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

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This webinar was produced for the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care under contract number 47QRAA23D0087/75R60223F80123. This publication lists non-federal resources in order to provide additional information to consumers. Neither HHS nor HRSA has formally approved the non-federal resources in this manual. Listing these is not an endorsement by HHS or HRSA

# Opening Remarks

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

# Agenda

1. Discuss Uniform Data System (UDS) reporting instructions on clinical quality measures (CQMs)
2. Review UDS screening and preventive care measures reporting requirements
3. Identify reporting strategies and tips for data reporting
4. Review 2025 UDS training resources

# Objectives

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

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

# 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 CQM Reporting

## Electronic Clinical Quality Improvement (eCQI) Resource Center

## Key Resources

# Components of Each Clinical Quality Measure

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

# Other Key Terms in UDS CQM Measurement

| | |
|---|---|
| **Specification Guidance** | The Centers for Medicare & Medicaid Services (CMS) measures guidance that assists with understanding and implementing CQMs. |
| **UDS Reporting Considerations** | Additional BPHC requirements and guidance that must be applied to the specific measure and that may differ from or expand on the CQM specifications. |
| **CQMs** | Quantified health care indicators used to evaluate how well the health center is achieving standards. |
| **eCQMs** | CQMs expressed and formatted to use data from electronic health record (EHR) and/or health information technology (health IT) systems to measure health care quality. |
| **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 Value Set Authority Center (VSAC)–hosted standard clinical vocabularies (such as CPT, ICD,SNOMED CT, RxNorm, and LOINC®) that define clinical concepts. |
| **Measurement Period** | Represents calendar year (CY) 2025 (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 CQM has a measure steward. |

# Denominators: Qualifying Encounters

To be included in any given UDS-reported CQM denominator, patients must have:

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

**and**

- A **visit that meets the qualifying encounter definitions** for that particular CQM measure criteria and specifications.
- Each measure has its own qualifying encounters, defined in its specifications.

# 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 (e.g., medical, dental, mental health, substance use disorder) if they meet the countable visit definition.

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

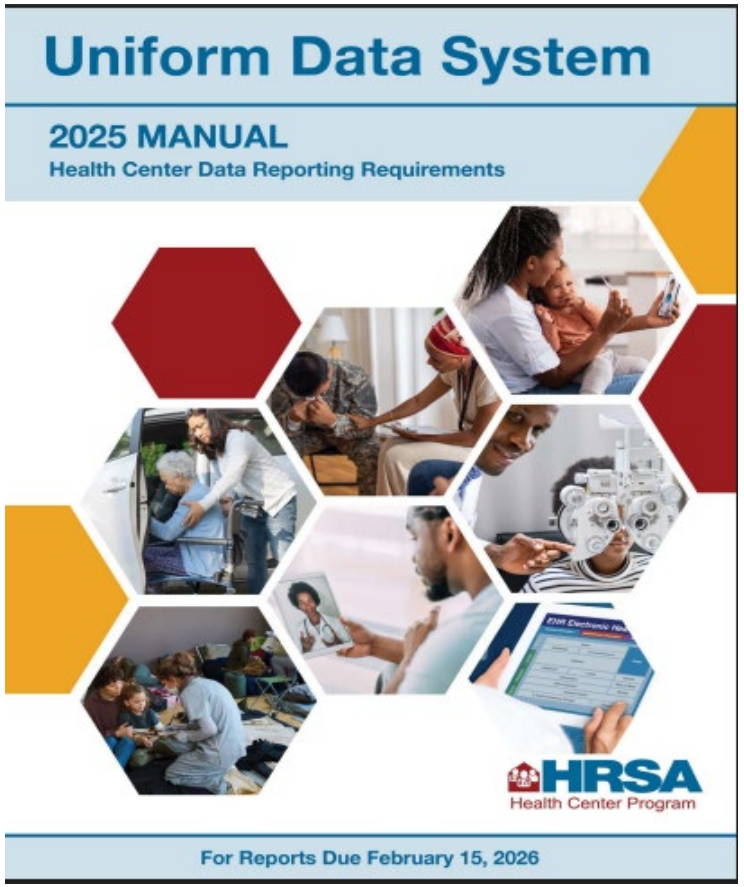
Eligible visit types depend on specifications defined by the measure steward and must be assessed for each measure individually.

**It is essential to review and use the codes listed in the CQM specifications.**

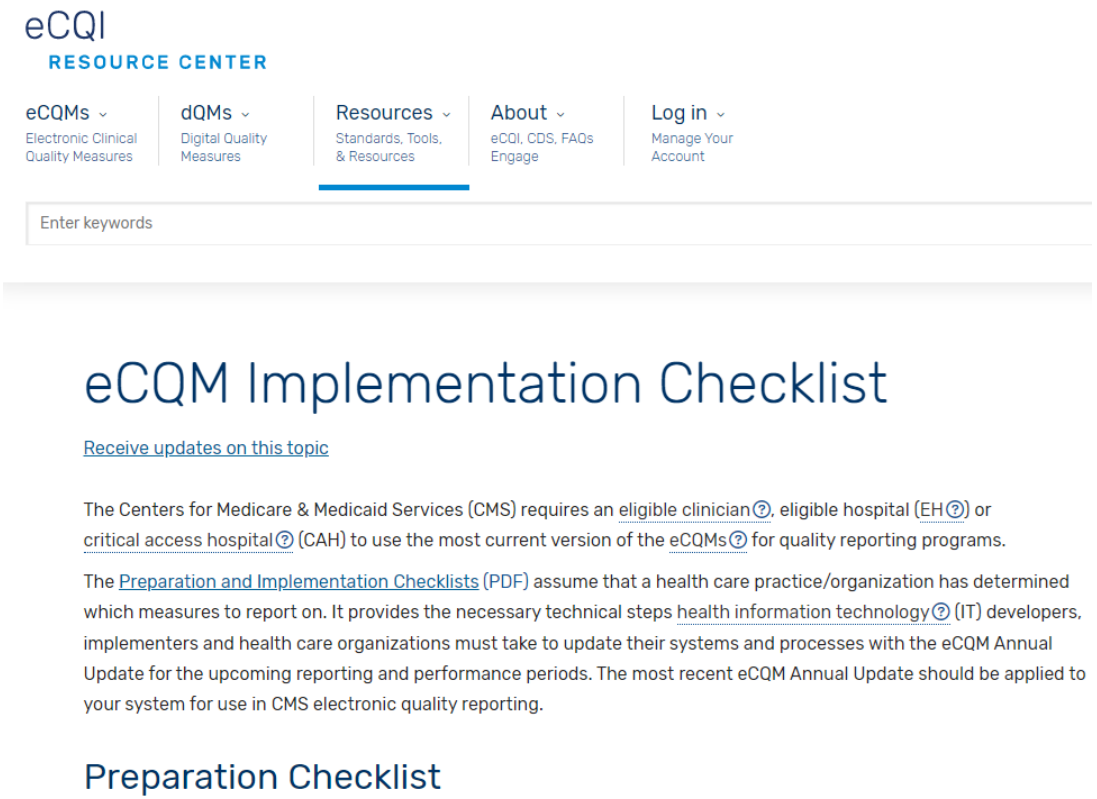
Many CQMs have denominators that are limited to patients who have had at least a medical visit during the year, but in some measures, other visit types might also be included in applicable CQM value sets.

