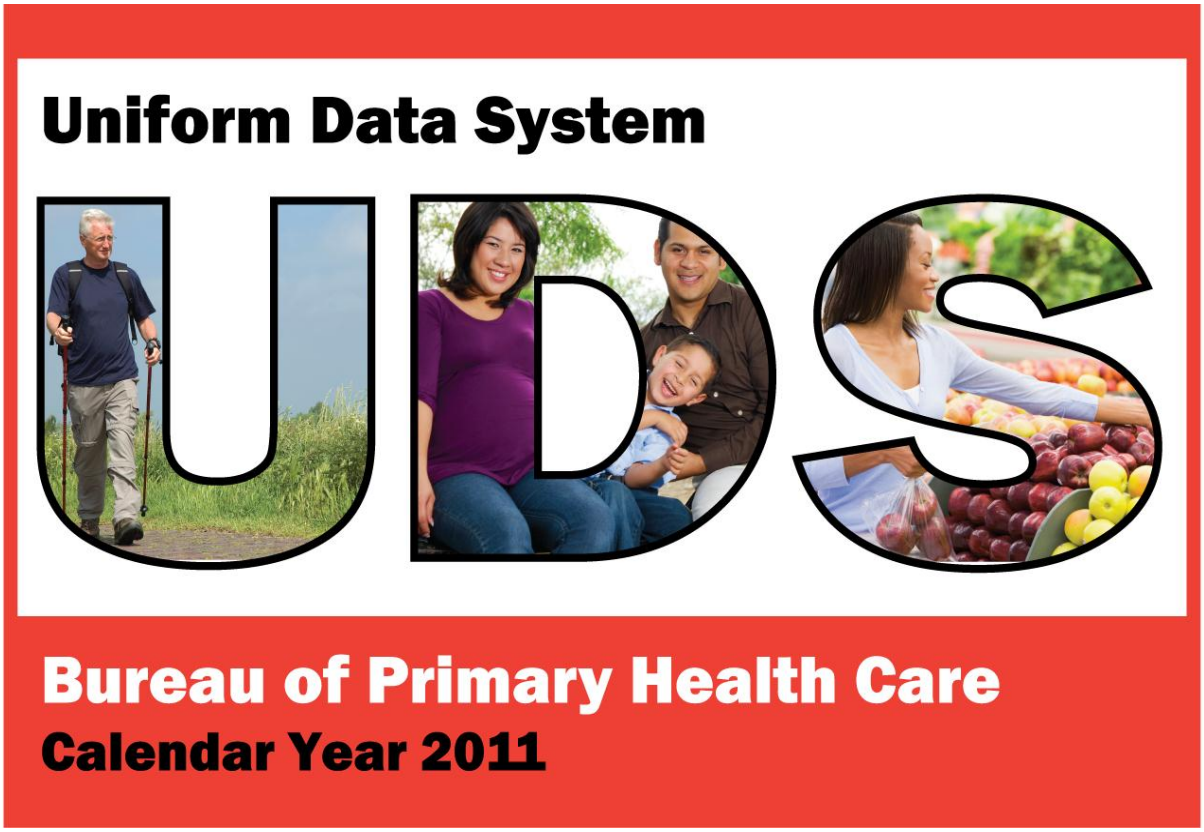
Bureau of Primary Health Care



UNIFORM DATA SYSTEM (UDS)
Calendar Year 2011

UDS Reporting Instructions for Section 330 Grantees

For help contact: 866-837-4357 (866-UDS-HELP) or udshelp330@bphcdata.net

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

BUREAU OF PRIMARY HEALTH CARE

BPHC UNIFORM DATA SYSTEM MANUAL

For use to submit Calendar Year 2011 UDS Data

Health Resources and Services Administration
BUREAU OF PRIMARY HEALTH CARE
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2011 UNIFORM DATA SYSTEM MANUAL

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NOTE: TABLES 1, 2, 8B, 9A, 9B, AND 9C WHICH WERE INCLUDED IN EARLIER VERSIONS OF THE UDS, HAVE BEEN DELETED.

INTRODUCTION

This is the 16th edition of the Bureau of Primary Health Care's User's Manual: Uniform Data System. It is designed for use in submitting Calendar Year 2011 UDS Data, and updates all instructions and modifications issued since the first UDS reporting year (1996). **This Manual supersedes all previous manuals, including instructions provided on the BPHC Web site prior to December 13, 2011.**

The Manual includes a brief introduction to the Uniform Data System, definitions of terms as they are used in the UDS, instructions for completing each of the tables, and information on submission of UDS to the Bureau of Primary Health Care (BPHC) through HRSA's Electronic Handbook (EHB) system. Table-specific instructions also include a set of "Questions and Answers," addressing issues that are frequently raised when completing the tables and highlighting changes to the table that may have been implemented during the year. Five appendices are included which: (A) list personnel by category and designation of personnel as providers who can produce countable "visits" for the purpose of the UDS; (B) describe how to report issues which have impact on multiple tables; (C) provide sampling methodologies for selecting charts for clinical reviews; (D) explain the reporting of Electronic Health Record (EHR) system capabilities; and (E) explain reporting differences for FQHC Look-Alike Designees.

The Uniform Data System (UDS) contains the annual reporting requirements for the cluster of primary care grantees funded by the Health Resources and Services Administration (HRSA). The UDS includes reporting requirements for grantees of the following primary care programs:

- **Community Health Center**, as defined in section 330(e) of the Consolidated Health Centers Act as amended;
- **Migrant Health Center**, as defined in section 330(g) of the Act;
- **Health Care for the Homeless**, as defined in section 330(h) of the Act;
- **Public Housing Primary Care**, as defined in section 330(i) of the Act, and
- **Other grantees under Section 330**

The authorizing statute is section 330 of the Public Health Service Act, as amended. FQHC Look-Alikes do not receive grant funds, but report certain UDS data to HRSA in order to permit monitoring of their performance. American Recovery and Reinvestment Act (ARRA) and Affordable Care Act (ACA) funded activities are also reported in the UDS, since activities (patients, visits, income, and expenses) which have been and/or are being supported by one or more element of the ARRA and the ACA are integrated with other section 330 funded activities. (NOTE: Grantees are also required to report ARRA funded activities to BPHC in a separate Health Center Quarterly Report (HCQR). These instructions are included in a separate HCQR Reporting Manual available on the BPHC Web site and are not addressed in this manual.)

HRSA collects data in the UDS which are used to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. To meet these objectives, BPHC requires a core set of data collected annually that is appropriate for monitoring and evaluating performance and reporting on annual trends. The UDS is the vehicle used by BPHC to obtain this information.

The UDS includes two components:

- The **Universal Report**, completed by all grantees. The Universal Report consists of one copy of each of the UDS reporting tables. This report provides data on patients,

services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.

- The **Grant Reports**, completed by a sub-set of grantees **who receive multiple grants** from the BPHC health center program. The Grant Report consists of additional copies of *only* Tables 3A, 3B, 4, 6A, and part of Table 5. The Grant reports provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant.** Separate Grant Reports are required for grantees funded through the Migrant Health Center, Health Care for the Homeless, and Public Housing Primary Care programs *unless* a grantee is funded under one and only one of these programs. No Grant Report is submitted for the portion of multi-funded grantee's activities supported by the Community Health Center grant.

The UDS is comprised of 11 tables designed to yield consistent clinical, operational, and financial data that can be compared with other National and State data and trended over time. These tables are:

- Patient Origin form: Patients served by ZIP code.
- Table 3A: Patients by age and gender.
- Table 3B: Patients by race, ethnicity, and language.
- Table 4: Patients by income (percent of poverty level) and third party medical insurance source. It also reports the number of special population patients receiving services.
- Table 5: Full-time equivalent staff by position, and visits and patients by provider type and service type.
- Table 6A: Primary diagnoses for medical and mental health visits and selected medical and dental services provided.
- Table 6B: Quality of care indicators.
- Table 7: Health outcomes and health disparities.
- Table 8: Direct and indirect expenses by cost center.
- Table 9D: Full charges, collections, and allowances by payor type as well as sliding discounts and patient bad debt.
- Table 9E: Non patient-service income.

BPHC will continue to collect information on the status of EHR adoption at 330 funded programs. This form will be included in the EHB along with the regular tables and must be completed prior to submitting your UDS report.

The UDS report is always a calendar year report. Agencies whose funding begins, either in whole or in part, after the beginning of the year, or whose funding is terminated, again either in whole or in part, before the end of the year, are still required to report on the entire year to the best of their ability.

