



Uniform Data System (UDS) Clinical Tables

Part 2: Maternal and Child Health

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Vision: Healthy Communities, Healthy People



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Opening Remarks

Alysha Darden
Data and Evaluation
Office of Quality Improvement
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

Agenda



- Discuss Uniform Data System (UDS) reporting instructions on clinical quality measures (CQMs)
- Review UDS maternal care and child health measures reporting requirements
- Identify reporting strategies and tips for data reporting
- Review 2026 UDS training resources

Objectives

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

- Understand reporting requirements for maternal and child health CQMs.
- Identify opportunities for quality improvement.
- Access additional reporting support.



UDS CQM Reporting

Key considerations and structures to accurately report CQMs in the UDS



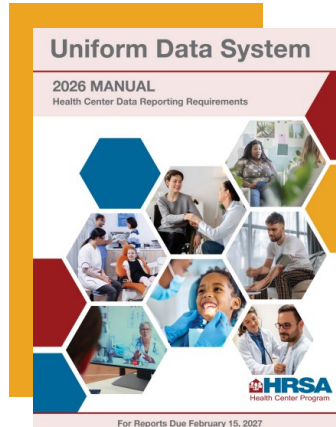
Key Terms in UDS CQM Measurement

Specification Guidance	The 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 electronic clinical quality measure (eCQM) specifications.
CQMs	A mechanism used for assessing the degree to which a clinician competently and safely delivers clinical services appropriate for the patient in an optimal time frame.
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.
Clinical Quality Language (CQL)	An open-source standard that allows a human-readable description of clinical quality logic to express clinical knowledge.
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 2026 (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.

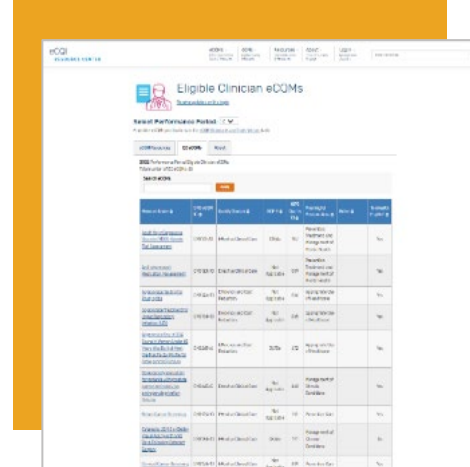


Getting Started with CQMs

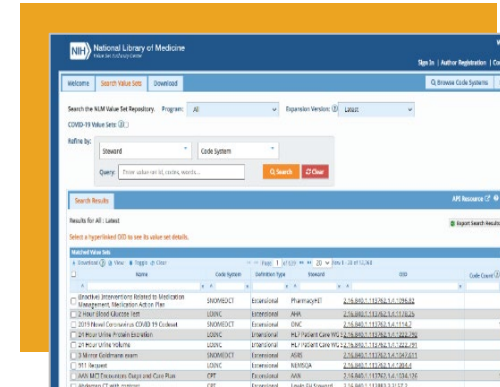
Key Resources



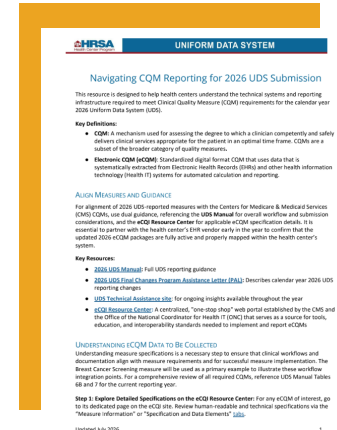
The [UDS Manual](#) provides an overview of the UDS, covers UDS-specific considerations, and links to measure specifications.



The manual links to the [Electronic Clinical Quality Improvement \(eCQI\) 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 [Value Set Authority Center \(VSAC\)](#) site.



[Navigating CQM Reporting](#) is a new resource with step-by-step guidance on how to access eCQM data to be collected.



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 eCQM's measure criteria and specifications, if applicable. (Each measure has its own qualifying encounters definition in its specifications.)

Understanding Qualifying Encounters for CQMs



Does this mean that *all* patients with UDS countable visits are 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 weight assessment and counseling for nutrition for our pediatric dental patients?

Dental visit types are not specified in the denominator for the weight assessment and counseling for nutrition and physical activity for children and adolescents measure. 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.

After a review of CQMs, we will apply this logic to one of the specific measures discussed today!

Tables 6B and 7 CQMs

Reporting format

Key changes

UDS CQMs



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: As used in clinical quality measure reporting, specific conditions or circumstances that remove certain patients from the measure's denominator because the measure criteria are not appropriate for them. EXCEPTIONS: As used in clinical quality measure reporting, allowable reasons within the denominator for not meeting the measure's requirements, acknowledging valid clinical, patient-centered, or system-related factors that justify why the expected care was not provided.

UDS CQMs

Screening and Preventive Care	Maternal and Child Health	Disease Management
• Cervical Cancer Screening • Breast Cancer Screening • Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan • Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention • Colorectal Cancer Screening • HIV Screening • Preventive Care and Screening: Screening for Depression and Follow-Up Plan • Screening for Future Falls Risk Webinar recorded on October 15, 2026	• Prenatal Care Provided by Referral Only • Age of Prenatal Care Patients • Early Entry into Prenatal Care • HIV-Positive Pregnant Women • Deliveries Performed by Health Center's Providers • Prenatal Care Patients Who Delivered During the Year • Low Birth Weight • Childhood Immunization Status • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents • Sealant Receipt on Permanent First Molars	• Statin Therapy for the Prevention and Treatment of Cardiovascular Disease • Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet • HIV Linkage to Care • Depression Remission at Twelve Months • Initiation and Engagement of Substance Use Disorder Treatment • Controlling High Blood Pressure • Diabetes: Glycemic Status Assessment Greater than 9% Webinar on October 29, 2:00–3:30 p.m. ET

Children's Health Measures



UDS Table	Measure	eCQM
Table 6B, Line 10	Childhood Immunization Status	CMS117v14
Table 6B, Line 12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CMS155v14
Table 6B, Lines 22a and 22b	Sealant Receipt on Permanent First Molars	SFM-CH-A*

*Access measure value set details on the [Clinical Care](#) page of the UDS Technical Assistance site.