# Getting Started with CQMs
## Finding UDS Guidance

- Review the 2025 UDS Manual, which includes:
  - Definitions and instructions specific to the UDS
  - Links to all CQMs, as well as UDS-specific considerations
  - Descriptions of additional resources to support reporting
- Review year-over-year changes via:
  - 2025 Program Assistance Letter (PAL)
  - UDS Changes Webinar (held June 26, 2025)
  - Upcoming technical assistance webinars and annual UDS trainings co-hosted with Primary Care Associations



# Getting Started with eCQMs
## eCQI Resource Center



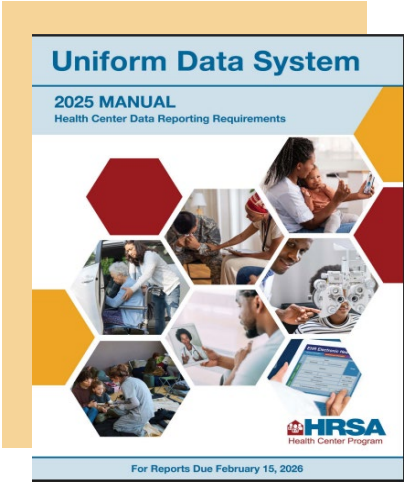

### eCQM Implementation Checklist

- Six preparation steps and seven implementation steps.

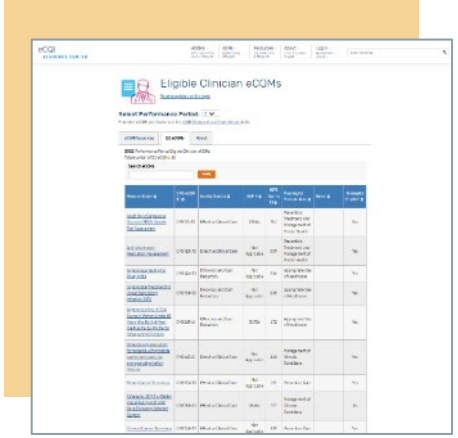
### eCQM supports include:

- eCQI Resource Center: For each measure, in the "Measure Information" tab, there is the option to "compare" (e.g., 2024 to 2025). **This highlights changes year over year.**
- eCQM Flows: Workflows for each eCQM, updated annually; downloads as a ZIP file.
- Technical Release Notes: 2025 Performance Period eCQMs for Eligible Clinicians
- eCQM value sets: The Value Set Authority Center (VSAC) site allows you to search value sets.
- Additional resources are available on the Eligible Clinician eCQM Resources page.

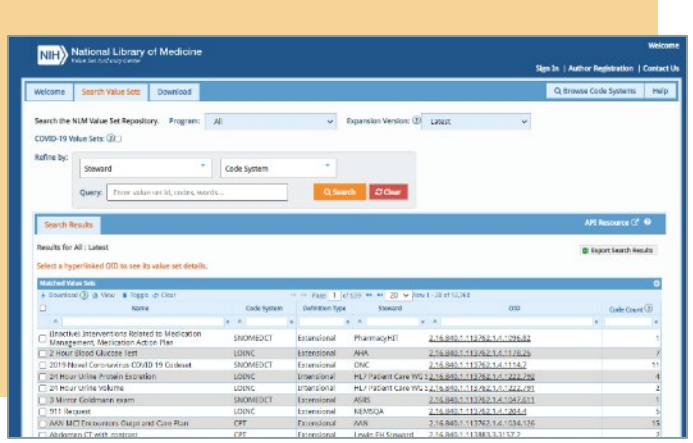
# Getting Started with CQMs
## Key Resources




The UDS Manual provides specific UDS table and form reporting instructions, covers UDS-specific considerations, and links to measure specifications.




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



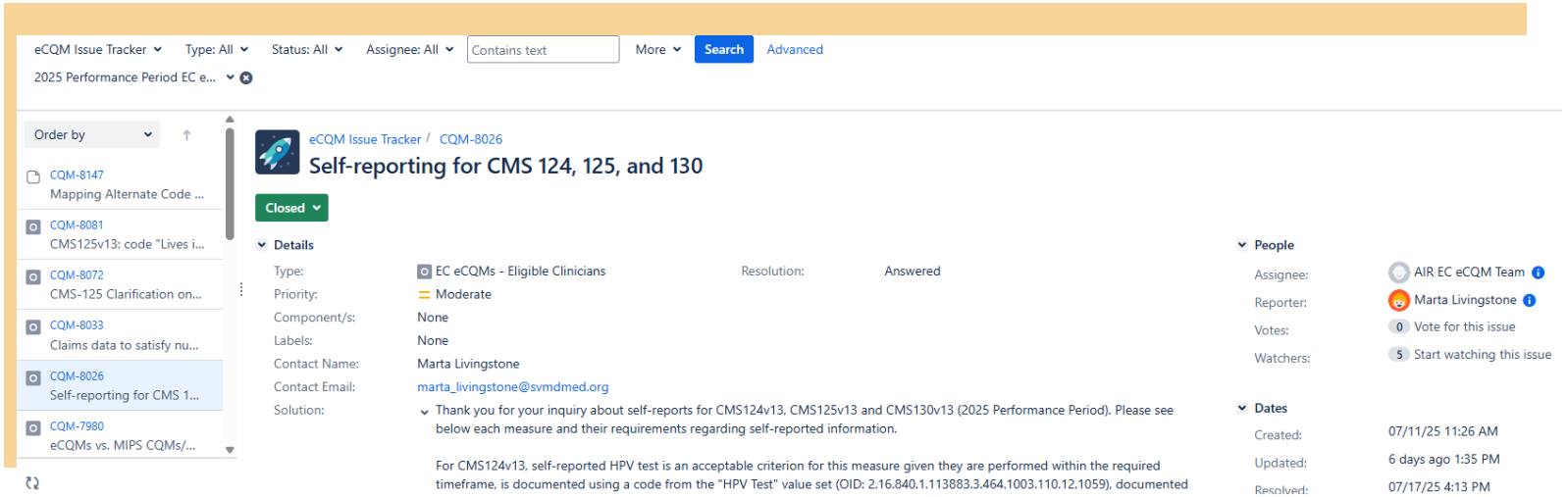

The codes that make up each value set within the measure specifications are available from the VSAC site.

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

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

Sign up for an OITS account.

Post questions in the eCQM Issue Tracker.



# Knowledge Check #1

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

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

B. Only patients who had a countable UDS visit **and** a visit that meets the qualifying encounter definitions for that particular CQM measure criteria and specifications 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 a countable UDS visit and a visit that meets the qualifying encounter definitions for that particular CQM measure criteria and specifications during the measurement period as specified in the measure.**

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

D. None of the above.

# Table 6B CQMs

## Reporting Format

## Key Changes

## UDS CQMs

# UDS CQMs

## Screening and Preventive Care Measures

Today's webinar

## Maternal Care and Children's Health Measures

UDS Clinical Tables Part 2: October 21, 2025, 2:00–3:30 p.m. ET

## Disease Management Measures

UDS Clinical Tables Part 3: October 29, 2025, 2:00–3:30 p.m. ET

Register for future UDS webinars and **view past webinar recordings**.

# 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 percent of Column A | Number of records from Column B that meet the numerator criteria for the measure |

# Changes to Align with eCQMs

Table 6B was updated to align with the latest CMS eCQMs. The 2025 UDS CQM Criteria handout is available to review for 2025 updates.

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

| Line | Clinical Quality Care Measure | Updated eCQM |
|---|---|---|
| 11 | Cervical Cancer Screening | CMS124v13 |
| 11a | Breast Cancer Screening | CMS125v13 |
| 13 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | CMS69v13 |
| 14a | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | CMS138v13 |
| 19 | Colorectal Cancer Screening | CMS130v13 |
| 20a | HIV Screening | CMS349v7 |
| 21 | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | CMS2v14 |

# Table 6B CQMs:
# Screening and Preventive Care

# General Reporting Guidelines

- 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, unless otherwise noted.
- 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.