GENERAL INSTRUCTIONS

This section describes submission requirements including who submits UDS reports, when and where to submit UDS data, and how data are submitted.

WHO SUBMITS REPORTS AND REPORTING PERIODS

Reports should be submitted directly by the BPHC grantee. A **grantee** is the direct recipient of one or more BPHC grants. All grantees that were funded before October 1, 2011 are expected to report. Grantees must report activity for the entire calendar year, even if they were funded, in whole or in part, for less than the full year, and even if they did not draw down any grant funds in the year. Grantees who are funded for the first time after October 1, 2011 and who received no other funds from BPHC during the year are not required to submit a 2011 UDS report. Under extreme circumstances, most commonly involving the destruction of the health center, exemptions may be granted. Grantees may request such exemptions directly from BPHC.

DUE DATES AND REVISIONS TO REPORTS

UDS Reports may be submitted after January 1, 2012 and are initially ***due by February 15, 2012***. Between February 15th and March 31st grantees work with their UDS reviewer to identify and correct possible errors. Final submission is due by March 31st and changes after this date are not accepted. To request assistance at any time, please contact the UDS helpline at 1-866-UDS-HELP.

HOW AND WHERE TO SUBMIT DATA

Starting with the CY 2008 submission, the UDS has been reported on-line, making use of a Web based data collection system that is integrated with the HRSA Electronic Handbooks (EHBs). Health center users will utilize their EHB user name and password to log into the EHB to complete their UDS submission. Users are able to submit the UDS report data using standard Web browsers[1] through a Section 508 compliant user interface. The system will present users with electronic forms that will guide them in completing their reports.

Users will be able to work on the forms in sections, saving interim or partial versions online as they work, and return to complete them later as necessary. Work is saved in the EHB, but not considered "filed" until the responsible party at the health center takes this final action. Grantees may distribute the data entry responsibilities to multiple users if required, however one individual must be designated the UDS Coordinator and should understand and be able to explain all of the tables during the review process. Note that health center staff must be assigned either "view" or "edit" privileges for the *entire* UDS, not just specific tables. Automated edits will check for inconsistent or questionable quantitative and qualitative data to ensure that the data submitted are as accurate as possible.

The EHB will provide users with a summary of which tables are complete and, once they are complete, with a list of audit questions to assist in clearing possible errors.

[1] While most popular browsers should work with the EHB, it is certified to work with Internet Explorer Version 7 or higher. Grantees having a problem with other browsers should consider using IE-7 for this task.

DEFINITIONS OF VISITS, PROVIDERS, PATIENTS, AND FTES

This section provides definitions which are critical for consistent reporting of UDS data across grantees. Most definitions have been in use for year or decades and permit inter-year comparisons as well.

VISITS

Visit definitions are needed both to determine who is counted as a patient (Tables 3A, 3B, 4, 6A, 6B, and 7) and to report visits by type of provider staff (Table 5) and visits where selected diagnoses were made or where selected services were provided (Table 6A). Visits are defined as **documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient.** To be included as a visit, services rendered **must be documented in a chart in the possession of the grantee**. Appendix A provides a list of health center personnel and the *usual* status of each as a provider or non-provider for purposes of UDS reporting. Visits which are provided by contractors, **and paid for by the grantee,** such as Migrant Voucher visits or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be visits to be counted on the UDS to the extent that they meet all other criteria. In these instances, a summary of the visit may appear in the grantee's charts.

Many activities carried out by Health Centers, with both patients and non-patients, are not included in this definition and are not reported on the UDS report. Many of these are critical to the care of the patient and/or the health of the community and are not unimportant. Rather, they are activities for which BPHC has chosen not to require detailed grantee reports.

Further elaborations of the definitions and criteria for defining and reporting visits are included below.

1. To meet the criterion for **"<u>independent professional judgment</u>,"** the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **<u>is not</u>** credited with a separate visit. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers. Eligible medical visits usually involve one of the "Evaluation and Management" billing codes (99281-85, 99291-95) or one of the health maintenance codes (99381-87, 99391-97).

2. To meet the criterion for **"<u>documentation</u>,"** the service (and associated patient information) must be recorded in written or electronic form in a system which permits ready retrieval of current data for the patient. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record are not completed. A provider who sees their patient at a hospital or nursing home and makes a note in the institutional file can satisfy this criteria by including a summary note from the hospital or nursing home indicating activities for each of the dates for which a visit is claimed. Screenings such as those frequently conducted at health fairs, immunization drives for children or the elderly, and similar public health efforts do not

result in visits regardless of the level of documentation.

3. When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of service is noted in **each** person's health record. Such visits are limited to behavioral health services. Examples of such non-medical "group visits" include: family therapy or counseling sessions, and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. *Medical* visits must be provided on an individual basis in order to be counted in the UDS. Patient education or health education *classes* (e.g., smoking cessation) are not credited as visits.

4. A visit may take place in the health center or at any other approved site or location in which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. (If visits at these sites occur on a regularly scheduled basis the site *must* be an approved site within the scope of the agency's grant.) Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the grantee for these services and the patient is billed either for the specific service or through a global fee. A reporting entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so.

5. Services such as drawing blood, collecting urine specimens, performing laboratory tests (including pregnancy tests and PPDs), taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions do not constitute visits, regardless of the level or quantity of supportive services.

6. Under certain circumstances a patient may have more than one visit with the health center in a day. The number of visits per service delivery location per day is limited as follows. On any given day a patient may have, at a maximum:
   - One medical visit (physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse).
   - One dental visit (dentist or hygienist).
   - One "other health" visit *for each type of "other health" provider* (nutritionist, podiatrist, speech therapist, acupuncturist, etc.).
   - One "vision services" visit (ophthalmologist, optometrist).
   - One enabling service visit *for each type of enabling provider* (case management or health education).
   - One mental health visit.
   - One substance abuse visit.

   If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and in Internist treats hypertension) *only one of these visits may be counted on the UDS. While some third party payors may recognize these as billable, only one of them is* ***countable.*** *The decision as to which provider gets credit for the visit on the UDS is up to the grantee. Internally, the grantee may follow any protocol it wishes in terms of crediting providers with visits.*

An exception to this rule, designed to address the operational structure of homeless and migrant programs, allows medical services provided by two *different medical providers* located at two *different sites* to be counted on the same day. This permits patients who are seen in clinically problematic environments (e.g., homeless shelters or migrant camps), especially by non-physician providers, to be seen later in the same day at the grantee's fixed clinic site by a different – possibly higher level-provider.

7. Any given provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided.

8. The visit criteria **are not** met in the following circumstances:
   - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
   - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
   - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
   - When the **only** services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings, and/or prescription refills.
   - Services performed under the auspices of a WIC program or a WIC contract.

Further definitions of visits for different provider types follow.

PHYSICIAN VISIT – A visit between a physician and a patient.

NURSE PRACTITIONER VISIT – A visit between a Nurse Practitioner and a patient in which the practitioner acts as an independent provider.

PHYSICIAN ASSISTANT VISIT – A visit between a Physician Assistant and a patient in which the practitioner acts as an independent provider.

CERTIFIED NURSE MIDWIFE VISIT – A visit between a Certified Nurse Midwife and a patient in which the practitioner acts as an independent provider.

NURSE VISIT (Medical) – A visit between an R.N., L.V.N., or L.P.N. and a patient in which the nurse acts as an independent provider of medical services exercising independent judgment, such as in a triage visit. Services which meet this criteria may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician, Nurse Practitioner, Physicians Assistant, or Certified Nurse Midwife (NP/PA/CNM) who has no direct contact with the patient during the visit, *but must still meet the requirement of exercising independent professional judgment*. (Note that most States prohibit an LVN or an LPN from exercising independent judgment, in which case no visits would be counted for them. Note also that under no circumstances are services provided by Medical Assistants or other non-nursing personnel counted as nursing visits.)

DENTAL SERVICES VISIT – A visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide independent services or the volume of service (number of procedures) provided.

MENTAL HEALTH VISIT – A visit between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other Masters Prepared mental health providers licensed by specific States) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided. (NOTE: The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance abuse disorders. All behavioral health visits, providers, and costs must be parsed out into mental health or substance abuse.)

SUBSTANCE ABUSE VISITS – A visit between a substance abuse provider (e.g., a mental health provider or a credentialed substance abuse counselor, rehabilitation therapist, psychologist etc.) and a patient, during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, or aftercare) are provided. (NOTE: The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance abuse disorders. All behavioral health visits, providers, and costs must be parsed out into mental health or substance abuse.)