What's New in 2026?

- Table 6B was updated to align with the latest CMS eCQMs. The [2026 UDS CQM Criteria](#) handout is available to review for 2026 updates.
- Childhood Immunization Status reporting is voluntary for performance year 2026.
- Dental sealants measure is replaced with Sealant Receipt on Permanent First Molars.

Child Immunization Status (CMS117v14)

- The child immunization status measure reporting is voluntary for 2026.
- Health centers that choose not to report these data will be required to provide an explanation to the system edit that will flag when Line 10 is left blank.

Section C—Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (A)	Number of Records Reviewed (B)	Number of Patients Immunized (C)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday			

Childhood Immunization Status

Table 6B, Line 10 ([CMS117v14](#))

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.

Denominator	Exclusions	Numerator
Children who turn 2 years of age during the measurement period and who had a 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 Children with any of the following on or before their second birthday: • Severe combined immunodeficiency • Immunodeficiency • Human immunodeficiency virus (HIV) • Lymphoreticular cancer, multiple myeloma, or leukemia • Intussusception	Demonstrated vaccinations for DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, and flu Or anaphylaxis due to DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, or flu vaccinations

Childhood Immunization Status



- Do not include children here or anywhere on the UDS if they only received a vaccination and did not have a countable visit during the calendar year.
- Use immunization registries to ensure patient health records are up to date and complete.
 - Registries can be used to fill any voids in the immunization record prior to or immediately after a visit and before the end of the measurement period, as long as the health IT/EHR is updated with the immunization details and coded correctly.
- Assess patient health records for evidence of vaccinations per specifications.
- If a patient was seen via telehealth, determine whether the record shows evidence of vaccine completion or whether the patient will need to be seen in person to complete the immunization series.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **Table 6B, Line 12** ([CMS155v14](#))

Percentage of patients 3–17 years of age who had an outpatient visit with a primary care physician (PCP) or obstetrician/gynecologist (OB/GYN); evidence of height, weight, and BMI percentile documentation; documentation of counseling for nutrition; and documentation of counseling for physical activity during the measurement period.

Denominator	Exclusions	Numerator
Patients 3 through 17 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 who have a diagnosis of pregnancy during the measurement period Patients who were in hospice care for any part of the measurement period	Children and adolescents who have had: • Their height, weight, and BMI percentile recorded during the measurement period and • Counseling for nutrition during the measurement period and • Counseling for physical activity during the measurement period

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (CMS155v14)



- The patient must have all three numerator components completed and documented to meet the measurement standard.
- This measure requires that the height and weight measurements and counseling for physical activity and nutrition be performed by health center staff or paid for by the health center.
 - Include qualifying encounters performed by any provider, as included in the specification criteria. Note that this is different from the eCQM description, which states that the visit must be performed by a PCP or an OB/GYN.
- Height and weight are to be captured using a standardized, set process for consistency.
 - Patient-reported height and weight are allowed, provided the information is recorded in the EHR and is sufficiently accurate for use in clinical care. Determining the acceptability, reliability, and validity of patient-reported information is left to the discretion of the clinician.
 - Counseling for physical activity and nutrition may also be provided via telehealth.
 - Refer to the Jira ticket on this measure for more information.

Sealant Receipt on Permanent First Molars (SFM-CH-A)

- The dental sealants for children between 6–9 years measure has been replaced with **a new measure with two rates** for sealant receipt on permanent first molars.
- **Measure:** Sealant Receipt on Permanent First Molars
- **Denominator:** Children who turn 10 years of age during the measurement period, and had at least one qualifying encounter during the measurement period, as specified in the measure criteria
- **Numerator 1 (Line 22a):** Children who received a sealant on at least one permanent first molar tooth in the 48 months prior to their 10th birthday
- **Numerator 2 (Line 22b):** Children who received sealants on all four permanent first molars in the 48 months prior to the 10th birthday

Line	Sealant Receipt on Permanent First Molars	Total Patients with 10 th Birthday (A)	Number of Records Reviewed (B)	Number of Patients with Sealants to First Molars (C)
22a	MEASURE: Percentage of children who have ever received at least one sealant on a permanent first molar tooth			
22b	MEASURE: Percentage of children who have received sealants on all four permanent first molar teeth			

Knowledge Check #1

Which statement accurately reflects UDS reporting requirements for Children's Health measures on Table 6B for the 2026 reporting year?

- A. Reporting on Childhood Immunization Status (CMS117v14) is voluntary for health centers for the 2026 reporting year.
- B. The Dental Sealants measure still evaluates children ages 6 through 9 who are assessed at high risk for caries.
- C. Documentation of parental refusal satisfies the numerator requirement for Childhood Immunization Status.
- D. Dental Sealants reporting is evaluated using a single rate across all age groups.
- E. Health centers can meet the Weight Assessment numerator by documenting either nutrition counseling or physical activity counseling, as long as the child's BMI percentile is recorded.



Knowledge Check #1 Answer

Which statement accurately reflects UDS reporting requirements for Children's Health measures on Table 6B for the 2026 reporting year?

- A. Reporting on Childhood Immunization Status (CMS117v14) is voluntary for health centers for the 2026 reporting year.**
- B. Sealants measure still evaluates children ages 6 through 9 who are assessed at high risk for caries.
- C. Documentation of parental refusal satisfies the numerator requirement for Childhood Immunization Status.
- D. Dental Sealants reporting is evaluated using a single rate across all age groups.
- E. Health centers can meet the Weight Assessment numerator by documenting either nutrition counseling or physical activity counseling, as long as the child's BMI percentile is recorded.

Maternal Care: Prenatal and Birth Outcome Measures

Table 6B: Prenatal Care Patients

Report *all* women who received prenatal care services (either from the health center directly or its referral network) in the year by:

- age as of December 31 and
- trimester of entry (based on last menstrual period or documented estimated date of delivery).