# Cervical Cancer Screening: CMS124v13

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria | Women who had a hysterectomy with no residual cervix or a congenital absence of cervix<br><br>Patients who were in hospice care for any part of the measurement period<br><br>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:<br><br>• Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.<br>• Cervical human papillomavirus (HPV) testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test. |

# Cervical Cancer Screening: CMS124v13 *(cont.)*

## Clarifications, Tips, and Frequently Asked Questions (FAQs)

- Evaluates whether tests were performed after a woman turned 21 years of age. The youngest age in the initial population is a patient who turned 24 years old on December 31.
- Evidence of high-risk human papillomavirus (hrHPV) testing within the last 5 years also captures patients who had cotesting, therefore, additional methods to identify cotesting are not necessary.
- The method of collection *is not* specified in the eCQM specifications. HPV tests that are documented using the codes specified in the value set meet the numerator criteria. This question specific to self-swab collection was captured in Jira in February 2025.
- **Screening performed elsewhere?** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.

# Breast Cancer Screening: CMS125v13

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Women 52 through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria | Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy on or before the end of the measurement period<br><br>Patients who were in hospice care for any part of the measurement period<br><br>Patients aged 66 or older by the end of the measurement period<br>• Who were living long-term in a nursing home any time on or before the end of the measurement period<br>• With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria:<br>– Advanced illness diagnosis during the measurement period or the year prior; or<br>– Taking dementia medications during the measurement period or the year prior<br><br>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 (CMS125v13)

- The Breast Cancer Screening measure includes revised denominator exclusion language for the advanced illness criteria.

| 2024 Denominator Exclusions | 2025 Denominator Exclusions |
|---|---|
| Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:<br><br>– Advanced illness with two outpatient encounters during the measurement period or the year prior<br>– OR advanced illness with one inpatient encounter during the measurement period or the year prior<br>– OR taking dementia medications during the measurement period or the year prior | Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:<br><br>– Advanced illness **diagnosis** during the measurement period or the year prior<br>– OR taking dementia medications during the measurement period or the year prior |

# Breast Cancer Screening: CMS125v13 *(cont.)*

## Clarifications, Tips, and FAQs

- 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.
- **Do not** count biopsies, breast ultrasounds, or magnetic resonance imaging, because they are not appropriate methods for *primary breast cancer screening*.
- ***Mammogram performed elsewhere?*** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.

# Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v13

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

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

# Body Mass Index (BMI) Screening and Follow-Up Plan (CMS69v13)

- Updates clarify the timing of documentation of exception criteria.

| 2024 Guidance | 2025 Guidance |
|---|---|
| This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying encounter and the measure-specific denominator coding. | This measure may be reported by eligible **clinicians** who perform the quality actions described in the measure based on the services provided at the time of the qualifying encounter **or during the measurement period** and the measure-specific denominator coding. |
| Not applicable | **If a patient meets exception criteria for the denominator (i.e., the patient refuses height or weight measurement or has a documented medical reason for not documenting BMI or a follow-up plan), an eligible clinician must document those criteria on the same day as the qualifying encounter.** |

# Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v13 *(cont.)*

**Clarifications, Tips, and FAQs**

- 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.
- Normal BMI parameters are defined as BMI >= 18.5 and < 25 kg/m2.
- 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: CMS138v13

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients aged 12 years and older at the start of the measurement period seen for at least two qualifying encounters in the measurement period **or** at least one preventive care qualifying encounter during the measurement period, as specified in the measure criteria | Patients who were in hospice care for any part of the measurement period | Not applicable | Patients who were:<br>• Screened for tobacco use at least once during the measurement period and ***not*** identified as a tobacco user<br>• Screened for tobacco use at least once during the measurement period and, if identified as a tobacco user, received tobacco cessation intervention during the measurement period or during the 6 months prior to the measurement period |

# Tobacco Use: Screening and Cessation Intervention: CMS138v13 *(cont.)*[1]

## Clarifications, Tips, and FAQs

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

# Colorectal Cancer Screening: CMS130v13

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients 46 through 75 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria | Patients with a diagnosis or past history of colorectal cancer or a history of total colectomy<br><br>Patients who were in palliative or hospice care for any part of the measurement period<br><br>Patients aged 66 or older by the end of the measurement period:<br>• Who were living long-term in a nursing home during any time on or before the end of the measurement period; **or**<br>• With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria:<br>– Advanced illness diagnosis during the measurement period or the year prior; or<br>– 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:<br>• Fecal occult blood test (FOBT) during measurement period<br>• Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT) during the measurement period or the two years prior to the measurement period<br>• Flexible sigmoidoscopy during the measurement period or the four years prior<br>• Computerized tomography (CT) during measurement period or four years prior<br>• Colonoscopy during measurement period or nine years prior |

# Colorectal Cancer Screening: CMS130v13

- The Colorectal Cancer Screening measure includes revised denominator exclusion language for the advanced illness criteria.

| 2024 Denominator Exclusions | 2025 Denominator Exclusions |
|---|---|
| Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:<br><br>- Advanced illness with two outpatient encounters during the measurement period or the year prior<br>- OR advanced illness with one inpatient encounter during the measurement period or the year prior<br>- OR taking dementia medications during the measurement period or the year prior | Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:<br><br>- Advanced illness **diagnosis** during the measurement period or the year prior<br>- OR taking dementia medications during the measurement period or the year prior |

# Colorectal Cancer Screening: CMS130v13 *(cont.)*[1]

**Clarifications, Tips, and FAQs**

- **Do not** count digital rectal exams (DREs) or fecal occult blood tests (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).
- Lab tests (FOBT and sDNA with FIT) performed elsewhere must be confirmed by documentation in the patient's health record: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- **Do not** use self-reported test results.
- Procedures and diagnostic studies are not acceptable via telehealth.
- iFOBT, gFOBT, and sDNA with FIT test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.

# HIV Screening: CMS349v7

| 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 qualifying encounter during the day of the measurement period, as specified in the measure criteria | Patients diagnosed with HIV prior to the day of the start of the measurement period | Patients who died on or before the end of the last day of the measurement period | Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday |

# HIV Screening: CMS349v7 *(cont.)*

**Clarifications, Tips, and FAQs**

- 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.
- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If the only visits during the year are telephone visits, exclude the patient from the denominator.

# Screening for Depression and Follow-Up Plan: CMS2v14

| Denominator | Exclusions | Exceptions | Numerator |
|---|---|---|---|
| Patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria | Patients who have been diagnosed with bipolar disorder at any time prior to the qualifying encounter | Patients:<br>• Who refuse to participate in or complete the depression screening<br>• Who are in urgent or emergent situations<br>• Who have a documented medical reason for not being screened for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results | Patients who were:<br>• 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 screened negative for depression<br>• 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, 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: CMS2v14

- The guidance statement has been updated to show the CY 2024 removal of the denominator exclusion for prior diagnosis of depression.

| 2024 Guidance | 2025 Guidance |
|---|---|
| The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter used to evaluate the numerator will be excluded from the measure regardless of whether the diagnosis is active or not. | The intent of the measure is to **screen all patients for depression** except those with a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter will be excluded from the measure regardless of whether the diagnosis is active or not. |

# Screening for Depression and Follow-Up Plan: CMS2v14 *(cont.)*

**Clarifications, Tips, and FAQs**

- The depression screening must be completed on the date of the visit **or** up to 14 days prior to the date of the visit and must be reviewed and addressed in the office of the provider on the date of the visit. Screening may occur outside of a countable visit.
- A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
- The denominator exclusion for patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter applies regardless of whether the diagnosis is active or not.
- If a patient has had multiple screenings in the measurement period, use the most recent screening results.
- Do not exclude patients seen for routine care in urgent care centers or emergency rooms from the denominator.
- A Patient Health Questionnaire (PHQ)-9 following a PHQ-2 does not meet the numerator requirements for a follow-up plan to a positive depression screening.