VISION SERVICES VISIT – A visit between a vision service provider and a patient during which eye exams are performed by an Ophthalmologist or an Optometrist for the purpose of early detection, care, treatment, and prevention for those with eye disease or chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis. These exams also provide opportunities to promote behavioral changes linked to eye health (e.g., smoking, excessive use of alcohol.)

OTHER PROFESSIONAL VISIT – A visit between a provider, other than those listed above and a patient during which other forms of health services are provided. Examples are provided in Appendix A.

CASE MANAGEMENT VISIT – A visit between a case management provider and a patient during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems. These must be face to face with the patient. Third party interactions on behalf of a patient are not counted as case management visits.

HEALTH EDUCATION VISIT – A one-on-one visit between a health education provider and a patient in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, or specific diseases). Participants in health education classes are not considered to have had visits.

PROVIDER

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during a visit. Only one provider who exercises independent judgment is credited with the visit, even when two or

more providers are present and participate. If two or more providers of the same type divide up the services for a patient (e.g., a family practitioner and a pediatrician both seeing a child or an ObGyn and an FP both seeing a pregnant woman for different purposes) only one may be credited with a visit. Where health center staff are following a patient in the hospital, the primary responsible center staff person in attendance during the visit is the provider (and is credited with a visit), even if other staff from the health center and/or hospital are present. (Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate visits for purposes of UDS reporting.)

Providers may be employees of the health center, contracted staff, or volunteers. Contract providers who are part of the scope of the approved grant-funded program and who are paid by the center with grant funds or program income, serve center patients and document their services in the center's records, are considered providers. (A discharge summary or similar document in the medical record will meet this criteria.) Also, contract providers paid for specific visits or services with grant funds or program income, who report patient visits to the direct recipient of a BPHC grant (e.g., under a migrant voucher program or contractors with homeless grantees) are considered providers and their activities are to be reported by the direct recipient of the BPHC grant. Since there is no time basis in their report, no FTE is reported for such individuals. Volunteer providers who serve center patients ***at the grantee's sites or locations under the supervision of the center's staff*** and document their services in the center's records are also considered providers. Their time is known and should be documented.

PATIENT

Patients are individuals who have at least one reportable visit *during the reporting year*[2], as defined above. The term "patient" is not limited to recipients of medical or dental services; the term is used universally to describe all persons who receive UDS-countable visits.

The **Universal Report** includes all patients who have at least one visit during the year which is within the scope of activities supported by **any** of the BPHC grants covered by the UDS. These visits are reported on Table 5. On Tables 3A and 3B, and in each section of Tables 4 and 6A of the Universal Report, each patient may be counted once and only once, even if s/he received more than one type of service (e.g., medical, dental, enabling, etc.) or receives services supported by more than one BPHC grant. For each **Grant Report**, patients reported are those who have at least one visit during the year within the scope of project activities supported by the specific BPHC grant. A patient counted in any cell on a Grant Report is also included in the same cell on the Universal Report.

Persons who *only* receive services from community based efforts such as immunization programs, screening programs, and health fairs *are not counted as patients*. Persons whose only service from the grantee is a part of the WIC program or other programs are not counted as patients.

During the course of addressing the health care needs of the community, health centers see many individuals who do not become patients as defined by and counted in the UDS process. "Patients," as defined for the UDS, never include individuals who have such limited contacts with the grantee, whether or not documented on an individual basis. These other service users include, but are not limited to, persons whose only contact is:

[2] Certain other reporting systems including BPHC's HCQR report for the ARRA program use a different definition of a patient. Patients should be counted in both reports, according to the definitions for each report.

- When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
- When the only health service provided is part of a large-scale effort, such as an immunization program, screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the **only** services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings, and/or filling or refilling a prescription.
- Services performed under the auspices of a WIC program or a WIC contract.

FULL-TIME EQUIVALENT EMPLOYEE

A full-time equivalent (FTE) of 1.0 describes staff who individually or as a group worked the equivalent of full-time for one year. Each agency defines the number of hours for "full-time" work and may define it differently for different positions. For example, it is not uncommon for a physician to be hired as a full-time employee but required to work only nine four-hour sessions (36 hours) per week. S/he would still be considered to be 1.0 FTE. The full-time equivalent is based on employment contracts for clinicians and other exempt employees.

FTE is calculated based on paid hours for non-exempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40 hour work week (2080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. Thus, if physicians work 36 hours per week, this would be considered 1.0 FTE, and an 18 hour per week physician would be considered as 0.5 FTE, regardless of whether other employees work 40 hour weeks. FTE is also based on the part of the year that the employee works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).

Staff may provide services on behalf of the grantee under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health Service Corps assignment, under contract, or donated time. Interns, residents, and volunteers are counted consistent with their time with the grantee and their licensing. (See Appendix B for further discussion.) Individuals who are paid by the grantee on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours.

INSTRUCTIONS BY TABLE

This section provides an overview of the UDS report and detailed instructions for completing each UDS table.

OVERVIEW OF UDS REPORT

The UDS includes two components:

- The **Universal Report** is completed by all grantees. This report provides data on services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.

- **Grant Reports** are completed by a sub-set of grantees **who receive BPHC grants under multiple program authorizations**. These reports repeat all or part of the elements of five of the Universal Report tables. Grant reports provide comparable data for that portion of their program that falls within the scope of a project **funded through a specific funding authority**. Separate Grant Reports are required for Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *except for* grantees funded under one and only one of these programs which receive no other BPHC funding. No Grant Report is submitted for the portion of a grantee's activities supported by the Community Health Center grant.

The **Universal Report** provides a comprehensive picture of all activities within the scope of BPHC-supported projects. In this report, grantees should report on the total unduplicated number of patients and activities for the reporting year which are **within the scope of projects supported by any and all BPHC primary care programs covered by the UDS** *including those supported by the ARRA program and reported separately in Health Center Quarterly Reports (HCQRs) and those supported through the Affordable Care Act's (ACA) CHC fund program*.

For **Grant Reports,** grantees provide data on the patients and activities within that part of their program which is **funded under a particular program**. Because a patient can receive services through more than one BPHC program, and not all grants are reported separately, totals from the Grant Reports cannot be aggregated to generate totals in the Universal Report.

Grantees that receive funds under only one BPHC funding authority are required to complete only the Universal Report and do not submit grant reports. Agencies funded through multiple BPHC funding authorities, complete a Universal Report for the combined projects and a separate grant report for each Migrant, Homeless, and/or Public Housing program grant. Examples include the following:

- A CHC grantee (section 330e) that also has Health Care for the Homeless support (section 330h) completes a Universal Report and a Homeless Grant Report, but does not complete a Grant Report for the CHC grant.
- A CHC grantee (section 330e) that also has Migrant Health (section 330g) and Homeless (section 330h) support, completes a Universal Report, a Grant Report for the Homeless program, and a Grant Report for the Migrant program.
- A grantee which is funded under the Health Care for the Homeless program and the Public Housing program completes a Universal Report and two Grant Reports – one for

Homeless and one for Public Housing.

NOTE: The EHB reporting system will automatically identify the reports which must be filed and prompt the grantee if some or all of the Universal or Grant Report is left blank. Conversely, if a grantee is *not* required to submit a specific grant report, that report will not appear in the EHB for completion.

The table below indicates which tables are included in the Universal Report and Grant Reports. Also listed are tables that have been deleted from the UDS since the system was initiated in 1996. No further reference to any of the deleted tables is made in this Manual.

TABLE		UNIVERSAL REPORT	GRANT REPORTS
SERVICE AREA			
Grantee Profile	Patients by ZIP code	X	
Cover Sheet	NO LONGER REPORTED		
Table 2	NO LONGER REPORTED		
PATIENT PROFILE			
Table 3A	Patients by Age and Gender	X	X
Table 3B	Patients by Hispanic/Latino Ethnicity and Race; Patients best served in a language other than English	X	X
Table 4	Selected Patient Characteristics	X	X
STAFFING AND UTILIZATION			
Table 5	Staffing and Utilization	X	<partial>
CLINICAL			
Table 6A	Selected Diagnoses and Services	X	X
Table 6B	Quality of Care Indicators	X	
Table 7	Health Outcomes and Disparities	X	
FINANCIAL			
Table 8A	Costs	X	
Table 8B	NO LONGER REPORTED		
Table 9 (A-B-C)	NO LONGER REPORTED		
Table 9 (D-E)	Revenues	X	
OTHER FORMS			
Appendix D	EHR Capabilities	X	

INSTRUCTIONS FOR ZIP CODE DATA

PATIENT BY ZIP CODE

Grantees must report the number of patients served by ZIP code. This information enables BPHC to better identify areas served by health centers as well as minimize problems arising as a result of service area overlaps. Although patients may be mobile during the reporting period, grantees will report patients as of the *most recent ZIP* code on file.

