

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

October 14, 2025, 2–3:30 p.m. ET

Elise George | Training and Technical Assistance Specialist

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)

3

Identify reporting strategies and tips for data reporting

2

Review UDS screening and preventive care measures reporting requirements

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
<ul style="list-style-type: none">• Patients who are to be evaluated for whether they have received the specific service, test, or outcome.• Equal to the initial population identified in the CQM.• Reported in Column A.	<ul style="list-style-type: none">• Measures whether the service, event, test, or outcome requirements were met.• Each patient in the denominator is assessed to determine if they meet the numerator.• Reported in Column C.	<ul style="list-style-type: none">• EXCLUSIONS: Patients who meet exclusion criteria are not to be considered for the measure. They are removed from the denominator before determining if numerator criteria are met.• EXCEPTIONS: Patients who do meet denominator criteria but do not meet numerator criteria and meet any of the 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.



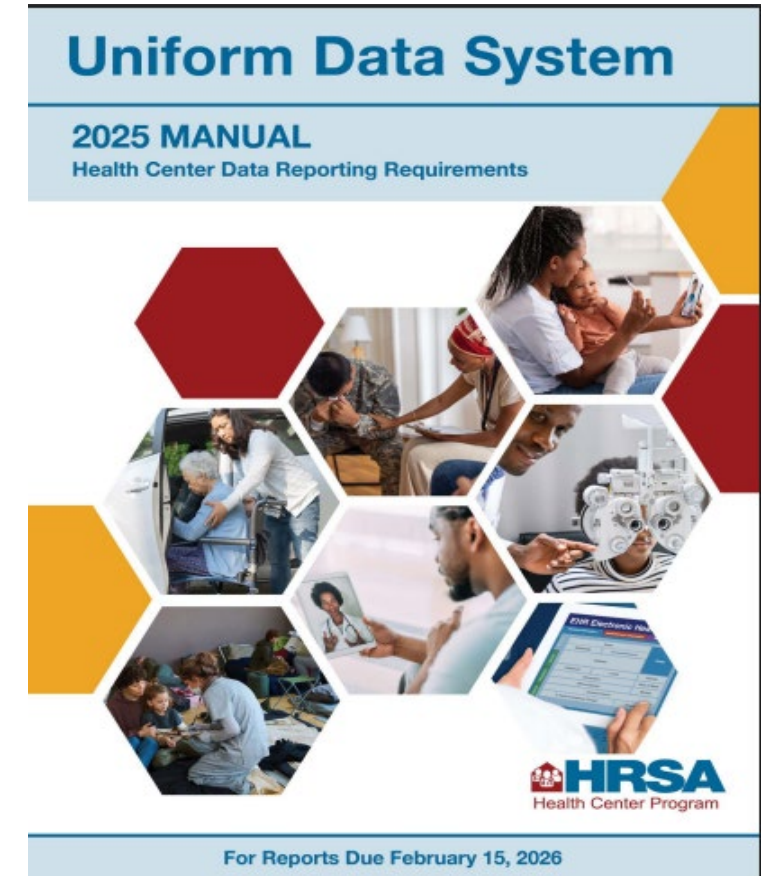
It is essential to review and use the codes listed in the CQM specifications.

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

eCQI RESOURCE CENTER

eCQMs ▾

Electronic Clinical
Quality Measures

dQMs ▾

Digital Quality
Measures

Resources ▾

Standards, Tools,
& Resources

About ▾

eCQI, CDS, FAQs
Engage

Log in ▾

Manage Your
Account

Enter keywords

eCQM Implementation Checklist

[Receive updates on this topic](#)

The Centers for Medicare & Medicaid Services (CMS) requires an [eligible clinician](#) (EC), [eligible hospital](#) (EH) or [critical access hospital](#) (CAH) to use the most current version of the [eCQMs](#) for quality reporting programs.

The [Preparation and Implementation Checklists](#) (PDF) assume that a health care practice/organization has determined which measures to report on. It provides the necessary technical steps [health information technology](#) (IT) developers, implementers and health care organizations must take to update their systems and processes with the eCQM Annual Update for the upcoming reporting and performance periods. The most recent eCQM Annual Update should be applied to your system for use in CMS electronic quality reporting.