# Knowledge Check #2

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

A. Sign up for an OITS account
B. Post questions to the measure stewards and review questions others have asked
C. Review known issues for implementation information for eCQMs
D. All of the above

# Knowledge Check #2 Answer

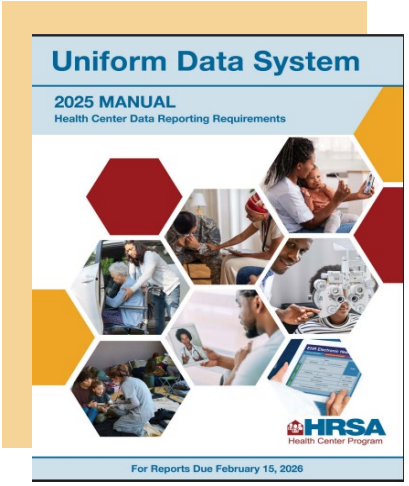
**What is the best way to receive clarification and guidance for eCQMS not already addressed with the measure specifications or CQL?**

A. Sign up for an OITS account
B. Post questions to the measure stewards and review questions others have asked
C. Review known issues for implementation information for eCQMs
**D. All of the above**

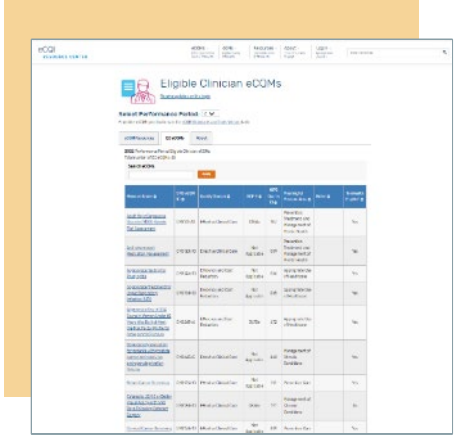
# UDS Workflow for eCQMs Demonstration

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

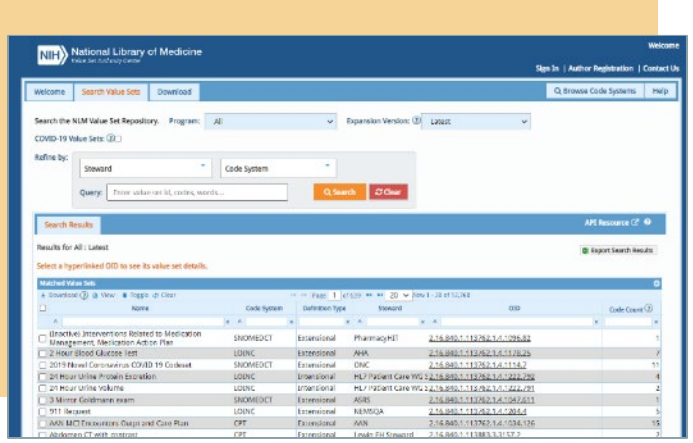
# Reminder: Getting Started with CQMs
## Key Resources




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




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

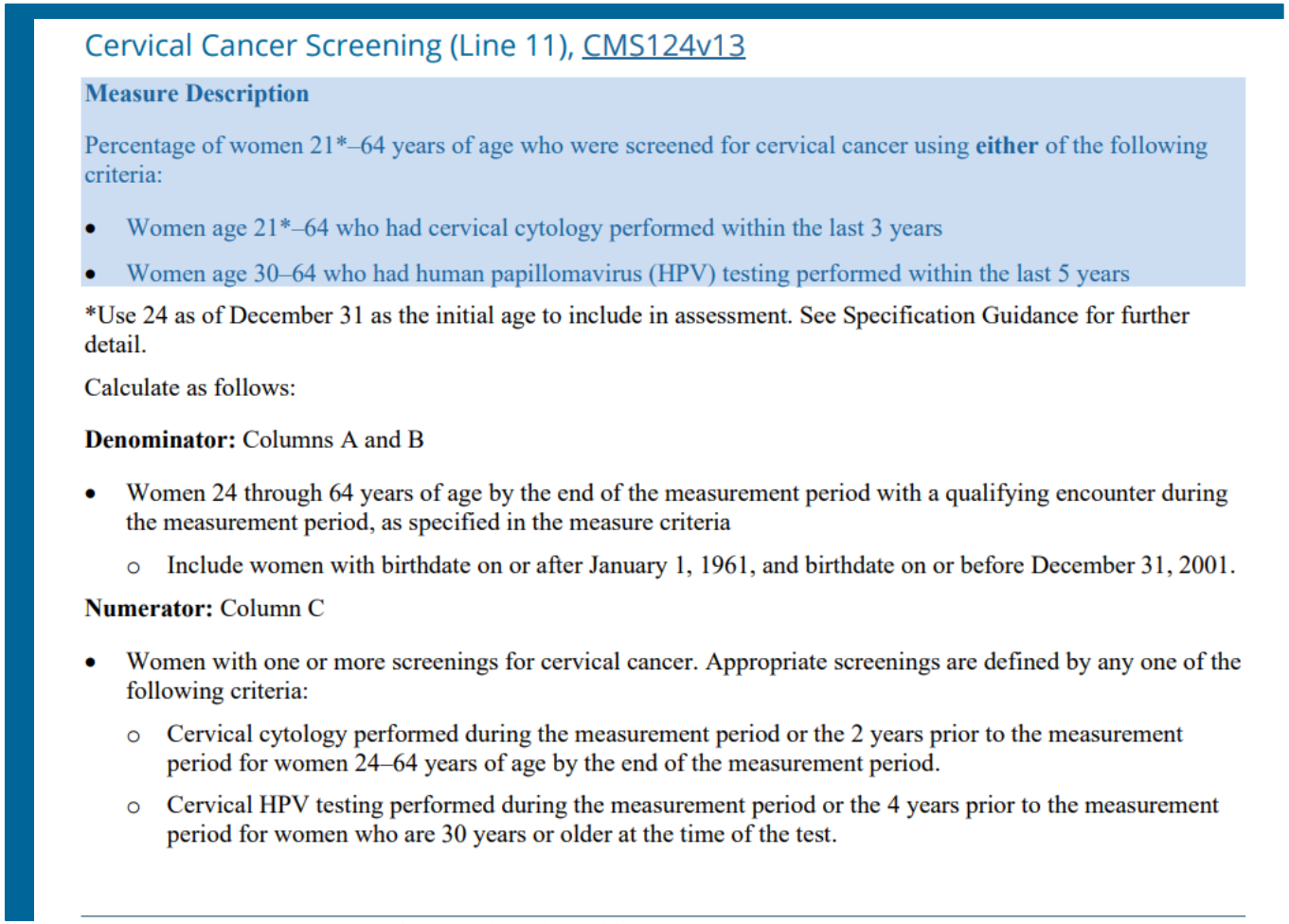



The codes that make up each value set within the measure specifications are available from the VSAC site.

**Example question:** Does XYZ test meet the numerator criteria for the Cervical Cancer Screening 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 CQMs.
- **UDS Reporting Considerations** offer additional requirements and guidance that must be applied to a specific measure and may differ from or expand on CQM specifications, when applicable.



Cervical Cancer Screening (Line 11), CMS124v13

**Measure Description**

Percentage of women 21*–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 21*–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

*Use 24 as of December 31 as the initial age to include in assessment. See Specification Guidance for further detail.