It is the BPHC's goal to identify residence by ZIP code for all patients served, but it is understood that residence information may be missing for a small number of patients. This is particularly true for centers that serve transient groups. Special instructions cover two of these groups:

- Homeless Patients: While many homeless patients live in shelters, transitional housing, and other locations *for which a ZIP code can be obtained*, others – especially those living on the street – do not know or will not share an exact location. Where a ZIP code location cannot be obtained or the location offered is questionable, grantees should use the ZIP code of the location where the patient is being served as a proxy. Similarly, if the patient has no other ZIP code and receives services on a mobile van, the ZIP code of the location where the van was parked that day should be used.

- Farm Worker Patients: Many if not most Migrant and Seasonal Farm Workers have a permanent residence in a community far from the location of their work and the site where they are receiving services. For the purpose of the UDS report, grantees are to use the ZIP code of the patient's temporary housing location near the service delivery location. Patients living in cars or on the land where a precise ZIP code is unavailable should be reported using the ZIP code for the location (fixed site or mobile camp outreach) where they are being treated.

For the small number of patients for whom residence is not known or for whom a proxy is not available, residence should be reported as "Unknown."

Although grantees are expected to report residence by ZIP code for all patients, it is recognized that large centers, as well as those located in tourist or hunting/fishing locations, may draw a number of patients from a large number of ZIP codes outside of their normal service area. To ease the burden of reporting, ZIP *codes with ten or less patients* may be aggregated and reported in an "Other" category.

QUESTIONS AND ANSWERS FOR ZIP CODE REPORTING

1. **Are there any changes to this table?**
   No.

2. **Do we need to collect information on and report on the ZIP code of all of our patients?**
   Yes. Instead of asking that individual sites be identified by area served, grantees are now asked to report on the ZIP codes of their patients. Although grantees are expected to report residence by ZIP-code for all patients, it is recognized that large centers may draw a number of patients from a large number of ZIP-codes which are outside of their normal service area. To ease the burden of reporting, ZIP codes with 10 or less patients may be aggregated and reported in an "Other" category.

3. **Does the number of patients reported by ZIP code need to equal the total number of unduplicated patients reported on Tables 3A, 3B, and 4?**
   Yes. The total number of patients reported by ZIP code (including "unknown" and "other") on the Grantee Profile must equal the number of total unduplicated patients reported on Tables 3A, 3B, and 4. If ZIP code information is missing for some patients, residence should be reported as unknown.

PATIENTS BY ZIP CODE

Zip Code	Patients
Other ZIP Codes	
Unknown Residence	
TOTAL	

NOTE: This is a representation of the form, however the actual on-line input process will look significantly different, as may the printed output from the EHB.

INSTRUCTIONS FOR TABLE 3A PATIENTS BY AGE AND GENDER AND TABLE 3B – PATIENTS BY RACE AND ETHNICITY AND PATIENTS BY LANGUAGE

Tables 3A and 3B provide demographic data on patients in the program and are included in **both** the Universal Report and the Grant Reports. Note that patients supported through the ARRA programs are included in this report *to the extent that they qualify under all other UDS rules.*

For the **Universal Report**, include as patients all individuals receiving at least one face-to-face visit during the calendar year for services as described below which is within the scope of any of the programs covered by UDS. Regardless of the scope or volume of services received, each patient is to be counted only once on Table 3A and only once in ***each*** *of the two sections* of Table 3B: race and ethnicity, and language, if applicable.

The **Grant Reports** include only individuals who received at least one face-to-face visit within the scope of the program in question. As discussed above, patients are to be reported only once in each report filed, however if the same patient is served in more than one program, they will be reported on the grant report for each program that served them. All patients reported on the Grant Report will also be reported on the Universal Report

A visit is a face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient, and the services rendered must be documented to be counted as a visit. See the "Definitions of Visits, Providers, Patients, and FTE" section (above page 6) for complete definitions.

TABLE 3A: PATIENTS BY AGE AND GENDER

Report the number of patients by appropriate categories for age and gender. For reporting purposes, *use the individual's age on June 30 of the reporting period*. Note that on the non-prenatal portion of Tables 6B and 7, age is essentially defined as age on December 31st. The numbers on Table 3A will therefore *not* be the same as those on Tables 6B and 7, though they will be similar.

TABLE 3B: PATIENTS BY HISPANIC OR LATINO ETHNICITY/RACE/LANGUAGE

Table 3B displays the race and ethnicity of the patient population in a matrix format. This permits the reporting of the racial identification of all patients including those who identify with the Hispanic/Latino population. Race and ethnicity continue to be defined as in the past:

HISPANIC/LATINO ETHNICITY:

- This table collects information on whether or not patients consider themselves to be of Hispanic/Latino ethnicity *regardless of their race*.
    - Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do *not* count persons from Brazil or Haiti whose ethnicity is not tied to the Spanish language.

- Column B (Not Hispanic/Latino): Report the number of all other patients *except* those for whom there is neither racial *nor* Hispanic/Latino ethnicity data.
- Column C (Unreported/Refused to Report): Only one cell is available in this column. Report on Line 7, Column C only those patients who left the entire race and Hispanic/Latino Ethnicity part of the intake form totally blank.

- Patients who self-report as Hispanic/Latino but do not separately select a race are reported on Line 7, column A as Hispanic/Latino whose race is unreported or refused to report.

RACE:

- All patients must be classified in one of the racial categories (including "Unreported/Refused to Report"). This includes individuals who *also* consider themselves to be "Hispanic or Latino." Patients who self-report race but do not separately indicate if they are "Hispanic/Latino" are presumed to be non-Hispanic/Latino and are reported on the appropriate race line, Column B.
- Patients once categorized as "Asian/Pacific Islanders" are now divided on the Race table into three separate categories:
  - Line 2a. Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
  - Line 2b. Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia or Polynesia.
    - Line 2. "Total Hawaiian/Pacific Islander" must equal lines 2a+2b
  - Line 1. Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "American Indian/Alaska Native" (Line 4) includes persons who trace their origins to any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- "More than one race" (Line 6). Use this line *only* if your system captures multiple races (but *not* a race and an ethnicity) and the patient has chosen two or more races. This is usually done with an intake form which lists the races and tells the patient to "check one or more" or "check all that apply." "More than one race" must not be used as a default for Hispanic/Latinos who do not check a separate race. They are to be reported on Line 7 as noted above.

NOTE: Grantees are required to report race ***and*** ethnicity for all patients. Some grantees' patient registration systems are configured to capture data for patients who were asked to report race ***or*** ethnicity. Grantees who are unable to distinguish a White Hispanic/Latino patient from a Black Hispanic/Latino patient (because their system only asks patients if they are White, Black, or Hispanic/Latino), are instructed to report these Hispanic/Latino patients on Line 7, column A, as "unreported" race but included in the count of those with Hispanic or Latino ethnicity. *Grantees should take steps to enhance their registration system to permit the capture and reporting of these data in the future.*

LANGUAGE:

- Report on line 12 the number of patients who are best served in a language other than English or in sign language.
- Include those patients who were served in a second language by a bilingual provider and those who may have brought their own interpreter.
- Include patients residing in areas where a language other than English is the dominant language such as Puerto Rico or the pacific islands.

NOTE: Data reported on Line 12, Language, ***may*** be estimated if the health center does not maintain actual data in its Practice Management System (PMS). Wherever possible, the estimate should be based on a sample.

QUESTIONS AND ANSWERS FOR TABLES 3A AND 3B

1. **Have the data elements for Table 3B changed?**
   No. In general patients will be counted in the same racial category that they were counted in last year. In 2008 an additional race category was added for "More than one race." With the 2008 changes, the UDS classifications are now consistent with those used by the Census Bureau as per the October 30, 1997, Federal Register Notice entitled, ''Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity,'' issued by the Office of Management and Budget (OMB). These standards govern the categories used to collect and present Federal data on race and ethnicity. The OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian, or Other Pacific Islander) for race. In addition to the five race groups, the OMB also states that respondents should be offered the option of selecting more than one race. The addition of Line 6 permits reporting of those people who have chosen to report two or more races.