Table 7: Deliveries

Report all prenatal care patients.

Include stillbirths and multiple births, each as one delivery.

Miscarriages are not reported as deliveries.

Table 7: Birth Outcomes

Report babies according to their birth weight in grams by race and ethnicity of the baby.

Multiple births are reported separately by birth weight of each baby.

Stillbirths are not reported in the birth outcome section.

Maternal Health: Prenatal Care Measures



UDS Table	Measure	eCQM
Table 6B, Line 0	Prenatal Care by Referral Only	No eCQM
Table 6B, Lines 1–6	Age of Prenatal Care Patients	No eCQM
Table 6B, Lines 7–9	Early Entry into Prenatal Care	No eCQM

Maternal Health: Prenatal Care Measures



Who is considered a prenatal care patient for UDS reporting?

Health center patients who *initiate prenatal care with the health center or its referral network* are counted in the **Prenatal section of Table 6B** and are tracked through delivery and reported in the **Delivery and Birth Outcomes section of Table 7**.

Prenatal care initiated with “the health center or its referral network” refers to:

- Prenatal care initiated with the health center directly **or**
- Prenatal care initiated with a provider/entity with which the health center has formal referral contractual agreements (as indicated in Column II of Form 5A) **or**
- Prenatal care initiated with a provider/entity with which the health center has formal written referral arrangements (as indicated in Column III of Form 5A).

Tracking systems must be in place for all that apply!

Trimester of Entry

Reminder that determination for trimester of entry was updated in 2025.

Definition
Determine trimester of entry based on last menstrual period or when the prenatal care patient was clinically determined to have been in their first trimester based on documented estimated date of delivery.



Maternal Health: Key Reporting Nuances

- **Universal Requirement:** All HRSA-funded health centers and look-alikes are required to provide prenatal care—either directly or through a formal referral.
- **Pregnancies Cross Calendar Years:** Typically, about half of all reported prenatal patients will span across two UDS reporting years. For patients that:
 - Began prenatal care in 2025 and delivered in 2026: report on Table 6B (Section A) and Table 7 in 2026, even if the delivery is the only current-year contact.
 - Began prenatal care in 2026 and will deliver in 2027: report on Table 6B (Sections A & B) in 2026; track and report birth outcomes on Table 7 in 2027.
- **Capturing Transfer Patients:**
 - **Transfer-Ins:** Report under Column B (Section B) if the patient initiated care with an independent, external provider and transferred into your health center's care.
 - **Transfer-Outs:** If a patient initiated prenatal care with you but later transferred to an outside provider (even outside your referral network), they are still included in your 2026 UDS report.
- **On-Site Clinic Exams Are Not Required to Initiate Referrals:** If your health center provides prenatal care by referral only, you are not expected to perform a clinical prenatal exam to generate the referral—it can be made after a pregnancy screen or routine visit with prenatal care “beginning” once the patient receives a comprehensive exam from your referred network partner.



Table 7: Key Reporting Nuances

- Table 7, Deliveries:
 - Include stillbirths and multiple births, each as one delivery.
 - Miscarriages are not reported as deliveries.
- Table 7, Outcomes:
 - Multiple births are reported separately by birth weight of each baby.
 - Stillbirths are not reported in the birth outcome section.

Tips for Tracking Prenatal Care Patients



A positive pregnancy test, laboratory test, or dispensing vitamins alone does not make an individual a prenatal care patient for UDS reporting. Prenatal care officially begins for UDS purposes only when the patient receives a comprehensive prenatal clinical exam, either on-site or from a provider within your formal referral network.

Helpful tracking strategies:

- **Manage Status Changes:**

- Cross-Year Pregnancies: Flag patients who began care late in the year to ensure they are captured on Table 6B this year, while holding delivery reporting for Table 7 next year
- Transfer-In Patients (Column B): Intake staff should document the date of the patient's first exam with the prior independent provider to capture their original entry trimester.
- Transfer-Out Patients: Keep patients who initiated care with you on Table 6B, even if they later transferred to an outside provider.

- **Coordinate with Referral Partners:**

- Establish clear, collaborative communication loops with your formal written referral partners ([Form 5A](#), Columns II & III) to ensure they share exam and delivery dates back with your clinic.



Maternal Health: Prenatal Care Measures

Table 6B

Section A: Line 0: Mark the check box if your health center provides prenatal care through direct referral only.

0	Prenatal Care Provided by Referral Only (Check if Yes)
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Section A: Lines 1–6: Report all prenatal care patients by their age *as of December 31*.

Line	Age	Number of Patients (A)
1	Less than 15 years	
2	Ages 15–19	
3	Ages 20–24	
4	Ages 25–44	
5	Ages 45 and over	
6	Total Patients (Sum of Lines 1–5)	

Section B: Lines 7–9: Report all prenatal care patients by the trimester they began prenatal care (including any patient you may have referred out for care). Report in Column B if care began with another provider and was then transferred into your health center’s care.

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (A)	Patients Having First Visit with Another Provider (B)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Lines 7–9 Columns A and B: Report all prenatal care patients by the trimester they began prenatal care (first comprehensive prenatal visit), in Column A if care *began at your health center* (including any patient you may have referred out for care) or in Column B if care *began with another provider* and was then transferred into your health center’s care.



Maternal Health: Deliveries and Birth Weight Measures



UDS Table	Measure	eCQM
Table 7, Section A, Line 0	HIV-Positive Pregnant Women	No eCQM
Table 7, Section A, Line 2	Deliveries Performed by Health Center's Providers	No eCQM
Table 7, Section A, Lines 1a1m–h	Prenatal Care Patients Who Delivered During the Year (Column 1A)	No eCQM
Table 7, Section A, Lines 1a1m–h	Live Birth Weights (Columns 1B–1D)	No eCQM

Deliveries and Birth Outcomes

Table 7, Lines 0 and 2

Section A

Line 0: Number of health center patients who are pregnant and HIV positive, regardless of whether they received prenatal care from the health center or have a delivery during the year.