Calculate as follows:

**Denominator:** Columns A and B

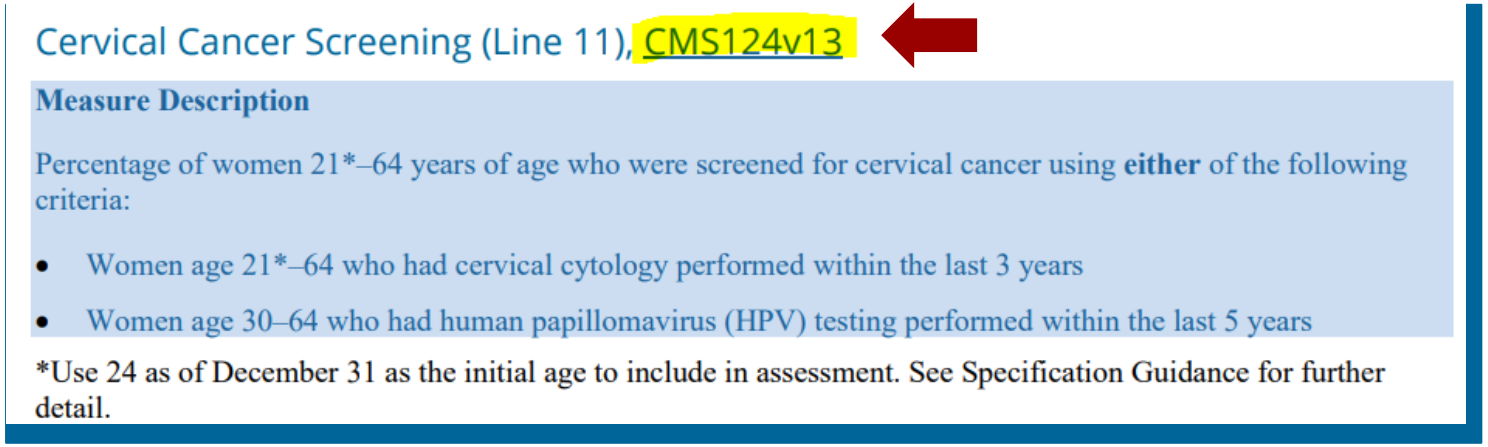
- Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include women with birthdate on or after January 1, 1961, and birthdate on or before December 31, 2001.

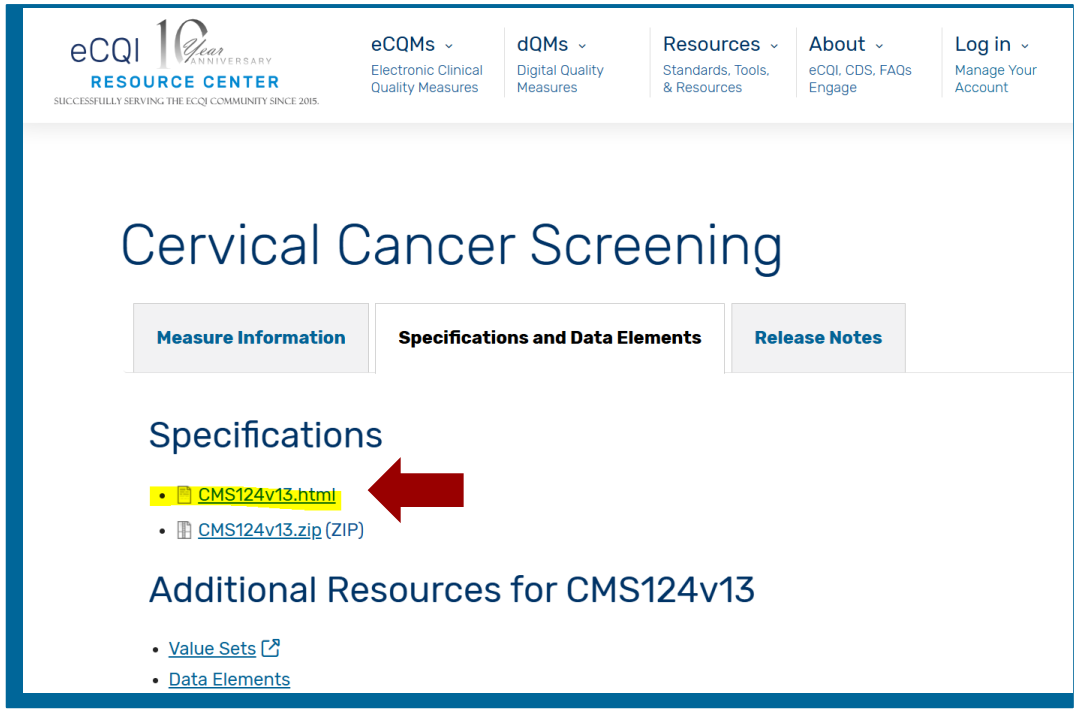
**Numerator:** Column C

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
  - Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.
  - Cervical 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.

# Step 2: Access the Measure Specifications

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




This will bring you to the measure page on the **eCQI Resource Center**. Click on the "Specifications and Data Elements" tab, then click on 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.

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

*exists "Cervical Cytology Within 3 Years" or exists "HPV tests Within 5 years for Women Age 30 and Older"*

# Step 3: Read Specifications for relevant Criteria, Definitions, and Terminology *(cont.)*

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

"Cervical Cytology Within 3 Years"

"HPV tests Within 5 years for Women Age 30 and Older" from the last slide

**Definitions**

**Absence of Cervix**

```
( ["Procedure, Performed": "Hysterectomy with No Residual Cervix"] NoCervixProcedure
    where Global."NormalizeInterval" ( NoCervixProcedure.relevantDatetime, NoCervixProcedure.relevantPeriod ) ends on or before end of "Measurement Period"
)
  union ( ["Diagnosis": "Congenital or Acquired Absence of Cervix"] NoCervixDiagnosis
      where NoCervixDiagnosis.prevalencePeriod starts on or before end of "Measurement Period"
    )
```

**Cervical Cytology Within 3 Years**

```
["Laboratory Test, Performed": "Pap Test"] CervicalCytology
    where Global."LatestOf" ( CervicalCytology.relevantDatetime, CervicalCytology.relevantPeriod ) during day of Interval[start of "Measurement Period" - 2 years, end of
"Measurement Period"]
    and CervicalCytology.result is not null
```

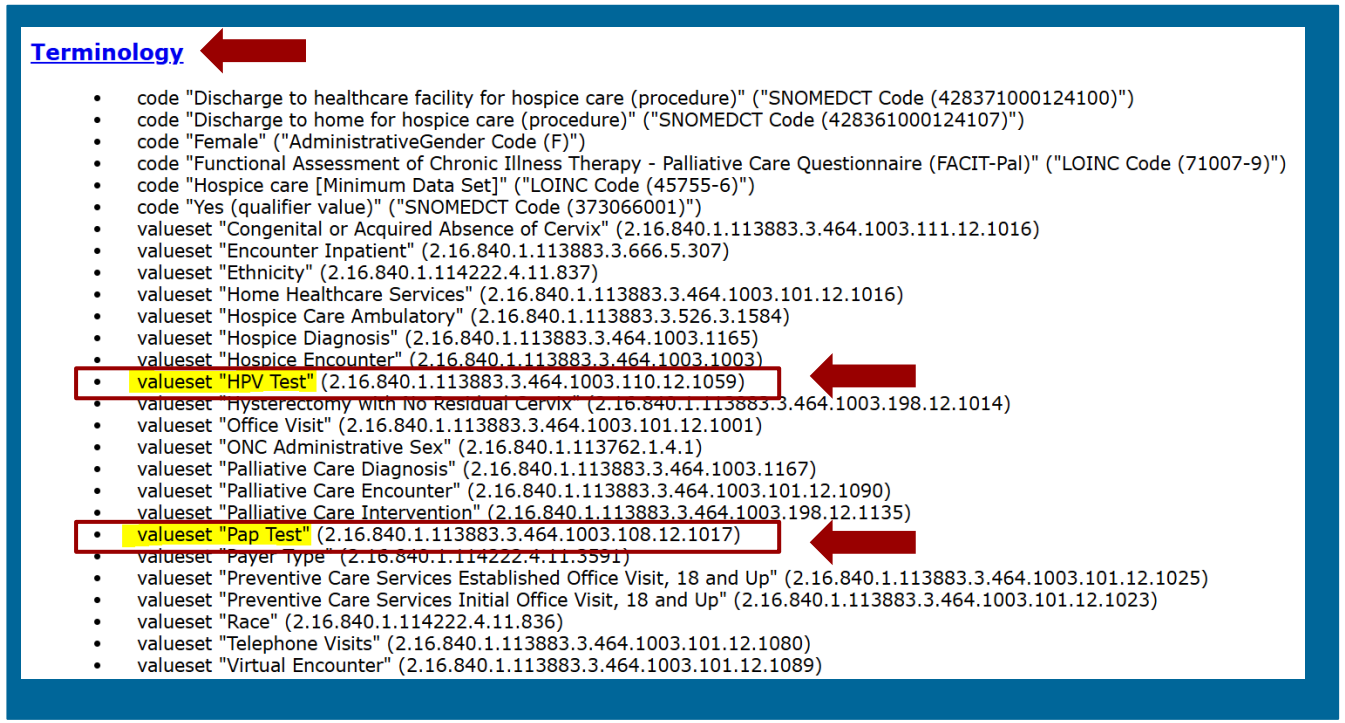
**HPV Test Within 5 Years for Women Age 30 and Older**

```
["Laboratory Test, Performed": "HPV Test"] HPVTest
  where AgeInYearsAt(date from Global."LatestOf"(HPVTest.relevantDatetime, HPVTest.relevantPeriod)) >= 30
    and Global."LatestOf" ( HPVTest.relevantDatetime, HPVTest.relevantPeriod ) during day of Interval[start of "Measurement Period" - 4 years, end of "Measurement
Period"]
    and HPVTest.result is not null
```