2. **How are patients of Hispanic/Latino ethnicity reported?**
   In 2009, Table 3B was revised to show race and ethnicity data in a matrix. Patients who were once reported as Hispanic/Latino, independent of race, are now reported in Column A as Hispanic/Latino where we can *also* show the race of these patients. Patients are to be reported on Lines 1 through 7 depending on their race. If "Hispanic/Latino" is the only identification recorded in the center's patient files, these patients will be reported in Column A on Line 7 as having an "Unreported" racial identification.

3. **Can we just have a choice on our registration form of "more than one race"**
   In order to count a patient as being of "more than one race" they *must* have the option of checking two or more boxes under race and have indeed checked more than one. This methodology is the same as used in the census and mandated by OMB.

4. **How are individuals who receive different types of services or use more than one of the grantee's service delivery sites reported? For example, a person who receives both medical and dental services or a woman who receives primary care from one clinic site, but gets prenatal care at another.**
   UDS Tables 3A and 3B provide unduplicated counts of patients. Grantees are required to report each patient once and only once on Table 3A and on Table 3B, regardless of the type or number of services they receive or where they receive them. Each person who has at least one visit reported on Table 5 is to be counted once and only once on Table 3A and on Table 3B. Visits are defined in detail in the "Definitions of Visits, Providers, Patients, and FTE" section (page 6). Note the following:
   - Persons who receive WIC services and no other services at the agency are not to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).
   - Persons who only receive lab services or whose only service was an immunization or screening test are also not to be counted as patients or reported on Table 3A or 3B.

5. **Must the numbers on Tables 3A and 3B tie to UDS data reported on other tables?**
   Yes. The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Line 8 Column D (total patients by Hispanic/Latino Ethnicity and Race); Total Patients by ZIP Code; Table 4, Line 6 (total patients by income); and Table 4 Line 12, Column A + B (total patients by insurance status). The sum of Table 3A, Lines 1-20, Column A + B (total patients age 0-19 years) must equal Table 4, Line 12, Column A (total patients age 0-19 years). The sum of Table 3A, Lines 21-38, Column A + B (total patients age 20 and above) must equal Table 4, Line 12, Column B (total patients age 20 and older).

6. **Does race ***and*** Hispanic/Latino ethnicity of all our patients need to be collected and reported?**
   Yes. The UDS requires the classification of race and Hispanic/Latino ethnicity information in order to assess health disparities across sub-populations. The format for the classification of this information has been stipulated by OMB, and the UDS manual follows the standards established by OMB. Grantees whose data systems do not support such reporting should endeavor to enhance their systems to permit the required level of reporting rather than using the "unreported/refused to report" categories.

7. **Do I count my ARRA patients on this table?**
   To the extent that they qualify as patients, they are counted. Note that the ARRA program maintains a cumulative count of patients and will require reporting a patient in 2011 reports who was seen only in 2009 or 2010. This is ***not*** the case with the UDS. Grantees will report only those ARRA patients who were actually seen in 2011.

8. **I have a separate data system for my Mental Health patients. How do I include their data on these tables?**
   Grantees are required to unduplicate their data so that the UDS report counts patients only once, regardless of the number of different types of services they receive. This may require the downloading and merger of data from each system in order to eliminate duplicates, or to check them manually. This can be a time consuming and potentially expensive process and should be initiated as soon as the year ends to ensure sufficient time to complete it prior to the initial submission date.

TABLE 3A – PATIENTS BY AGE AND GENDER

AGE GROUPS		MALE PATIENTS (a)	FEMALE PATIENTS (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Age 85 and over		
39	**TOTAL PATIENTS** (SUM LINES 1-38)		

TABLE 3B – PATIENTS BY HISPANIC OR LATINO ETHNICITY/RACE/LANGUAGE

PATIENTS BY RACE		PATIENTS BY HISPANIC OR LATINO ETHNICITY			
		HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED/ REFUSED TO REPORT (c)	TOTAL (d)
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	**T**otal **H**awaiian/**P**acific **I**slander (SUM LINES 2A + 2B)				
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported/Refused to report				
8.	**TOTAL PATIENTS** (SUM LINES 1+2 + 3 TO 7)				

PATIENTS BY LANGUAGE		NUMBER (a)
12.	**PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH**	

INSTRUCTIONS FOR TABLE 4 – SELECTED PATIENT CHARACTERISTICS

Table 4 provides descriptive data on selected characteristics of health center patients. The table is included in **both** the Universal Report and the Grant Reports. Note that patients supported through the ARRA programs ARE INCLUDED in this report *to the extent that they qualify under all other UDS rules.*

For the **Universal Report**, include all patients receiving at least one face-to-face visit during the calendar year for services within the scope of any of the programs covered by UDS. The **Grant Reports** include only patients who received at least one face-to-face visit that was within the scope of the program in question. All patients reported on the Grant Report will also be reported on the Universal Report. This means that no cell in a Grant Report may contain a number larger than the corresponding cell in the Universal Report. **Patients are to be reported only once per section in *each* report filed.**

Cross Table Check: The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Line 8 Column D (total patients by race and Hispanic/Latino ethnicity); Table 4, Line 6 (total patients by income); and Table 4 Line 12, Column A + B (total patients by medical insurance status). The sum of Table 3A, Lines 1-20, Column A + B (total patients age 0-19 years) must equal Table 4, Line 12, Column A (total patients age 0-19 years). The sum of Table 3A, Lines 21-38, Column A + B (total patients age 20 and above) must equal Table 4, Line 12, Column B (total patients age 20 and older).

INCOME AS PERCENT OF POVERTY LEVEL, LINES 1 - 6

Grantees are expected to collect income data on all patients, but are not required to collect this information more frequently than once during the year. If income information is updated during the year, report the most current information available. As a rule, family income is used. Except for minor-consent services, children will always be classified in terms of their parent's income. Patients for whom the information was not collected within a year of their last visit ***must*** be reported on Line 5 as unknown. Do not attempt to allocate patients with unknown income. Knowing that a patient is homeless or a migrant or on Medicaid is not adequate to classify that patient as having an income below the poverty level.

Income is defined in ranges relative to the Federal poverty guidelines (e.g., < 100 percent of the Federal poverty level). In determining a patient's income relative to the poverty level, grantees should use official poverty guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register during the first quarter of each year. The guidelines for CY 2011 are available at http://aspe.hhs.gov/poverty/11poverty.shtml.

Every patient reported on Table 3A must be reported once (and only once) on Table 4 Lines 1 through 5. The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income). The same is true for Grant Reports.

PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE, LINES 7 - 12

This portion of the table provides data on patients by principal source of insurance for primary medical care services. A patient's health insurance may change during the year. Report on this table the primary health insurance the patient had at the time of their last visit *regardless of whether or not that insurance was billed for or paid for the visit.* (Other forms of insurance, such as dental or vision coverage, are not reported.) Patients are divided into two age groups (Column A) 0 - 19 and (Column B) age 20+ based on their age on June 30th. Primary patient medical insurance is divided into seven types as follows:

- Uninsured (Line 7) – Patients who did not have *medical insurance* at the time of the last visit are counted on Line 7. This may include patients whose visit was paid for by a third party source that was *not* an insurance, such as EPSDT, BCCCP, or some State or local safety net program. Do *not* count patients as uninsured just because their medical insurance did not *pay for* their visit. For example, a patient with Medicare who was seen for an (uncovered) dental visit is still classified as having Medicare for this table. A patient with Private insurance that has a $200 deductible who had not yet reached that deductible is still considered a Private insurance patient. Medicaid (Line 8a, 8b, and 8) – State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act. Medicaid includes programs called by State-specific names (e.g., California's "Medi-Cal" program). In some States, the Children's Health Insurance Program (CHIP) is also included in the Medicaid program – see below. While Medicaid coverage is generally funded by Federal and State funds, some States also have "State-only" programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients) and these individuals are also included on Lines 8a or 8b and 8. NOTE: Individuals who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the State Medicaid agency *are still* reported as "Medicaid" not as privately insured.

- S-CHIP or CHIP or CHIP-RA (Line 8b or 10b) – The State Children's Health Insurance Program, covered in statute by the Children's Health Insurance Program Reauthorization Act (also known as CHIP-RA) provides primary health care coverage for children and, on a State by State basis, others – especially mothers or parents of these children. CHIP coverage can be provided through the State's Medicaid program and/or through contracts with private insurance plans.