Preparation Checklist

eCQM Implementation Checklist

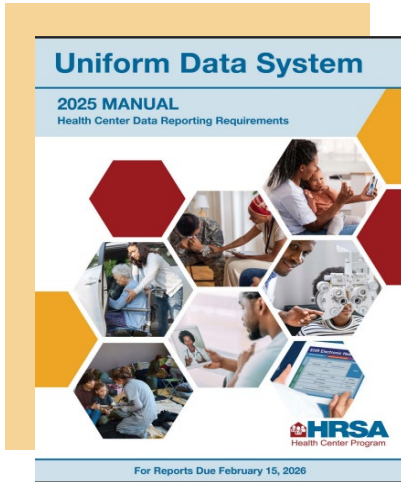
- Six preparation steps and seven implementation steps.

eCQM supports include:

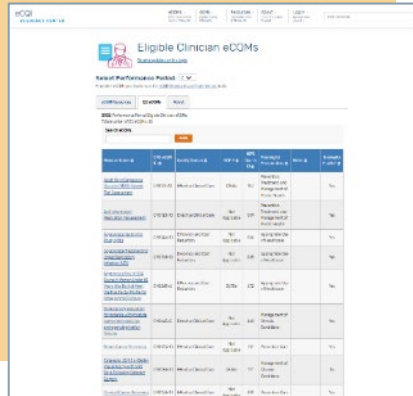
- eCQI Resource Center: For each measure, in the “Measure Information” tab, there is the option to “compare” (e.g., 2024 to 2025). **This highlights changes year over year.**
- eCQM Flows: Workflows for each eCQM, updated annually; downloads as a ZIP file.
- Technical Release Notes: 2025 Performance 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

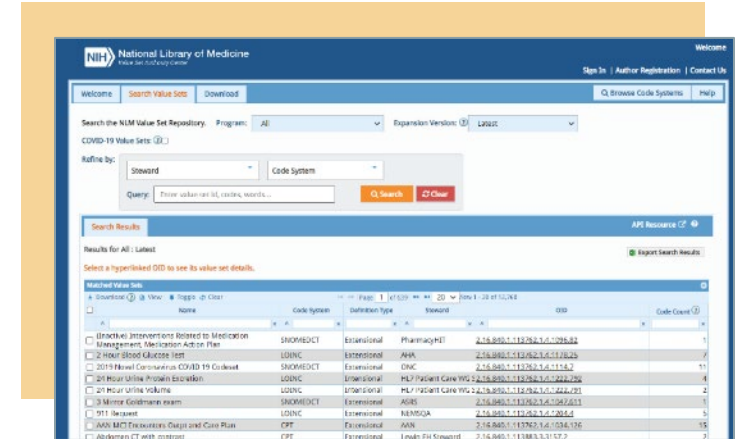
Key Resources



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](#).

The screenshot displays the eCQM Issue Tracker interface. On the left, a sidebar lists several issues, including CQM-8147, CQM-8081, CQM-8072, CQM-8033, CQM-8026 (highlighted), and CQM-7980. The main area shows the details for issue CQM-8026, titled "Self-reporting for CMS 124, 125, and 130". The issue is marked as "Closed" and "Answered". The details section includes fields for Type (EC eCQMs - Eligible Clinicians), Priority (Moderate), Component/s (None), Labels (None), Contact Name (Marta Livingstone), Contact Email (marta_livingstone@svmdmed.org), and Solution (Thank you for your inquiry about self-reports for CMS124v13, CMS125v13 and CMS130v13 (2025 Performance Period). Please see below each measure and their requirements regarding self-reported information. For CMS124v13, self-reported HPV test is an acceptable criterion for this measure given they are performed within the required timeframe, is documented using a code from the "HPV Test" value set (OID: 2.16.840.1.113883.3.464.1003.110.12.1059), documented). The right sidebar shows the "People" section with Assignee (AIR EC eCQM Team), Reporter (Marta Livingstone), and a "Vote for this issue" button. The "Dates" section shows the issue was Created on 07/11/25 11:26 AM, Updated 6 days ago 1:35 PM, and Resolved on 07/17/25 4:13 PM.