We see that these data element definitions include two lab tests:

*"Laboratory Test, Performed": "Pap Test"* and *"Laboratory Test, Performed": "HPV Test"*

# Step 4: Find the Relevant Value Set in Measure Specifications




Scroll down to the **terminology** section of the specifications, where all value sets for the measure will be found. Here are the **"HPV Test"** and **"Pap Test"** value sets that are part of the numerator criteria.

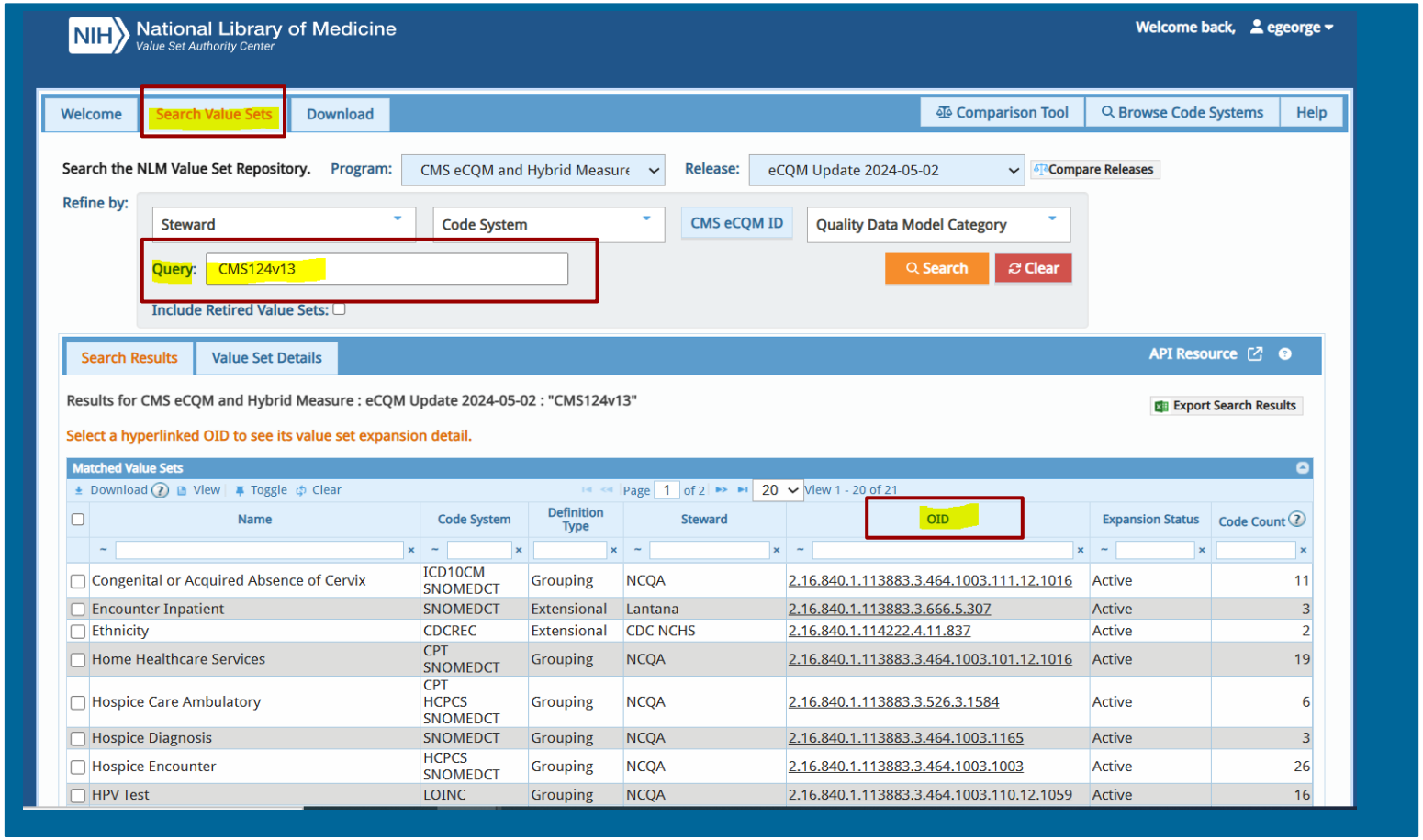
The string of numbers beginning with "2" next to the value set name is the **value set ID**. This can be used to search the VSAC for codes included in the "HPV Test" and "Pap Test" value sets.

# 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.

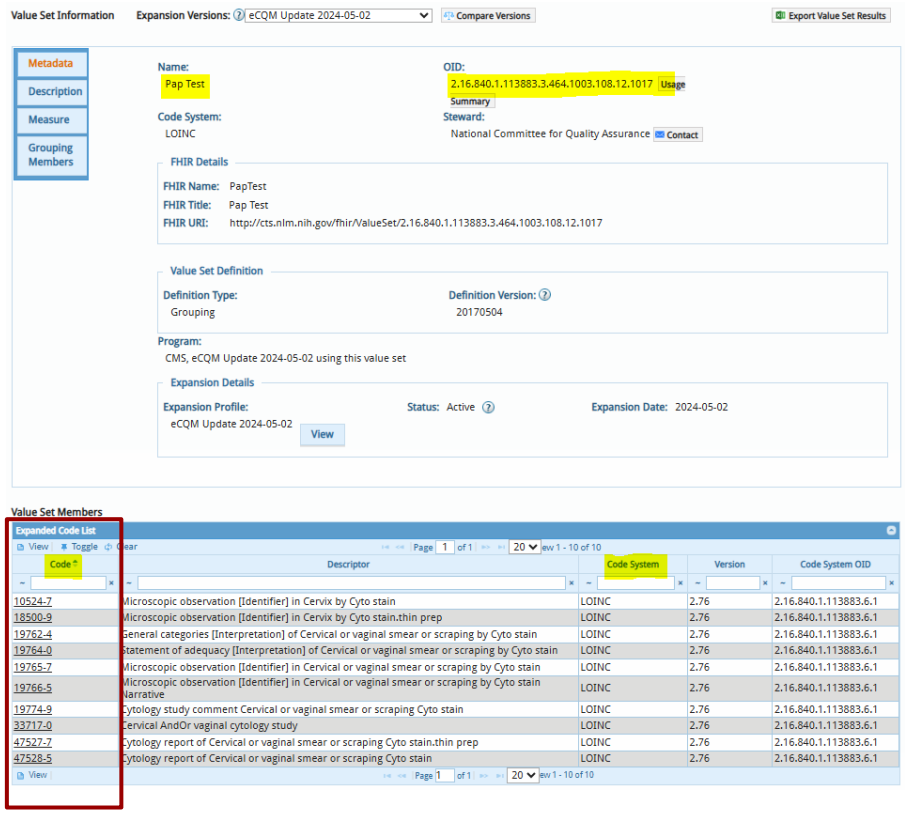
Or just search for the specific “HPV Test” and “Pap Test” value sets using the **value set ID** shown on the last slide.