Line 2: Number of deliveries performed by health center clinicians, including deliveries to non–health center patients.

Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	
2	Deliveries Performed by Health Center’s Providers	

Deliveries and Birth Outcomes

Deliveries

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1A)	Live Births: <1500 grams (1B)	Live Births: 1500–2499 grams (1C)	Live Births: ≥2500 grams (1D)
<section divider>	Mexican, Mexican American, Chicano/a	<section divider>	<section divider>	<section divider>	<section divider>
1a1m	Asian Indian				
1a2m	Chinese				
1a3m	Filipino				
1a4m	Japanese				
1a5m	Korean				
1a6m	Vietnamese				
1a7m	Other Asian				
1b1m	Native Hawaiian				
1b2m	Other Pacific Islander				
1b3m	Guamanian or Chamorro				
1b4m	Samoan				
1cm	Black or African American				
1dm	American Indian/Alaska Native				
1em	White				
1fm	More than One Race				
1gm	Unreported/Chose Not to Disclose Race				
	Subtotal Mexican, Mexican American, Chicano/a				

Column 1A: Include prenatal care **patients who delivered** during the calendar year (exclude miscarriages) **by their race and ethnicity**.

- For multiple births (e.g., twins), report only one patient as having delivered.
- Report on patients who were successfully referred out for care.

Deliveries and Birth Outcomes

Birth Weight

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
Mexican, Mexican American, Chicano/a					
1a1m	Asian Indian				
1a2m	Chinese				
1a3m	Filipino				
1a4m	Japanese				
1a5m	Korean				
1a6m	Vietnamese				
1a7m	Other Asian				
1b1m	Native Hawaiian				
1b2m	Other Pacific Islander				

Columns 1B–1D: Report each live birth by **birth weight** (exclude stillbirths or miscarriages) and **by race and ethnicity of baby**.

- Count twins as two births, triplets as three, etc.
- Column 1D (≥ 2,500 grams) is normal birth weight.
- Column 1C (1,500–2,499 grams) is low birth weight.
- Column 1B (< 1,500 grams) is very low birth weight.

Deliveries and Birth Outcomes



- Deliveries reported on Table 7 are those deliveries of the health center's prenatal patients.
- The babies reported in the birth outcome section of Table 7 do not need to have their own separate visits, nor do they need to be health center patients; they just need to be delivered to a health center prenatal patient who delivered in the year.



Deliveries and Birth Outcomes (cont'd)



Report delivery and birth outcome data regardless of whether the health center performed the delivery or referred the delivery to another provider and regardless of whether the patient transferred to another provider on their own. Tracking and follow-up on all prenatal care patients are required.

Deliveries (Column 1A)

- Report one patient as having delivered, even if the delivery results in multiple births (e.g., twins or triplets) or is a stillbirth.
- *Do not* include deliveries when you have no documentation that the delivery occurred (patients lost to follow-up).
- *Do not* include miscarriages.
- *Do not* include patients who, based on their due date, should have delivered but for whom you *do not* have explicit documentation of the delivery.

Birth Outcomes (Columns 1B–1D)

- If the delivery is of multiple babies (e.g., twins or triplets), report the birth weight of each baby separately.



Tips for Tracking Delivery and Birth Outcomes



Positive pregnancy diagnosis codes can be added to the prenatal care patient's health record and provide a reporting mechanism for monitoring outcomes. Include corresponding fields to track whether a patient is referred to a prenatal care provider or receiving prenatal care from the health center or its network partners.

To obtain delivery and birth outcomes:

- Some health centers match the baby birth record to the prenatal care patient. This may be direct if their providers perform the delivery or the baby becomes a patient.
- For health centers without direct care (referrals), obtain the information from the referral provider, hospital, or patient self-report.
 - Staff can call the patient to discuss how far along they were and enter that into their systems. Follow up with the prenatal care patient after 9 months to ask birth weight.
 - Perform quarterly check-ins with the health center's referral network for patients referred.
 - When establishing referral arrangements, make it clear that these data are to be communicated back to the health center.

Tips for Tracking Delivery and Birth Outcomes (cont'd)



Establishment of agreements to receive prenatal care and delivery details from referral providers and from delivery hospitals is a necessary step to leveraging health information exchange and communications.

- Specifying and agreeing to the method for accessing the necessary data should be created to incorporate standardized processes for data access or data transfer.
- These may include establishing data exchange protocols, access to vital records, or other building system notification processes to share with prenatal and delivery partners so they may update the records.
- Establishing systematic processes that allow for updates on pregnancy can be further expanded at initiation of care to get prenatal patient engaged in a pregnancy/delivery portal update process, so the prenatal patient can provide updates on care and delivery details, as well as receive pre-, intra-, and post-partum supports and information.

Knowledge Check #2

A patient comes to the health center for their annual wellness exam with a health center provider, during which pregnancy is identified. The health center does not deliver prenatal visits directly; they refer patients to their referral network providers for prenatal care. The patient was referred and received care from a referral network provider for prenatal care. How should this patient and her care be reported on the 2026 UDS Report?

- A. The patient is reported on Table 5 as a medical patient with a medical visit (for the wellness exam) and reported on Table 6B (Sections A & B) as a prenatal care patient. Report delivery and birth outcome on Table 7 if the patient delivered during the calendar year.
- B. The patient is reported as a medical patient with a medical visit on Table 5 but is excluded from Table 6B because prenatal care visits were not provided directly by health center staff.
- C. The patient is reported on Table 6B (Sections A & B) as a prenatal patient, and the annual wellness exam is reclassified on Table 5 as a "Patient Support Services" visit since it resulted in a referral.



Knowledge Check #2 Answer

A patient comes to the health center for their annual wellness exam with a health center provider, during which pregnancy is identified. The health center does not deliver prenatal visits directly; they refer patients to their referral network providers for prenatal care. The patient was referred and received care from a referral network provider for prenatal care. How should this patient and her care be reported on the 2026 UDS Report?

