health care setting.

Promote Transparency

Provide an open, transparent decision-making process on UDS changes such as measure selection, information technology, and reporting improvements.



Benefits of UDS+

Patient-level data collection will enable HRSA to better:

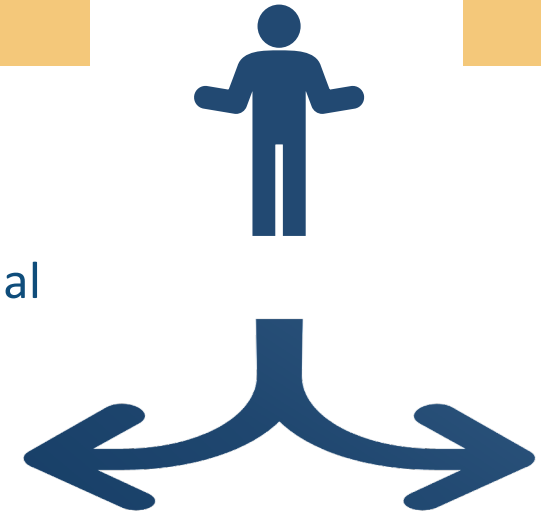
- Articulate the **unique characteristics** and **needs** of health center patients
- Illustrate the **breadth and depth** of health center **services** and their impact on **health outcomes**
- Inform **TTA, research and evaluation**, and **health equity** work
- Improve **preparedness** for public health emergencies
- Improve ability to communicate the **complexity of the patient populations** health centers serve and provide **evidence for aligned reimbursements** for care provided
- Inform **investments and interventions** based on trends identified in patient-level data (e.g., targeted needs of specific communities/patients, social determinants of health)

2023 Calendar Year: UDS Reporting

All health centers are **required** to submit **aggregated** UDS data.

Health centers also have the **option** to submit **patient-level data (UDS+)**.

- 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



UDS+ FHIR Implementation Guide provides architectural details and technical reporting specifications for submission.

2023 Calendar Year: Optional UDS+ Submission

1. Submit data for your entire universe of patients (not a subset)

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 ***all or part of*** the clinical tables data
   - **Table 6A**: Selected Diagnoses and Services Rendered – optional
   - **Table 6B**: Quality of Care Measures – submit 2 or more eCQMs from this table
   - **Table 7**: Health Outcomes and Disparities – submit 2 or more eCQMs from this table

2023 Calendar Year: Optional UDS+ Submission cont'd

- The UDS Test Cooperative (UTC) suggests health centers may be the most ready to submit these eCQMs:
  - **Table 6B: Quality of Care Measures**
    - ✔ Cervical Cancer Screening
    - ✔ Colorectal Cancer Screening
  - **Table 7: Health Outcomes and Disparities**
    - ✔ Controlling High Blood Pressure
    - ✔ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

REMEMBER:

Submit both demographic and clinical data for the entire patient population, not a subset of patients

- Health centers may choose any eCQM from these tables as long as they submit at least two measures from each table

Resources

For the latest UDS Test Cooperative (UTC) and UDS+ information, please subscribe to the Primary Health Care Digest and visit the UDS+ technical assistance webpages:

- UTC
- UDS Modernization Initiative
- UDS Modernization FAQ

Submit a ticket via the BPHC Contact Form to:

- Join the UTC
- Access the UDS+ Health Center Program Community
- Participate in a readiness assessment to discuss UDS+ submissions use cases
- Learn more about the UDS+ FHIR Implementation Guide

Questions and Answers

Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net ***or*** Health Center Program Support

1-866-837-4357

bphc.hrsa.gov

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