- CHIP-Medicaid (Line 8b) – In States that make use of Medicaid, it is sometimes difficult or even impossible to distinguish between "regular Medicaid" and "CHIP-Medicaid." In other States the distinction is readily apparent (e.g., they may have different cards). Even where it is not obvious, CHIP patients may still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a State. Obtain information from the State and/or county on their coding practice. *If there is no way to distinguish between regular Medicaid and CHIP Medicaid, classify all covered patients as "regular" Medicaid (Line 8a).*

- Medicare (Line 9) – Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

- Other Public Insurance (Line 10a) – State and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, providing a broad set of benefits for eligible individuals. Include public paid or subsidized private insurance not listed elsewhere. Do not include any CHIP, Medicaid, or Medicare

patients on Line 10a. Do not include uninsured individuals whose visit may be covered by a public source with limited benefits such as the Early Prevention, Screening, Detection and Treatment (EPSDT) program or the Breast and Cervical Cancer Control Program, (BCCCP), etc. ALSO DO NOT INCLUDE persons covered by workers' compensation, as this is not health insurance for the patient, it is liability insurance for the employer.

- Other Public (CHIP) (Line 10b) – In those States where CHIP is contracted through a private third party payor, participants are to be classified as "other public-CHIP" (Line 10b) *not* as private, even if the third party is, in fact, a traditional third party payor such as Blue Cross. CHIP programs which are run through the private sector, are often covered through HMOs. The coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and counted on Line 10b.

- Private Insurance (Line 11) – Health insurance provided by commercial and non-profit companies. Individuals may obtain insurance through employers or on their own. Private insurance includes insurance purchased for public employees or retirees such as Tricare, Trigon, Veterans Administration, the Federal Employees Benefits Program, etc.

Every patient reported on Table 3A must be reported once (and only once) on Lines 7 through 11. Note that there is no "unknown" insurance classification on this table – BPHC *requires* grantees obtain medical coverage (if any) from all patients in order to maximize third party payments. The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 12 Column A + B (total patients by insurance status). The same is true for Grant Reports.

SOURCE OF INSURANCE: Further information

Grantees should report the patient's **primary health insurance covering medical care**, if any, **as of the last visit** during the reporting period. **Primary** insurance is defined as the insurance plan/program that the grantee would normally **bill first** for services rendered. NOTE: Patients who have both Medicare and Medicaid, would be reported as Medicare patients because Medicare is billed before Medicaid. The exception to the Medicare first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.

In rare instances a patient may have an insurance which the grantee cannot or does not bill. This may be a patient who is enrolled in Medicaid, but assigned to another primary care provider, or a patient with a private insurance where the grantees' providers have not been credentialed to bill that payor. In these instances the grantee will *still* report the patient as being insured and report the type of insurance.

Patients *for whom no other information is available*, whose services are paid for by grant programs, including family planning, BCEDP, immunizations, TB control, as well as patients served in correctional facilities, may be classified as uninsured.

Similarly, patients whose services are subsidized through State/local government "indigent care programs" are considered to be uninsured. Examples of State government "indigent care programs" include New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California's Expanded Assistance for Primary Care, and Colorado Indigent Care Program.

For both Medicaid and Other Public Insurance, the table distinguishes between "regular" enrollees and enrollees in CHIP.

> **MEDICAID =** Line 8b includes Medicaid-CHIP enrollees only; Line 8a includes all other enrollees; and Line 8 is the sum of 8a + 8b.
>
> **OTHER PUBLIC =** Line 10b includes CHIP enrollees who are covered by a plan other than Medicaid; Line 10a includes all other persons with other public insurance (Grantees are asked to describe the programs so the UDS reviewer can make sure that the classification of the program as other public is appropriate); and Line 10 is the sum of 10a + 10b.

As a rule there is a relationship between the member months reported on Lines 13a and 13b and the insured persons on Lines 7 through 11. It would be unusual for the number of member months for any one payor (e.g., Medicaid) to exceed 12 times the number of Medicaid patients reported on Line 8.

As a rule there is a relationship between the member months reported on Lines 13a and the income reported on Table 9D on Lines 2a, 5a, 8a, and/or 11a. One can generally expect a relationship between the member months reported on Lines 13b and the income reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.

MANAGED CARE UTILIZATION, LINES 13a – 13c

This section on "Managed Care Utilization" is to report patient Member Months in managed care plans. Do not report in this section enrollees in Primary Care Case Management (PCCM) programs which pay a small monthly fee (less than $10 per member per month) to "manage" patient care. Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical *and* dental (for example) *is* counted.

MEMBER MONTHS: A member month is defined as 1 member being enrolled for 1 month. An individual who is a member of a plan for a full year generates 12 member months; a family of 5 enrolled for 6 months generates (5 X 6) 30 member months; etc. Member month information is most often obtained from monthly enrollment lists generally supplied by managed care companies to their providers. Grantees should always save these documents and, in the event they have not been saved, should request duplicates early so as to permit timely filing of the UDS report.

> **MEMBER MONTHS FOR MANAGED CARE (CAPITATED)** (Line 13a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month. A patient is in a capitated plan if the contract between the grantee and the Health Maintenance Organization (HMO) stipulates that for a flat payment per month, the grantee will perform all of the services on a negotiated list. This usually includes, at a minimum, all office visits. Payments are received regardless of whether any service is rendered to the patient in that particular month. In the case of Medicaid, Medicare, and CHIP-RA, it is common for there to be a second "wrap-around" payment for managed care visits to adjust total payment to FQHC/PPS rates.
>
> **MEMBER MONTHS FOR MANAGED CARE (FEE-FOR-SERVICE)** (Line 13b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month

is defined as one patient being assigned to a service delivery location for one month during which time the patient may use only that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: It is common for patients to have their primary care covered by capitation, but other services, such as behavioral health or pharmacy, paid separately on a fee-for-service basis as a "carve out" in addition to the capitation. Do not include member months for individuals who receive "carved-out" services under a fee-for-service arrangement if those individuals have already been counted for the same month as a capitated member month.

TOTAL MEMBER MONTHS (Line 13c) – Enter the total of Lines 13a + 13b.

As a rule there is a relationship between the member months reported on Lines 13a and 13b and the insured persons on Lines 7 through 11. It would be unusual for the number of member months for any one payor (e.g., Medicaid) to exceed 12 times the number of Medicaid patients reported on Line 8.

As a rule there is a relationship between the member months reported on Lines 13a and the income reported on Table 9D on Lines 2a, 5a, 8a, and/or 11a. Similarly, one can generally expect a relationship between the member months reported on Lines 13b and the income reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.

CHARACTERISTICS OF TARGETED SPECIAL POPULATIONS, LINES 14 - 25

This section on "characteristics" asks for a count of patients from targeted special populations including persons who are homeless, migrant and seasonal agricultural workers, patients who are served by school-based health centers, and patients who are veterans.

MIGRANT OR SEASONAL AGRICULTURAL WORKERS AND THEIR DEPENDENTS, LINES 14 - 16

All grantees are required to report on Line 16 the combined total number of patients seen during the reporting period who were either migrant or seasonal agricultural workers or their dependents. (See definitions below.) Only Section 330(g) Migrant Health Center grantees are required to provide separate totals for migrant and for seasonal agricultural workers on Lines 14 and 15. For Section 330(g) grantees, Lines 14 + 15 = 16.

DEFINITIONS OF MIGRANT AND SEASONAL AGRICULTURAL WORKERS

MIGRANT AGRICULTURAL WORKERS – Defined by Section 330(g) of the Public Health Service Act, a migrant agricultural worker is an individual *whose principal employment is in agriculture* on a seasonal basis (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. Migrant agricultural workers are usually hired laborers who are paid piecework, hourly or daily wages. The definition includes those individuals who have had such work as their principle source of income within 24 months of their last visit as well as their *dependent* family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who *leave* a community to work elsewhere are just as eligible to be classified as migrants in their home community as are those who migrate *to* a community to work there.

SEASONAL AGRICULTURAL WORKERS – Seasonal agricultural workers are individuals *whose principal employment is in agriculture* on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily

wages. The definition includes those individuals who have been so employed within 24 months of their last visit and their dependent family members who have also used the center.

For both categories of workers, agriculture is defined as farming in all its branches, including:

(i) cultivation and tillage of the soil;
(ii) the production, cultivation, growing, and harvesting of any commodity grown on, or in the land, or as an adjunct to or part of a commodity grown on or in the land; and
(iii) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity describes in clause (ii).

Persons employed in *aqua*culture, lumbering, poultry processing, cattle ranching, tourism, and all other non-farm-related seasonal work are **not** included.