- A. The patient is reported on Table 5 as a medical patient with a medical visit (for the wellness exam) and reported on Table 6B (Sections A & B) as a prenatal care patient. Report delivery and birth outcome on Table 7 if the patient delivered during the calendar year.**
- B. The patient is reported as a medical patient with a medical visit on Table 5 but is excluded from Table 6B because prenatal care visits were not provided directly by health center staff.
- C. The patient is reported on Table 6B (Sections A & B) as a prenatal patient, and the annual wellness exam is reclassified on Table 5 as a "Patient Support Services" visit since it resulted in a referral.



Knowledge Check #3

A patient began prenatal care in November 2025 through your formal referral network. She had no visits at your health center in 2026, but your team confirms she delivered a live birth in April 2026. How should this patient be reported in your 2026 UDS Report?

- A. Report the patient on Table 6B (Prenatal Care) and Table 7 (Birth Outcomes) only. Do **not** report her on Table 5 or the demographic tables (Tables 3A, 3B, 4).
- B. Report the patient on Tables 3A, 3B, 4, 5, 6B, and 7.
- C. Do not report the patient anywhere in the 2026 UDS Report because she had no 2026 visits at the health center.
- D. Report the patient on Table 7 only for the delivery, but exclude her from Table 6B.

Knowledge Check #3 Answer

A patient began prenatal care in November 2025 through your formal referral network. She had no visits at your health center in 2026, but your team confirms she delivered a live birth in April 2026. How should this patient be reported in your 2026 UDS Report?

- A. Report the patient on Table 6B (Prenatal Care) and Table 7 (Birth Outcomes) only. Do not report her on Table 5 or the demographic tables (Tables 3A, 3B, 4).**
- B. Report the patient on Tables 3A, 3B, 4, 5, 6B, and 7.
- C. Do not report the patient anywhere in the 2026 UDS Report because she had no 2026 visits at the health center.
- D. Report the patient on Table 7 only for the delivery, but exclude her from Table 6B.

UDS Workflow for eCQMs Demonstration

Goal: Learn how to access and assess the measure specifications and value sets for UDS eCQMs.





Example question: What constitutes as “nutrition counseling” for the weight assessment and counseling for children and adolescents measure?

Step 1: Review CQM Guidance in the UDS Manual

- Familiarize yourself with the measure by reviewing UDS Manual guidance.
- **Specification Guidance** summarizes CMS guidance to help with understanding and implementing eCQMs.
- **UDS Reporting Considerations** offer additional requirements and guidance that must be applied to a specific measure and may differ from or expand on eCQM specifications.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Line 12), [CMS155v14](#)

Measure Description

Percentage of patients 3–17 years of age who had an outpatient visit with a **primary care physician (PCP) or obstetrician/gynecologist (OB/GYN)** and who had evidence of height, weight, and body mass index (BMI) percentile documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement period

Calculate as follows:

Denominator: Columns A and B

- Patients 3 through 17 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
 - Include children and adolescents with birthdate on or after January 1, 2009, and birthdate on or before December 31, 2023.

Numerator: Column C

- Children and adolescents who have had:
 - their height, weight, and BMI percentile recorded during the measurement period **and**
 - counseling for nutrition during the measurement period **and**
 - counseling for physical activity during the measurement period.

Exclusions/Exceptions

- Denominator Exclusions
 - Patients who were in hospice care for any part of the measurement period
 - Women who have a diagnosis of pregnancy during the measurement period
- Denominator Exceptions
 - Not applicable



Step 2: Access the Measure Specifications

Click the link next to the measure name in the UDS Manual.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Line 12), CMS155v14 

Measure Description

Percentage of patients 3–17 years of age who had an outpatient visit with a **primary care physician (PCP) or obstetrician/gynecologist (OB/GYN)** and who had evidence of height, weight, and body mass index (BMI) percentile documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement period

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Information

Specifications and Data Elements

Release Notes

Specifications

-  [CMS155-v14.0.000-QDM.html](#) 
-  [CMS155-v14.0.000-QDM.zip](#) (ZIP)

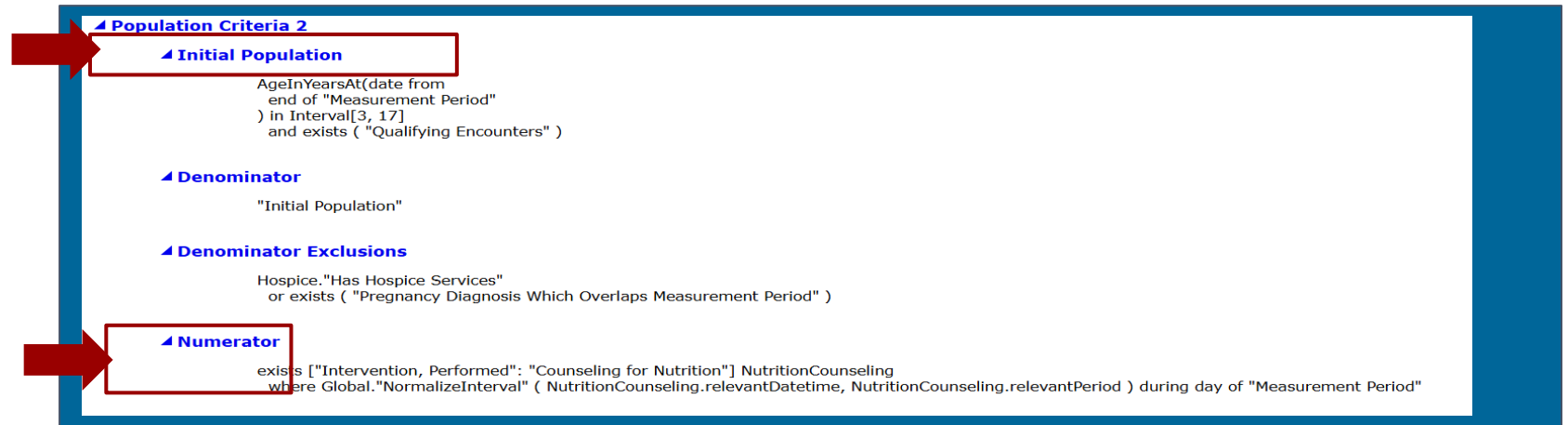
Additional Resources for CMS155v14

- [Value Sets](#) 
- [Data Elements](#)
- [eCQM Flow \(PDF\)](#)

This will bring you to the measure page on the eCQI Resource Center. Click on the “Specifications and Data Elements” tab, then select the first .html file to access the measure specifications.