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

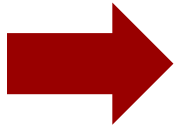
Reporting Format

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	<u>CMS124v13</u>
11a	Breast Cancer Screening	<u>CMS125v13</u>
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	<u>CMS69v13</u>
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	<u>CMS138v13</u>
19	Colorectal Cancer Screening	<u>CMS130v13</u>
20a	HIV Screening	<u>CMS349v7</u>
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	<u>CMS2v14</u>

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	<p>Women who had a hysterectomy with no residual cervix or a congenital absence of cervix</p> <p>Patients who were in hospice care for any part of the measurement period</p> <p>Patients who received palliative care for any part of the measurement period</p>	Not applicable	<p>Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:</p> <ul style="list-style-type: none">• Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.• Cervical human papillomavirus (HPV) testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

Cervical Cancer Screening: 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	<p>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</p> <p>Patients who were in hospice care for any part of the measurement period</p> <p>Patients aged 66 or older by the end of the measurement period</p> <ul style="list-style-type: none"> • Who were living long-term in a nursing home any time on or before the end of the measurement period • With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria: <ul style="list-style-type: none"> – Advanced illness diagnosis during the measurement period or the year prior; or – Taking dementia medications during the measurement period or the year prior <p>Patients who received palliative care during the measurement period</p>	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
<p>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:</p> <ul style="list-style-type: none">– Advanced illness with two outpatient encounters during the measurement period or the year prior– OR advanced illness with one inpatient encounter during the measurement period or the year prior– OR taking dementia medications during the measurement period or the year prior	<p>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:</p> <ul style="list-style-type: none">– Advanced illness diagnosis during the measurement period or the year prior– 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
<p>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</p> <p>Do not include patients who had only virtual visits during the year</p>	<p>Women who are pregnant at any time during the measurement period</p> <p>Patients receiving palliative or hospice care at any time during the measurement period</p>	<p>Patients who refuse measurement of height and/or weight</p> <p>Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan outside normal parameters</p>	<p>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</p>



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: <ul style="list-style-type: none">Screened for tobacco use at least once during the measurement period and not identified as a tobacco userScreened 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	<p>Patients with a diagnosis or past history of colorectal cancer or a history of total colectomy</p> <p>Patients who were in palliative or hospice care for any part of the measurement period</p> <p>Patients aged 66 or older by the end of the measurement period:</p> <ul style="list-style-type: none">• Who were living long-term in a nursing home during any time on or before the end of the measurement period; or• With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria:<ul style="list-style-type: none">– Advanced illness diagnosis during the measurement period or the year prior; or– Taking dementia medications during the measurement period or the year prior	Not applicable	<p>Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following:</p> <ul style="list-style-type: none">• Fecal occult blood test (FOBT) during measurement period• Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT) during the measurement period or the two years prior to the measurement period• Flexible sigmoidoscopy during the measurement period or the four years prior• Computerized tomography (CT) during measurement period or four years prior• Colonoscopy during measurement period or nine years prior

Colorectal Cancer Screening: CMS130v13

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

2024 Denominator Exclusions	2025 Denominator Exclusions
<p>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:</p> <ul style="list-style-type: none">- Advanced illness with two outpatient encounters during the measurement period or the year prior- OR advanced illness with one inpatient encounter during the measurement period or the year prior- OR taking dementia medications during the measurement period or the year prior	<p>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:</p> <ul style="list-style-type: none">- Advanced illness diagnosis during the measurement period or the year prior- 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: <ul style="list-style-type: none">• Who refuse to participate in or complete the depression screening• Who are in urgent or emergent situations• Who have a documented medical reason for not being screened for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results	Patients who were: <ul style="list-style-type: none">• 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• 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?

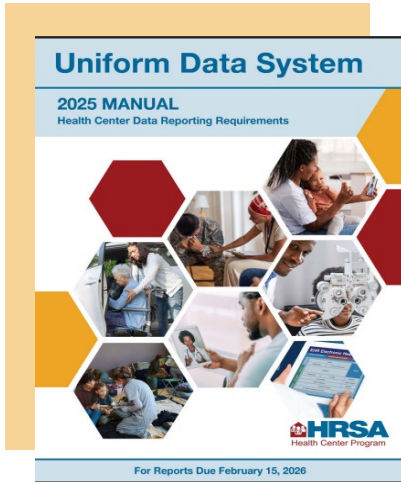
- A. Sign up for an OITS account
- B. Post questions to the measure stewards and review questions others have asked
- C. Review known issues for implementation information for eCQMs
- D. **All of the above**

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 image is a screenshot of the 'Eligible Clinician eCQMs' page on the eCQI website. It displays a table of eligible measures with columns for Measure ID, Measure Name, Measure Type, and a link to the measure details. The table lists several measures related to patient care and clinical quality.