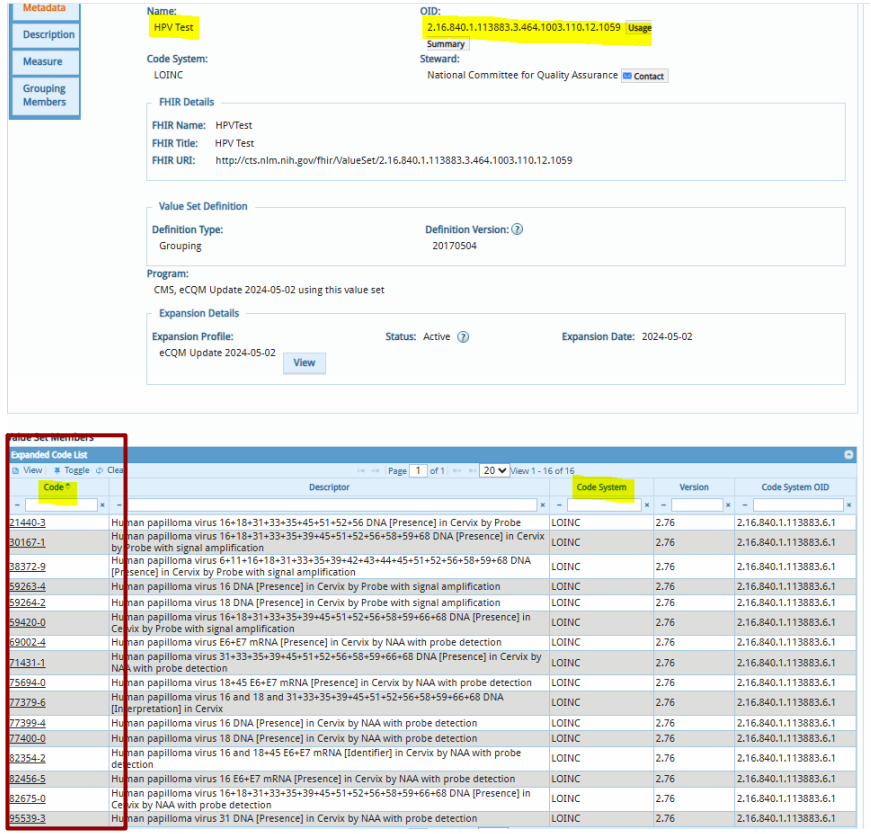
Click on any value set in the Object Identifier (**OID**) column to see the list of included codes.



# Step 6: Review Codes

Review the codes included in both the “Pap Test” and “HPV Test” value sets to determine if the particular test from our original question is included.



# Pro Tip: How to Access Codes for All Measures

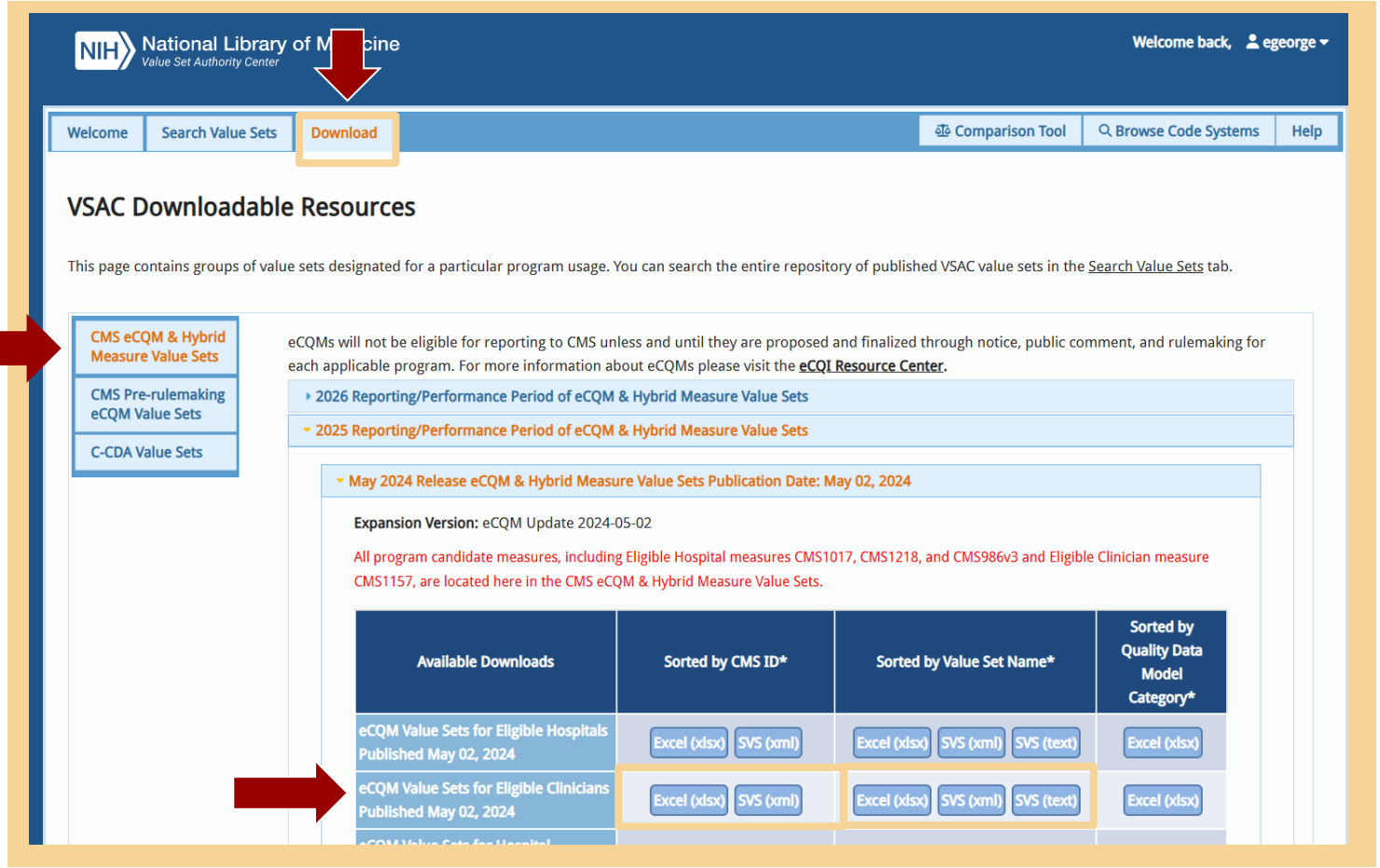
**To download all codes from the VSAC site:**

- **Create a free Unified Medical Language System account.**
- Once you are logged in, go to Download tab → 2025 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—you'll 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.)