HOMELESS PATIENTS, LINES 17 - 23

HOMELESS PATIENTS – Are defined as patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing. All grantees are to report the total number of patients, known to have been homeless at the time of any service provided during the reporting period, on Line 23. Only section 330(h) Homeless Program grantees will provide separate totals for homeless program patients by type of shelter arrangement.

For section 330 (h) grantees Line 23 will equal the sum of Lines 17 through 22. For Lines 17 through 22:

- The shelter arrangement reported is the patient's arrangement as of the first visit during the reporting period. This is normally assumed to be where the person was housed the prior night.
- Persons who spent the prior night incarcerated, in an institutional treatment program (mental health, substance abuse, etc.) or in a hospital should be reported based on where they intend to spend the night after their visit/release. If they do not know, report them on Line 20: "street."
- Line 17 – Shelter. Patients who are living in an organized shelter for homeless persons at the time of their first visit. Shelters generally provide for meals as well as a place to sleep.
- Line 18 – Transitional Housing. Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters.
- Line 19 – Doubled Up. Patients who are living with others. The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.
- Line 20 – Street – includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy.
- Line 21 – Other – may be used to report previously homeless patients who were housed when first seen *but who were still eligible for the program.* (HCH rules permit a patient to continue to be seen for 12 months after their last visit regardless of their housing status.) Patients residing in SRO (single room occupancy hotels) or motels or other day-to-day paid for housing should also be classified as "other," Line 21.

SCHOOL BASED HEALTH CENTER PATIENTS, LINE 24

All grantees that identified a school based health center as a service delivery site in their grant application and scope of project description are to report the total number of patients who received primary health care services at the school service delivery sites(s) listed. A school based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services.

VETERANS, LINE 25

All grantees report the total number of patients served who have been discharged from the uniformed services of the United States. It is expected that this element will be included in the patient information/intake form at each center. Report only those who affirmatively indicate they are veterans. Persons who do not respond or who have no information are not counted, regardless of other indicators. Persons who are *still in* the uniform services, including soldiers on leave and National Guard members not on active duty, are not considered Veterans, Veterans of other nation's military are not counted here, even if they served in wars in which the United States was also involved.

QUESTIONS AND ANSWERS FOR TABLE 4

1. **Are there any changes to this table?**
   No.

2. **If we do not receive direct support under the Health Care for the Homeless, or Migrant Health programs, do we need to report the total number of special population patients served?**
   Yes. All grantees, regardless of whether they receive targeted grant funding for special populations, are required to complete Line 23 (total number of patients known to have been homeless at the time of service), Line 16 (the total number of patients seen during the reporting period who were either migrant or seasonal agricultural workers or their dependents), Line 24 (patients of an approved, in-scope school based clinic – regardless of whether or not special funding was ever obtained for that clinic), and Line 25 (Veterans). Grantees who did not receive special population funding are not required to complete Lines 14-15 and 17-22.

3. **Must the number of patients by income and insurance source equal the total number of unduplicated patients reported on Tables 3A and 3B?**
   Yes.

4. **We have never collected information on whether or not a patient is a veteran. Do we have to do this now for reporting?**
   Yes. As of January 1, 2008 all grantees are required to ask every patient who comes into their health center whether or not they are a veteran and add this to their profile so it can be reported.

5. **If a patient is seen only for dental care do we report the patient's *dental* insurance on lines 7 - 12?**
   No. Table 4 reports the *medical* coverage that health center patients have. All grantees must collect medical coverage information from all patients *even if the patient is not seeking medical services*. NOTE: If a patient has Medicaid, Private, or Other Public dental insurance you may presume that they have the same kind of medical insurance. If they *do not* have dental insurance you *may not* assume that they are uninsured for medical care, and must obtain this information from the patient.

6. **How are ARRA supported patients counted on this table?**
   ARRA patients are counted the same way as any other patient. If they had a UDS countable visit in the calendar year they are included in all of the counts.

7. **My ARRA grant says to count a patient as uninsured if they were uninsured at any time during the ARRA grant period. Do I count them the same way on the UDS?**
   No. On the UDS, insurance status *as of the last visit* is what gets reported. An ARRA patient may be reported as uninsured on the HCQR report, but if they had Medicaid (for example) at the time of their last visit, you would count them on Line 8a as a Medicaid patient.

TABLE 4 – SELECTED PATIENT CHARACTERISTICS

	CHARACTERISTIC	NUMBER OF PATIENTS (a)
INCOME AS PERCENT OF POVERTY LEVEL		
1.	100% and below	
2.	101 – 150%	
3.	151 – 200%	
4.	Over 200%	
5.	Unknown	
6.	**TOTAL** (SUM LINES 1 – 5)	

	PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE	0-19 YEARS OLD (a)	20 AND OLDER (b)
7.	**N**one/ **U**ninsured		
8a.	Regular Medicaid (Title XIX)		
8b.	CHIP Medicaid		
8.	**TOTAL MEDICAID (LINE 8A + 8B)**		
9.	**MEDICARE** (TITLE XVIII)		
10a.	Other Public Insurance Non-CHIP (specify:)		
10b.	Other Public Insurance CHIP		
10.	**TOTAL PUBLIC INSURANCE (LINE 10a + 10b)**		
11.	**PRIVATE INSURANCE**		
12.	**TOTAL (SUM LINES 7 + 8 + 9 +10 +11)**		

MANAGED CARE UTILIZATION						
Payor Category		MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING NON-MEDICAID CHIP (c)	PRIVATE (d)	TOTAL (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**TOTAL MEMBER MONTHS (13a + 13b)**					

	CHARACTERISTICS – SPECIAL POPULATIONS		NUMBER OF PATIENTS -- (a)
14.	Migrant	(330g grantees only)	
15.	Seasonal	(330g grantees only)	
16.	**TOTAL MIGRANT/SEASONAL AGRICULTURAL WORKER OR DEPENDENT (ALL GRANTEES REPORT THIS LINE)**		
17.	Homeless Shelter	(330h grantees only)	
18.	Transitional	(330h grantees only)	
19.	Doubling Up	(330h grantees only)	
20.	Street	(330h grantees only)	
21.	Other	(330h grantees only)	
22.	Unknown	(330h grantees only)	
23.	**TOTAL HOMELESS (ALL GRANTEES REPORT THIS LINE)**		
24.	**TOTAL SCHOOL BASED HEALTH CENTER PATIENTS (ALL GRANTEES REPORT THIS LINE)**		
25.	**TOTAL VETERANS (ALL GRANTEES REPORT THIS LINE)**		

INSTRUCTIONS FOR TABLE 5 – STAFFING AND UTILIZATION

This table provides a profile of grantee staff (Column A), the number of visits they render (Column B) and the number of patients served by service category (Column C). Unlike Tables 3A, 3B, and 4, where an unduplicated count of patients is reported, Column C is designed to report the number of unduplicated patients within each of seven service categories: medical, dental, mental health, substance abuse, vision, other professional, and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes. (NOTE: Staffing data are reported only on the Universal table, not the Grant Report tables.)

For the **Universal Report**, all staff, all visits and all patients are reported in Columns A, B and C. For the **Grant Reports**, ***only Columns B and C are to be completed***. (Column A will appear "grayed out" in the computer version and printouts of the Grant Report tables.) Every eligible visit must be counted on the Universal Report including all those reported in the Grant Reports. Grant Reports provide data on patients supported by funds which are within the scope of one of the non-CHC programs and the visits which they had during the year. This includes all visits supported with either grant or non-grant funds. Note that no cell in a Grant Report may contain a number larger than the corresponding cell in the Universal Report.

Staff, visits, and patients who are supported in whole or in part with ARRA related funds ARE included in this report *to the extent that they qualify under all other UDS rules.*

FULL TIME EQUIVALENTS (FTEs), COLUMN A

Table 5 includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the project for all of the programs covered by the UDS. (The FTE column is completed only on the Universal Report. Staff are not separated according to the different BPHC funding streams.) **All staff are to be reported in terms of *annualized* Full-Time Equivalents (FTEs)**. A person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." (This example is based on a 40 hour work week. Positions with less than a 40 hour base, especially clinicians, should be calculated on whatever they have as a base for that position. Agencies which have a 35 hour work week would consider 17.5 hours worked to be 0.5 FTE, etc.) Similarly, an employee who works 4 months out of the year would be reported as "0.33 FTE" (4 months/12 months). (See the "Full-Time Equivalent Employee" section, page 11 of this Manual for detailed instructions on calculating FTEs.)