Measure ID	Measure Name	Measure Type	Link
1001	1001: Patient Care	Measure	Link
1002	1002: Patient Care	Measure	Link
1003	1003: Patient Care	Measure	Link
1004	1004: Patient Care	Measure	Link
1005	1005: Patient Care	Measure	Link
1006	1006: Patient Care	Measure	Link
1007	1007: Patient Care	Measure	Link
1008	1008: Patient Care	Measure	Link
1009	1009: Patient Care	Measure	Link
1010	1010: Patient Care	Measure	Link

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

The image is a screenshot of the 'National Library of Medicine Value Set Repository' website. It shows a search interface with a search bar, filters for 'Program' and 'Expansion Version', and a table of search results. The table lists value sets with columns for Name, Code System, Definition Type, Standard, and Code Count.

Name	Code System	Definition Type	Standard	Code Count
2019 Patient Care	SNOMEDCT	Extensional	PharmacyNet	2,118,880
2019 Patient Care	SNOMEDCT	Extensional	DMC	2,118,880
2019 Patient Care	SNOMEDCT	Extensional	PLS Patient Care	2,118,880
2019 Patient Care	SNOMEDCT	Extensional	PLS Patient Care	2,118,880
2019 Patient Care	SNOMEDCT	Extensional	PLS Patient Care	2,118,880

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.

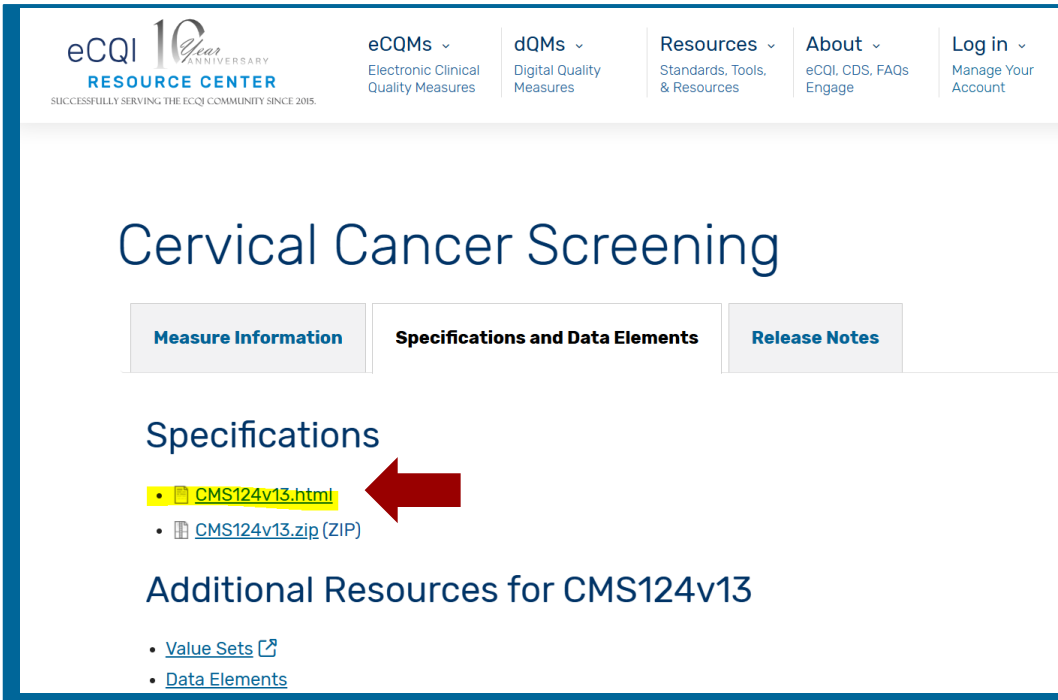
Cervical Cancer Screening (Line 11), [CMS124v13](#) 

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.





eCQI 10th ANNIVERSARY
RESOURCE CENTER
SUCCESSFULLY SERVING THE ECQI COMMUNITY SINCE 2015.

eCQMs  Electronic Clinical Quality Measures

dQMs  Digital Quality Measures

Resources  Standards, Tools, & Resources


About  eCQI, CDS, FAQs Engage

Log in  Manage Your Account


Cervical Cancer Screening

Measure Information Specifications and Data Elements Release Notes

Specifications

- [CMS124v13.html](#) 
- [CMS124v13.zip](#) (ZIP)

Additional Resources for CMS124v13

- [Value Sets](#) 
- [Data Elements](#)

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"

The screenshot displays the CQL specifications for a measure. It is divided into two main sections: 'Population Criteria' and 'Numerator'. The 'Population Criteria' section includes 'Initial Population', 'Denominator', and 'Denominator Exclusions'. The 'Numerator' section includes 'Numerator Exclusions', 'Denominator Exceptions', and 'Stratification'. Red arrows point to the 'Population Criteria' and 'Numerator' sections. The 'Numerator' section is highlighted with a yellow background.