Step 3: Read Specifications for Relevant Criteria, Definitions, and Terminology

The population criteria for the measure will be listed first in the specifications. This is the CQL that defines each population: denominator, numerator, exclusions, and exceptions.



Population Criteria 2

Initial Population

```
AgeInYearsAt(date from  
end of "Measurement Period"  
) in Interval[3, 17]  
and exists ( "Qualifying Encounters" )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"  
or exists ( "Pregnancy Diagnosis Which Overlaps Measurement Period" )
```

Numerator

```
exists ["Intervention, Performed": "Counseling for Nutrition"] NutritionCounseling  
where Global."NormalizeInterval" ( NutritionCounseling.relevantDatetime, NutritionCounseling.relevantPeriod ) during day of "Measurement Period"
```

The measure specifications show that the **numerator** for this measure is:

exists ("BMI Percentile in Measurement Period")

and exists ("Height in Measurement Period")

and exists ("Weight in Measurement Period")

exists ["Intervention, Performed": "Counseling for Nutrition"] NutritionCounseling

where Global."NormalizeInterval" (NutritionCounseling.relevantDatetime, NutritionCounseling.relevantPeriod)

during day of "Measurement Period"

exists ["Intervention, Performed": "Counseling for Physical Activity"] ActivityCounseling

where Global."NormalizeInterval" (ActivityCounseling.relevantDatetime, ActivityCounseling.relevantPeriod)

during day of "Measurement Period"

Step 3: Read Specifications for Relevant Criteria, Definitions, and Terminology (cont.)

The **definitions** section further define the numerator criteria:

“BMI Percentile in the Measurement Period”

“Height in Measurement Period”

“Weight in the Measurement Period”

“Counseling for Nutrition”

“Counseling for Physical Activity”

▲ Numerator 1

exists ("BMI Percentile in Measurement Period")
and exists ("Height in Measurement Period")
and exists ("Weight in Measurement Period")

▲ Numerator 2

exists ["Intervention, Performed": "Counseling for Nutrition"] NutritionCounseling
where Global."NormalizeInterval" (NutritionCounseling.relevantDatetime, NutritionCounseling.relevantPeriod) during day of "Measurement Period"

▲ Numerator 3

exists ["Intervention, Performed": "Counseling for Physical Activity"] ActivityCounseling
where Global."NormalizeInterval" (ActivityCounseling.relevantDatetime, ActivityCounseling.relevantPeriod) during day of "Measurement Period"

Step 4: Find the Relevant Value Set in Measure Specifications

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "BMI percentile" (2.16.840.1.113883.3.464.1003.121.12.1012)
- valueset "Counseling for Nutrition" (2.16.840.1.113883.3.464.1003.195.12.1003)
- valueset "Counseling for Physical Activity" (2.16.840.1.113883.3.464.1003.118.12.1035)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- valueset "Height" (2.16.840.1.113883.3.464.1003.121.12.1014)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Payer Type" (2.16.840.1.114222.4.11.3591)
- valueset "Pregnancy" (2.16.840.1.113883.3.526.3.378)
- valueset "Preventive Care Services Group Counseling" (2.16.840.1.113883.3.464.1003.101.12.1027)
- valueset "Preventive Care Services Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)
- valueset "Weight" (2.16.840.1.113883.3.464.1003.121.12.1015)

Scroll down to the **“Terminology”** section of the specifications, where all value sets for the measure will be found. Here are the **“Counseling for Nutrition”** and other relevant value sets that are part of the numerator criteria.

The string of numbers beginning with “2” next to the value set name is the **value set ID**. This can be used to search the VSAC for codes included in the value sets.

Step 5: Access Value Sets from VSAC

In the VSAC, you can use the query field to search for the **measure ID** and see all value sets included in the measure, as shown here.

Or just search for the specific “Counseling for Nutrition” value sets using the **value set ID** shown on the last slide.

Click on any value set in the **OID** [object identifier] column to see the list of included codes.

The screenshot shows the VSAC Search Value Sets interface. The search query field contains the measure ID: 2.16.840.1.113883.3.464.1003.195.12.1003. The search results show a table of matched value sets.

Name	Code System	Definition Type	Steward	OID	Expansion Status	Expansion Date	Code Count
Counseling for Nutrition	CPT SNOMEDCT	Grouping	NCQA	2.16.840.1.113883.3.464.1003.195.12.1003	Active	2026-03-27	73

Step 6: Review Codes

Review the codes included in the “Counseling for Nutrition” value sets to determine if the particular service from our original question is included.

Value Set Members

Expanded Code List

View Toggle Clear Columns ? Reset Columns Page 1 of 4 20 View 1 - 20 of 73

Code	Descriptor	Code System	Version	Code System OID
11816003	Diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
1230141004	Education about nutrition influence on health (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
14051000175103	Dietary education for cardiovascular disorder (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183059007	High fiber diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183060002	Low residue diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183061003	Low fat diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183062005	Low cholesterol diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183063000	Low salt diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183065007	Low carbohydrate diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183066008	Low protein diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183067004	High protein diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183070000	Vegetarian diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
183071001	Vegan diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
226067002	Food hygiene education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
266724001	Weight-reducing diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
275919002	Weight loss advised (situation)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
281085002	Sugar-free diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
284352003	Obesity diet education (procedure)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
305849009	Seen by dietetics service (finding)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96
305850009	Seen by community-based dietetics service (finding)	SNOMEDCT	2026-03	2.16.840.1.113883.6.96

View Page 1 of 4 20 View 1 - 20 of 73



Pro Tip: How to Access Codes for All Measures

To download all codes from the VSAC site:

- Create a free Unified Medical Language System (UMLS) account.
- Once you are logged in, go to the Download tab → 2026 Reporting → eCQM Value Sets for Eligible Clinicians.