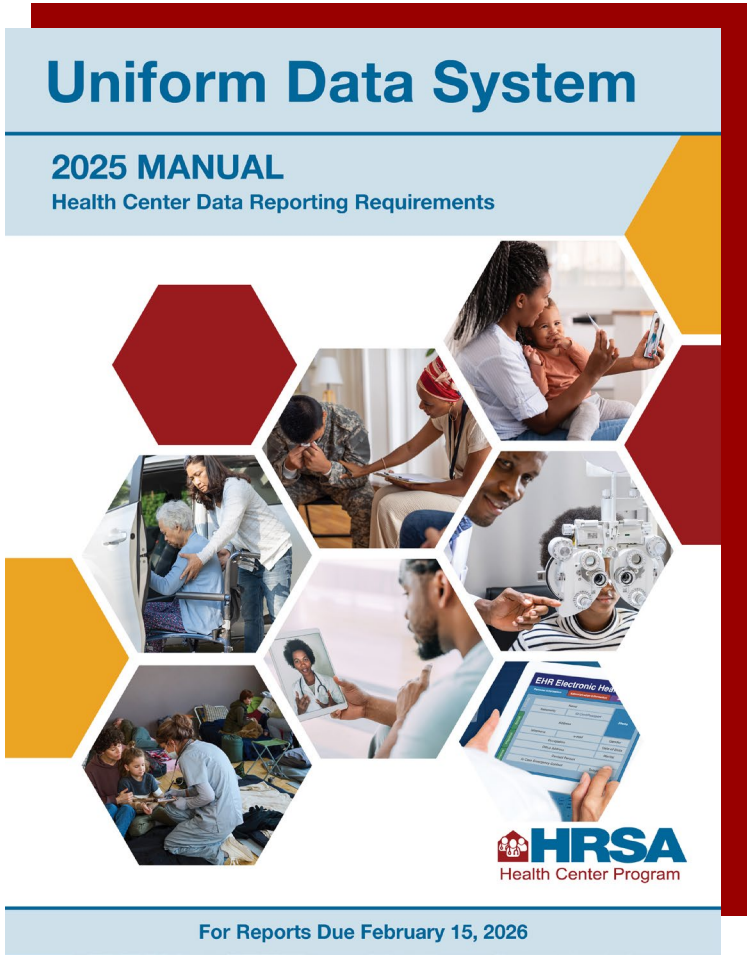
# How to Access Measure Specifications

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

# Strategies for Successful Reporting

# Follow UDS Guidance

- Thoroughly read definitions and instructions in the 2025 UDS Manual.
- See other available guidance:
  - PAL
  - eCQI Resource Center
  - VSAC
- The UDS Support Center offers help 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).



# Understanding Reported UDS Data

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

| | Table 6A | Table 6B | Table 6A | Table 6B |
|---|---|---|---|---|
| **Cervical Cancer Screening**<br>Table 6A: Line 23, Pap test<br>Table 6B: Line 11 | Current year | Includes a look-back period | Considers a more comprehensive age range | Includes specific age range |
| **Breast Cancer Screening**<br>Table 6A: Line 22, Mammograms<br>Table 6B: Line 11a | Current year | Includes a look-back period | Considers a more comprehensive age range | Includes specific age range |
| **HIV Screening**<br>Table 6A: Line 21, HIV Test<br>Table 6B: Line 20a | Current year | Includes a look-back period | Considers a more comprehensive age range | Includes specific age range |

# 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!
- Educate health center staff involved with UDS reporting on 2025 UDS changes.
- Work with your EHR and/or community health system vendor to validate data workflows and output and to verify that CY updates have been programmed.

**Reporting Guidance resources are available on the UDS Technical Assistance site.**

# Work as a Team

**Tables are interrelated.**

- Communicate early and throughout the process with your internal UDS data preparation team.
  - Identify appropriate team members responsible for submitting UDS data, including contingency/succession planning.
- Review data across tables to ensure data are consistent and reasonable.

**Use available tools.**

- Preliminary Reporting Environment will be available in fall 2025.
- Use the reporting features—Excel file, offline HTML file, comparison tool, and Excel mapping document—to help you prepare for UDS data reporting.
- Review changes in performance to validate accuracy and to identify potential areas for improvement.

# Available Resources

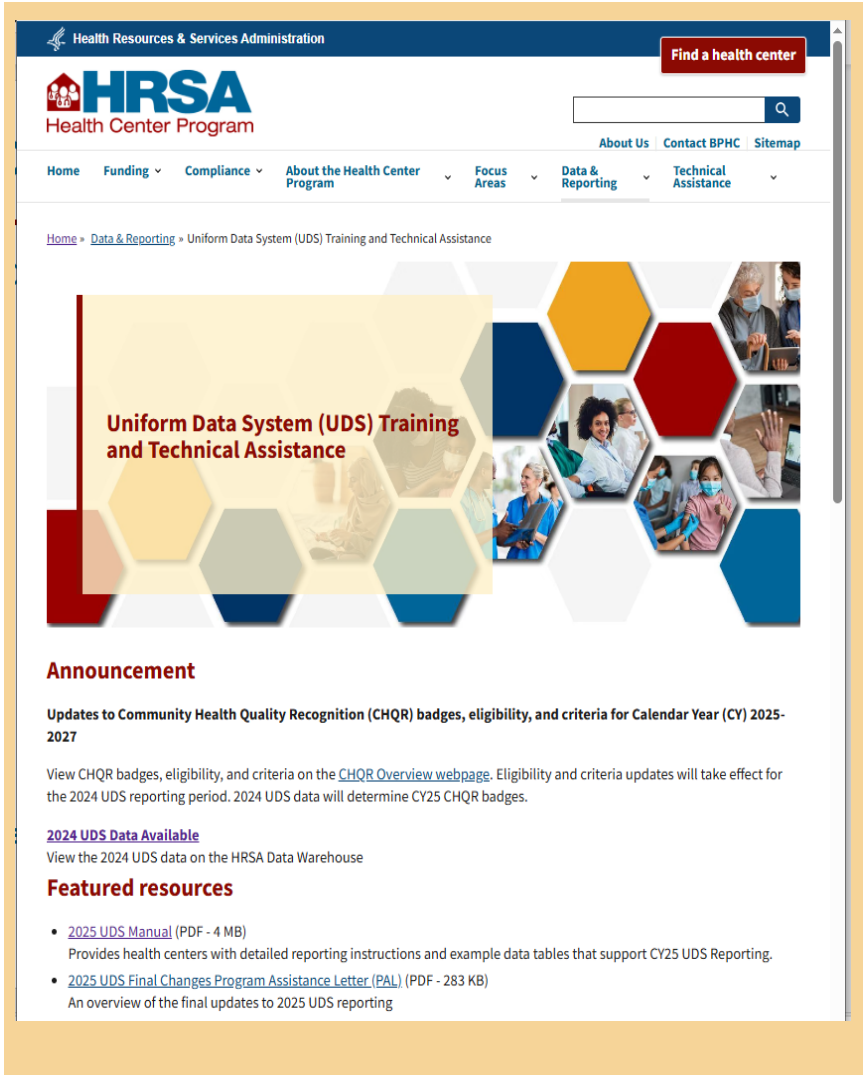
Resources are available to support your UDS reporting!

# UDS TTA Resources

## UDS reporting resources on the BPHC website

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

**Scan the QR code to go directly to the TTA page!**



# 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 Measures
- **UDS Clinical Tables Part 3:** Disease Management Measures
- **Reporting UDS Financial and Operational Tables**
- **Successful Submission Strategies**

**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 Uniform Data System/UDS Reporting.
- For Electronic Handbooks (EHBs) help and account access/roles questions:
  - 877-464-4772
  - BPHC Contact Form, select Technical Support/EHBs Tasks/EHBs Technical Issues.

For more information, visit the Technical Assistance Contacts webpage.

# Q&A

What questions do you have for us?

Uniform Data System

# Thank You!

**Call** the UDS Support Line at 1-866-837-4357

**Email** udshelp330@bphcdata.net

**Contact** us via the BPHC Contact Form

**Please fill out the evaluation form after the webinar!**