Population Criteria

- Initial Population
AgeInYearsAt(date from
end of "Measurement Period"
) in Interval[24, 64]
and exists (["Patient Characteristic Sex": "Female"])
and exists "Qualifying Encounters"
- Denominator
"Initial Population"
- Denominator Exclusions
Hospice."Has Hospice Services"
or exists "Absence of Cervix"
or PalliativeCare."Has Palliative Care in the Measurement Period"

Numerator

- Numerator Exclusions
None
- Denominator Exceptions
None
- Stratification
None

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

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 "Female" ("AdministrativeGender Code (F)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Congenital or Acquired Absence of Cervix" (2.16.840.1.113883.3.464.1003.111.12.1016)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- 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 "HPV Test" (2.16.840.1.113883.3.464.1003.110.12.1059)
- valueset "Hysterectomy with No Residual Cervix" (2.16.840.1.113883.3.464.1003.198.12.1014)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Pap Test" (2.16.840.1.113883.3.464.1003.108.12.1017)
- valueset "Payer Type" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- 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 "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

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.

NIH

National Library of Medicine

Value Set Authority Center

Welcome back, egeorge

Welcome

Search Value Sets

Download

Comparison Tool

Browse Code Systems

Help

Search the NLM Value Set Repository.

Program: CMS eCQM and Hybrid Measure

Release: eCQM Update 2024-05-02

Compare Releases

Refine by:

Steward

Code System

CMS eCQM ID

Quality Data Model Category

Query: CMS124v13

Search

Clear

Include Retired Value Sets:

Search Results

Value Set Details

API Resource

Results for CMS eCQM and Hybrid Measure : eCQM Update 2024-05-02 : "CMS124v13"

Export Search Results

Matched Value Sets

Download

View

Toggle

Clear

Page 1 of 2

View 1 - 20 of 21

	Name	Code System	Definition Type	Steward	OID	Expansion Status	Code Count
<input type="checkbox"/>	Congenital or Acquired Absence of Cervix	ICD10CM	Grouping	NCQA	2.16.840.1.113883.3.464.1003.111.12.1016	Active	11
<input type="checkbox"/>	Encounter Inpatient	SNOMEDCT	Extensional	Lantana	2.16.840.1.113883.3.666.5.307	Active	3
<input type="checkbox"/>	Ethnicity	CDCREC	Extensional	CDC NCHS	2.16.840.1.114222.4.11.837	Active	2
<input type="checkbox"/>	Home Healthcare Services	CPT	Grouping	NCQA	2.16.840.1.113883.3.464.1003.101.12.1016	Active	19
<input type="checkbox"/>	Hospice Care Ambulatory	SNOMEDCT	Grouping	NCQA	2.16.840.1.113883.3.526.3.1584	Active	6
<input type="checkbox"/>	Hospice Diagnosis	SNOMEDCT	Grouping	NCQA	2.16.840.1.113883.3.464.1003.1165	Active	3
<input type="checkbox"/>	Hospice Encounter	HCPCS	Grouping	NCQA	2.16.840.1.113883.3.464.1003.1003	Active	26
<input type="checkbox"/>	HPV Test	LOINC	Grouping	NCQA	2.16.840.1.113883.3.464.1003.110.12.1059	Active	16

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.

Value Set Information

Expansion Versions: eCQM Update 2024-05-02 Compare Versions Export Value Set Results

Metadata

Description

Measure

Grouping Members

Name: Pap Test

OID: 2.16.840.1.113883.3.464.1003.108.12.1017

Code System: LOINC

Steward: National Committee for Quality Assurance Contact

FHIR Details

FHIR Name: PapTest

FHIR Title: Pap Test

FHIR URI: http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113883.3.464.1003.108.12.1017