There are two download options:

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

NIH National Library of Medicine Value Set Authority Center

Welcome back, juliat1

Welcome Search Value Sets Download Comparison Tool Browse Code Systems Help

VSAC Downloadable Resources

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

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

- ▶ 2027 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets
- ▼ 2026 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets
 - ▼ May 2025 Release eCQM & Hybrid Measure Value Sets Publication Date: May 08, 2025

Expansion Version: eCQM Update 2025-05-08

The Eligible Hospital (EH) measures have been renamed to [Hospital Inpatient](#) and [Hospital Outpatient](#). All program candidate measures, including Hospital Outpatient measures CMS1244 and CMS1264 and Eligible Clinician measures CMS1154 and CMS1173, are located here in the CMS eCQM & Hybrid Measure Value Sets.

Available Downloads	Sorted by CMS ID*	Sorted by Value Set Name*	Sorted by Quality Data Model Category*
eCQM Value Sets for Hospital Inpatient Published May 08, 2025	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)
eCQM Value Sets for Eligible Clinicians Published May 08, 2025	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)

How to Access Measure Specifications

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



Strategies for Successful Reporting



QI for Maternal and Child Health (MCH) Measures

Consider re-visiting (or developing new) workflows for your MCH measures when

- Rates of completion are not improving year to year (monthly or quarterly)
- There is greater variation in completion among sub-populations
- Your health center's rate of completion varies from state/regional/national averages

Not all MCH workflows are the same

- Prenatal care definitions are complex and not intuitive (possible workflow for data quality and reporting)
- Frequency of visits in the prenatal and childhood periods make for “catch-up” opportunities (possible workflow for ideal and common alternatives)

QI for MCH Measures continued

Workflows ideally intersect (rather than compete) with one another. A Patient receiving a call on sequential days for a different care gap for a different family member can be inefficient, possibly ineffective, potentially irritating.

- Consider workflows for immunizations that look across family members (co-scheduling appointments)
- Consider workflows for sealants that integrate service lines (dental and medical, or dental and behavioral health)

Workflows shouldn't sit on the shelf, they should be used as tools of discovery to provide clues as to why intended outcomes aren't realized.

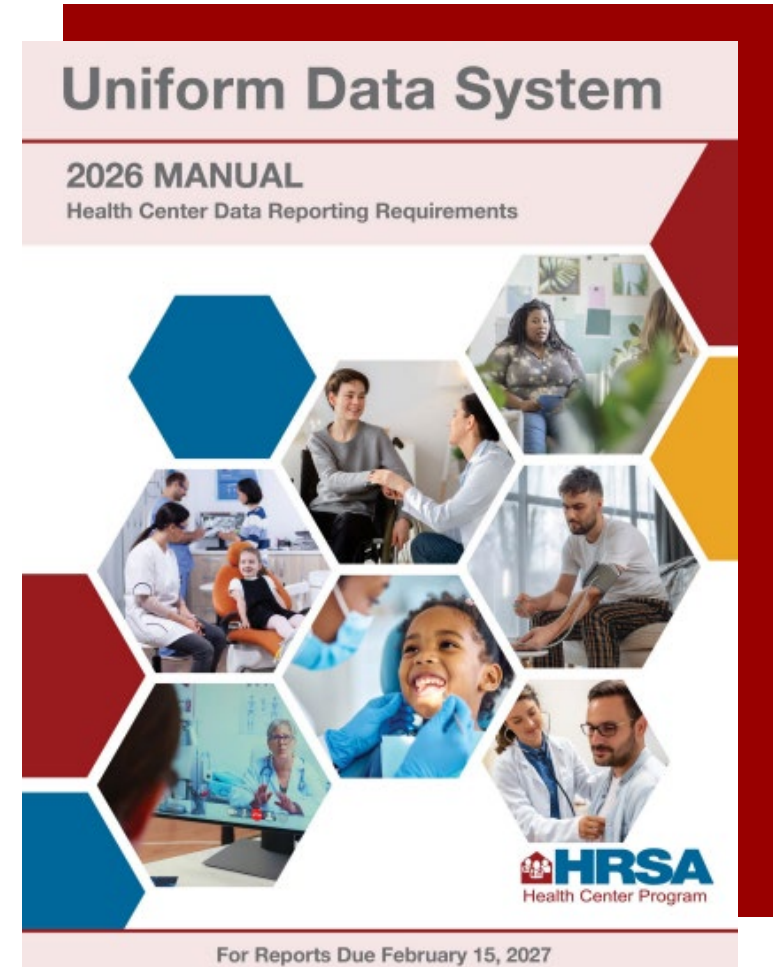
- Possible approaches: review resources staff use to understand prenatal measures and select best available while removing those that are inaccurate. Which staff would most benefit from education to improve the quality of prenatal care data? What is the process for securing delivery records from area hospitals?

New to workflows: See [here](#) for AHRQ's compilation of workflow tools



Follow UDS Guidance

- Thoroughly read definitions and instructions in the [2026 UDS Manual](#).
- See other available guidance:
 - [Program Assistance Letter](#)
 - [eCQI Resource Center](#)
 - [VSAC](#)
- The UDS Support Center offers assistance with UDS measures and requirements.
 - Call 866-UDS-HELP (available year-round from 8:30 a.m. to 5 p.m. ET).
 - Email udshelp330@bphcdata.net.
 - Submit a ticket via the [BPHC Contact Form](#) (select Uniform Data System/UDS 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 Electronic Handbooks (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.



Pre-Submission Validation: Cross-Table Relationships

- **Childhood Immunization Denominator vs. Table 3A (2-Year-Olds):** Compare Table 6B, Line 10, Column A (turn 2 in 2026) with Table 3A, Line 3, Columns A + B (Age 2). Understand the Variance: They will **not** be identical due to measure-specific exclusions, exceptions, and qualifying visit requirements.
- **Maternal Care: Prenatal Patients vs. Deliveries:** Divide Table 7, Column 1A (Deliveries) by Table 6B, Line 6, Column A (Prenatal Patients). Typically, about half your prenatal cohort will cross reporting years (the national average is 54 percent).
- **Cross-Table Demographic Checks:** The count of patients reported by race/ethnicity on Table 7 cannot exceed the total reported in those same categories on Table 3B.