Value Set Definition

Definition Type: Grouping

Definition Version: 20170504

Program: CMS, eCQM Update 2024-05-02 using this value set

Expansion Details

Expansion Profile: eCQM Update 2024-05-02

Status: Active

Expansion Date: 2024-05-02

View

Value Set Members

Expanded Code List

Code *

Descriptor

Code System

Version

Code System OID

10524.7	Microscopic observation [Identifier] in Cervix by Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
18500.9	Microscopic observation [Identifier] in Cervix by Cyto stain,thin prep	LOINC	2.76	2.16.840.1.113883.6.1
19762.4	General categories [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
19764.0	Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
19765.7	Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
19766.5	Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
19774.9	Narrative	LOINC	2.76	2.16.840.1.113883.6.1
33717.0	Cytology study comment Cervical or vaginal smear or scraping Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1
47527.7	Cervical And/or vaginal cytology study	LOINC	2.76	2.16.840.1.113883.6.1
47528.5	Cytology report of Cervical or vaginal smear or scraping Cyto stain,thin prep	LOINC	2.76	2.16.840.1.113883.6.1
47528.5	Cytology report of Cervical or vaginal smear or scraping Cyto stain	LOINC	2.76	2.16.840.1.113883.6.1

Metadata

Description

Measure

Grouping Members

Name: HPV Test

OID: 2.16.840.1.113883.3.464.1003.110.12.1059

Code System: LOINC

Steward: National Committee for Quality Assurance Contact

FHIR Details

FHIR Name: HPVTest

FHIR Title: HPV Test

FHIR URI: http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113883.3.464.1003.110.12.1059

Value Set Definition

Definition Type: Grouping

Definition Version: 20170504

Program: CMS, eCQM Update 2024-05-02 using this value set

Expansion Details

Expansion Profile: eCQM Update 2024-05-02

Status: Active

Expansion Date: 2024-05-02

View

Value Set Members

Expanded Code List

Code *

Descriptor

Code System

Version

Code System OID

21440.3	Human papilloma virus 16+18+31+33+35+45+51+52+56 DNA [Presence] in Cervix by Probe	LOINC	2.76	2.16.840.1.113883.6.1
30167.1	Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification	LOINC	2.76	2.16.840.1.113883.6.1
38372.9	Human papilloma virus 6+11+16+18+31+33+35+39+42+43+44+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification	LOINC	2.76	2.16.840.1.113883.6.1
59263.4	Human papilloma virus 16 DNA [Presence] in Cervix by Probe with signal amplification	LOINC	2.76	2.16.840.1.113883.6.1
59264.2	Human papilloma virus 18 DNA [Presence] in Cervix by Probe with signal amplification	LOINC	2.76	2.16.840.1.113883.6.1
59420.0	Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by Probe with signal amplification	LOINC	2.76	2.16.840.1.113883.6.1
69002.4	Human papilloma virus E6+E7 mRNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
71431.1	Human papilloma virus 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
75694.0	Human papilloma virus 18+45 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
77379.6	Human papilloma virus 16 and 18 and 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Interpretation] in Cervix	LOINC	2.76	2.16.840.1.113883.6.1
77399.4	Human papilloma virus 16 DNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
77400.0	Human papilloma virus 18 DNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
82354.2	Human papilloma virus 16 and 18+45 E6+E7 mRNA [Identifier] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
82456.5	Human papilloma virus 16 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
82675.0	Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1
95539.3	Human papilloma virus 31 DNA [Presence] in Cervix by NAA with probe detection	LOINC	2.76	2.16.840.1.113883.6.1

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.)

The screenshot shows the NIH Value Set Authority Center (VSAC) website. The top navigation bar includes 'Welcome', 'Search Value Sets', 'Download' (highlighted with a red arrow), 'Comparison Tool', 'Browse Code Systems', and 'Help'. The main heading is 'VSAC Downloadable Resources'. Below this, a text block states: '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.'

On the left, a sidebar lists three categories: 'CMS eCQM & Hybrid Measure Value Sets' (highlighted with a red arrow), 'CMS Pre-rulemaking eCQM Value Sets', and 'C-CDA Value Sets'.

The main content area displays a list of value sets. A red arrow points to the '2025 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets' section. Below this, a sub-section for 'May 2024 Release eCQM & Hybrid Measure Value Sets Publication Date: May 02, 2024' is shown. It includes an 'Expansion Version: eCQM Update 2024-05-02' and a note: 'All program candidate measures, including Eligible Hospital measures CMS1017, CMS1218, and CMS986v3 and Eligible Clinician measure CMS1157, are located here in the CMS eCQM & Hybrid Measure Value Sets.'

A table titled 'Available Downloads' is displayed, showing two rows of value sets. The first row is 'eCQM Value Sets for Eligible Hospitals Published May 02, 2024' and the second row is 'eCQM Value Sets for Eligible Clinicians Published May 02, 2024'. Each row has four columns: 'Sorted by CMS ID*', 'Sorted by Value Set Name*', and 'Sorted by Quality Data Model Category*'. The 'Sorted by CMS ID*' column for the 'Eligible Clinicians' row is highlighted with a red arrow.

Available Downloads	Sorted by CMS ID*	Sorted by Value Set Name*	Sorted by Quality Data Model Category*
eCQM Value Sets for Eligible Hospitals Published May 02, 2024	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)
eCQM Value Sets for Eligible Clinicians Published May 02, 2024	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)

How to Access Measure Specifications

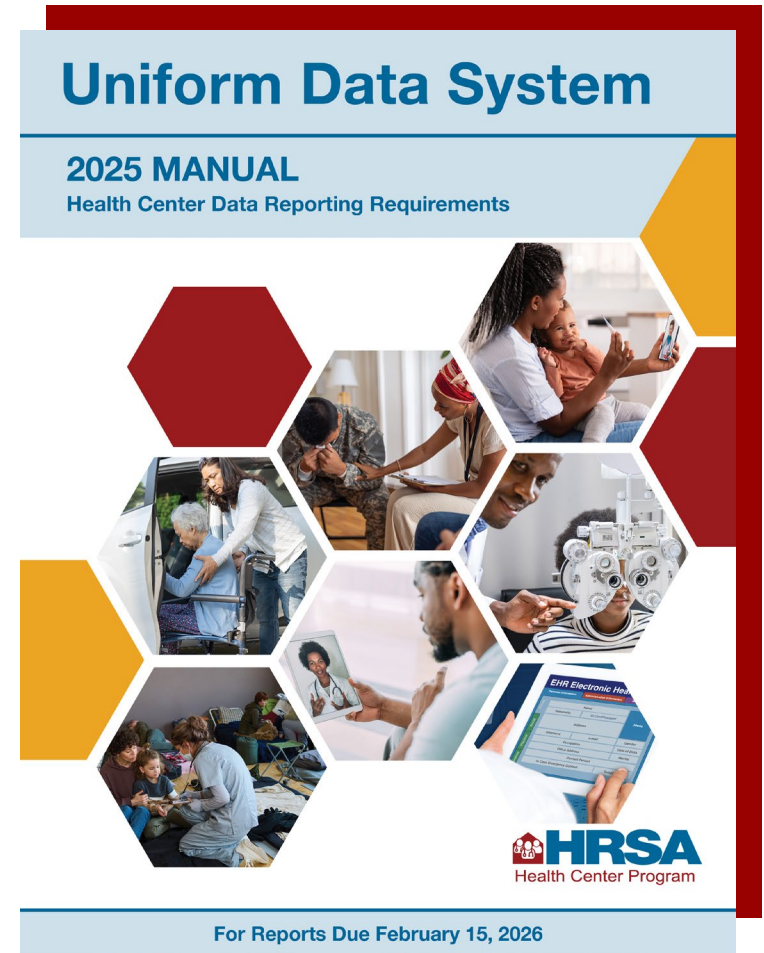
Available to all at
<https://vimeo.com/635520357>



Strategies for Successful Reporting

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

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!

The screenshot shows the HRSA Health Center Program website. The header includes the HRSA logo and navigation links: 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 workers. Below this, there is an 'Announcement' section titled 'Updates to Community Health Quality Recognition (CHQR) badges, eligibility, and criteria for Calendar Year (CY) 2025-2027'. The announcement text states: 'View CHQR badges, eligibility, and criteria on the [CHQR Overview webpage](#). Eligibility and criteria updates will take effect for the 2024 UDS reporting period. 2024 UDS data will determine CY25 CHQR badges.' There is also a link for '2024 UDS Data Available' with the text 'View the 2024 UDS data on the HRSA Data Warehouse'. The 'Featured resources' section lists two documents: '2025 UDS Manual (PDF - 4 MB)' and '2025 UDS Final Changes Program Assistance Letter (PAL) (PDF - 283 KB)'. The manual provides health centers with detailed reporting instructions and example data tables that support CY25 UDS Reporting. The PAL provides an overview of the final updates to 2025 UDS reporting.

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?

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!