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

- The Preliminary Reporting Environment will be available in fall 2026.
- Use the modernized reporting features—Excel file, offline HTML file, Comparison Tool, and Excel mapping document—to help you prepare for UDS data reporting.

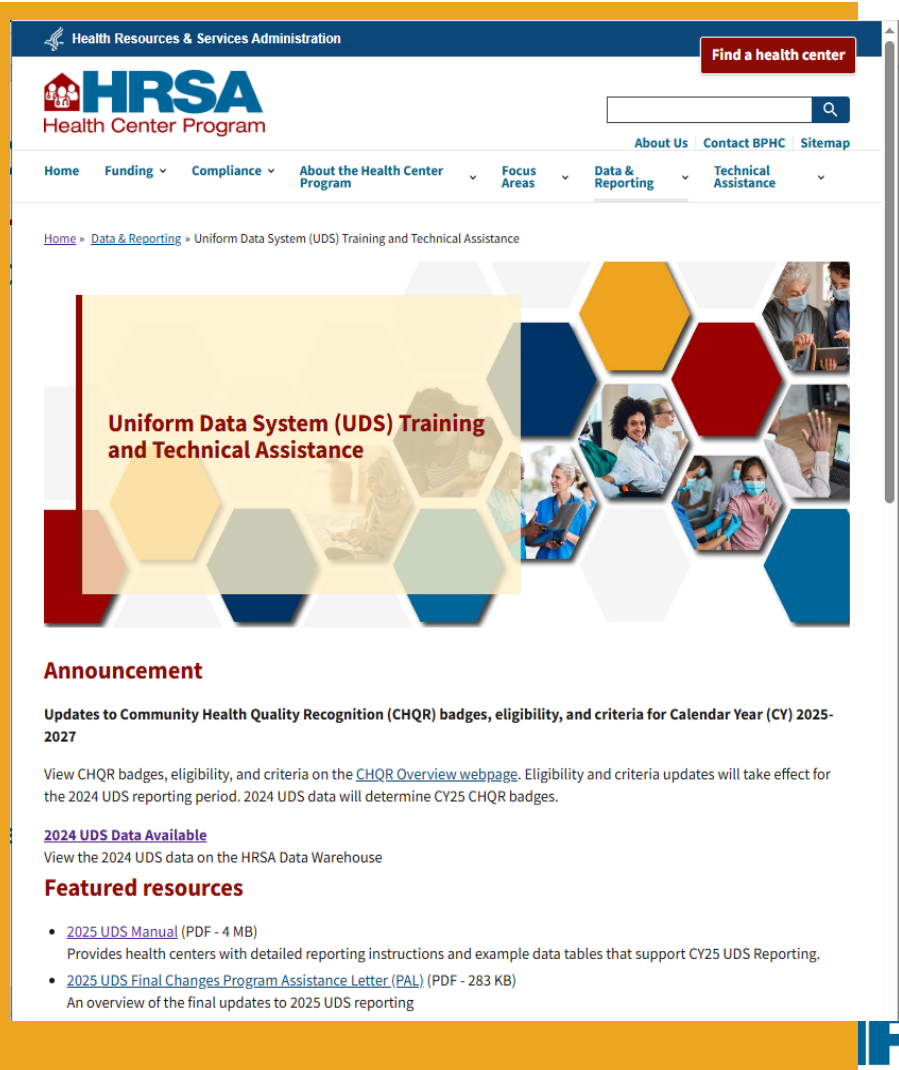
UDS Reporting Resources



UDS Technical Assistance Resources

UDS reporting resources on the UDS Technical Assistance website:

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



The screenshot displays the HRSA Health Center Program website. The header includes the HRSA logo and navigation links such as 'Home', 'Funding', 'Compliance', 'About the Health Center Program', 'Focus Areas', 'Data & Reporting', and 'Technical Assistance'. A search bar and a 'Find a health center' button are also present. The main content area features a large graphic with the text 'Uniform Data System (UDS) Training and Technical Assistance' and a collage of images showing healthcare professionals. Below this, an 'Announcement' section titled 'Updates to Community Health Quality Recognition (CHQR) badges, eligibility, and criteria for Calendar Year (CY) 2025-2027' provides information about CHQR updates. A '2024 UDS Data Available' section mentions the HRSA Data Warehouse. The 'Featured resources' section lists two PDF documents: the '2025 UDS Manual' (4 MB) and the '2025 UDS Final Changes Program Assistance Letter (PAL)' (283 KB).



UDS Reporting Webinar Series

The webinar series includes:

- UDS Changes Technical Assistance Webinar
- Understanding UDS Patient Characteristics Tables for Quality Improvement
- The Foundation of the UDS: Counting Visits
- UDS Clinical Tables Part 1: Screening and Preventive Care Measures
- UDS Clinical Tables Part 2: Maternal Care and Children's Health
- UDS Clinical Tables Part 3: Disease Management
- Preliminary Reporting Environment
- Reporting UDS Financial and Operational Tables
- Strategies for Successful Submission



All webinars are archived on the [HRSA website](#); watch them anytime!



Available Assistance

- Technical assistance materials, including local trainings, available online:
 - [UDS Technical Assistance](#)
- UDS Support Center for assistance with UDS reporting questions:
 - udshelp330@bphcdata.net
 - 866-UDS-HELP (866-837-4357)
 - [BPHC Contact Form](#), select UDS Reporting
- For EHBs help and account access/roles questions:
 - 877-464-4772
 - [BPHC Contact Form](#), select Technical and System Support
- For more information, visit the [Technical Assistance Contacts](#) webpage.



Q&A

What questions do you have for us?



Thank You!

Lisa Schamus, MPH, Training and Technical Assistance Specialist



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



1-866-837-4357

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