Staff may provide services on behalf of the grantee under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health Service Corps assignment, under contract, or donated time. Thus, FTEs reported on Table 5 Column A include paid staff, volunteers, contracted personnel (paid based on worked hours or FTE), interns, residents, and preceptors. Individuals who are paid by the grantee on a fee-for-service basis only are not counted in the FTE column since there is no basis for determining their hours.

All staff time is to be allocated *by function* among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week, and provided medical care services for the other 30 hours

per week, time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out the components of an interaction. The nurse who handles a referral after a visit as a part of that visit would *not* be allocated out of nursing. The nurse who vitals a patient who they then place in the exam room, and later provide instructions on wound care, for example, would not have a portion of the time counted as "health education" – it is all a part of nursing.

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing "administrative" work such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in QI activities, supervising nurses, etc., is counted as part of their overall medical care services time. The one exception to this rule is when a Medical Director is engaged in *corporate* administrative activities, in which case time can be allocated to administration. Corporate administration does not, however, include clinical administrative activities such as supervising the clinical staff, chairing or attending clinical meetings, writing clinical protocols, etc.

PERSONNEL BY MAJOR SERVICE CATEGORY – Staff are distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse services, vision services, other professional health services, pharmacy services, enabling services, other program related services, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a more detailed, though not exhaustive, list appears in Appendix A.

- **MEDICAL CARE SERVICES (Lines 1 – 15)**
  - **Physicians** - M.D.s and D.O.s, except psychiatrists, ophthalmologists, pathologists, and radiologists. Naturopaths and Chiropractors are *not* counted here. Note also that Psychiatrists and Ophthalmologists are reported separately on Lines 20a and 22a and are not included on the physician's line. Licensed residents are reported on these lines and credited with their own visits.
  - **Nurse Practitioners**
  - **Physician Assistants**
  - **Certified Nurse Midwives**
  - **Nurses** - registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.
  - **Laboratory Personnel** - pathologists, medical technologists, laboratory technicians and assistants, phlebotomists.
  - **X-ray Personnel** - radiologists, X-ray technologists, and X-ray technicians
  - **Other Medical Personnel** - medical assistants, nurses aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Staff who support the quality assurance/Electronic Health Records (EHR) program are shown as Other Medical Personnel. Do *not* report medical records and patient support staff here.

    NOTE: Quality Assurance Personnel – Individuals in any or all of the above positions may be involved in Quality Assurance and EHR activities. They will be classified on the line that describes their main responsibility, not on the "IT" line.

- **DENTAL SERVICES (Lines 16 – 19)**
  - **Dentists** - general practitioners, oral surgeons, periodontists, and pediodontists
  - **Dental Hygienists**
  - **Other Dental Personnel** - dental assistants, aides, and technicians

- **MENTAL HEALTH SERVICES (Lines 20a, a1, a2, b, c, and 20)** (NOTE: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between Lines 20a through 20c and Line 21 as appropriate unless they choose to identify all services as Mental Health Services.)
  - **Psychiatrists (Line 20a)**
  - **Licensed Clinical Psychologists (Line 20a1)**
  - **Licensed Clinical Social Workers (Line 20a2)**
  - **Other licensed mental health providers (Line 20b)**, including psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Masters Degree prepared clinicians.
  - **Other mental health staff, including (Line 20c)** unlicensed individuals, including "certified" individuals who provide counseling, treatment or support services related to mental health professionals. Unlicensed interns in any of the professions listed on Lines 20a through 20b are counted on Line 20c. Regardless of any billing practices at the center, these individuals are credited with their own visits and no other person is to be credited with these visits.

- **SUBSTANCE ABUSE SERVICES (Line 21)** – Substance abuse workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse. Neither licenses nor credentials are required by the UDS – each center will credential its own providers according to its own standards. (NOTE: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between Lines 20a through 20c and Line 21 as appropriate.)

- **OTHER PROFESSIONAL HEALTH SERVICES (Line 22)** – Other Professional Health Services includes a broad array of providers of care. Some common professions include occupational and physical therapists, nutritionists, podiatrists, naturopaths, chiropractors, and acupuncturists. Optometrists, previously included on this line, are now reported on Line 22b. NOTE: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff. (A more complete list is included in Appendix A.) Services other than those listed above must be described in a clear detailed statement. Grantees are encouraged to check the reporting of such services with the UDS help line or their reviewer. There is a "specify" box for this line that must be completed for all services. Explain the specific other professional health services included.

- **VISION SERVICES (Lines 22a – 22d) –** Persons working in the area of eye care, specifically
  - **Ophthalmologist (Line 22a)** – Medical doctors specializing in medical and surgical eye problems.
  - **Optometrist (Line 22b)** – Optometrists (O.D.) – not physicians.

- **Other Vision Care Staff (Line 22c)** – ophthalmologist/optometric assistants, aides and technicians.

- **PHARMACY SERVICES (Line 23)** – Pharmacists (including clinical pharmacists), Pharmacy Technicians, pharmacist assistants, and others supporting pharmaceutical services. Note that effective 2006, the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies are to be classified as "Eligibility Assistance Workers," on Line 27a. Individual employees who do both should be allocated by time spent in each category.

  Some States license "Clinical Pharmacists" whose scope of practice includes reviewing and altering medications. In some States they are permitted to order tests. Despite this expanded scope of practice, *no pharmacy visits are recorded on Table 5.* Clinical pharmacists must be reported on Line 23 and may not be allocated to medical lines.

- **ENABLING SERVICES (Lines 24 – 29)** – Specific types of enabling services are listed below and are reported on Lines 24 through 28. "Enabling services," and especially "other enabling services" (Line 28) are not to be used as a catch all for services which are not included on other lines. Often such services belong on Line 29a (other related services). If a service does not fit the strict descriptions for Lines 24 through 27, their inclusion on Line 28 must include a clear detailed statement of what is being reported. Grantees are encouraged to check such services with the UDS help line or their reviewer.

  - **Case Managers (Line 24)** – staff who assist patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking, and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff includes individuals who are trained as and specifically called Case Managers as well as individuals called Care Coordinators, Referral Coordinators and other local titles. Nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, may be included here, but not when these services are an integral part of their other function. (Thus, none of the time of a nurse providing comprehensive nursing support including making an appointment for a patient with another provider is counted here.) Care/Referral Coordinators are considered Case Managers.

  - **Patient and Community Education Specialists (Line 25)** – health educators, with or without specific degrees in this area. Family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach may also be included here. Services may be one-to-one with the patient or in a group, although the group visits will not be reported in Column B.

  - **Outreach Workers (Line 26)** – individuals conducting case finding, education or other services to identify potential clients, and/or facilitate access/referral of clients to available health center services.

- **Eligibility Assistance Workers (Line 27a)** – all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, Pharmacy Assistance Programs, and related assistance programs.

- **Interpretation Staff (Line 27b)** – Staff whose *full time or dedicated time* is devoted to translation and/or interpretation services. **Do not include** that portion of the time of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.

- **Personnel Performing Other Enabling Service Activities (Line 28)** – all other staff performing enabling services not described above. There is a "specify" field that must be used to describe what these staff are doing. "Other enabling services" is not to be used as an all inclusive category for services which are not included on other lines. Often such services belong on Line 29a (other related services). Be sure to include a clear detailed statement of what is being reported. Grantees are encouraged to check such services with the UDS help line or their reviewer.

- **OTHER PROGRAMS AND RELATED SERVICES STAFF (Line 29a)**

  Some grantees, especially "umbrella agencies," operate programs which, while within their scope of service, are not directly a part of the listed medical, dental, behavioral or other health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, child care, frail elderly support programs, Adult Day HealthCare programs, fitness or exercise programs, etc. The staff for these programs are reported under Other Programs and Related Services. The cost of these programs are reported on Table 8A on Line 12. There is a "specify" field that must be used to describe what these staff are doing.

- **ADMINISTRATION AND FACILITY (Lines 30a - 32)**
  - **Management and Support Staff (Line 30a)** – Management team including Chief Executive Officer, *Chief Financial Officer*, Chief Information Officer and Chief Medical Officer, other administrative staff and administrative office support (secretaries, administrative assistants, file clerks, etc.) for health center operations within the scope of the grant. Report only that portion of the management team's full-time equivalent corresponding to the management function.

  - **Fiscal and Billing Staff (Line 30b)** – Staff performing accounting and billing functions in support of health center operations for services performed within the scope of the grant, *excluding the Chief Financial Officer (who is reported on line 30a)*.

  - **IT Staff (Line 30c)** – Technical information technology and information systems staff supporting the maintenance and operation of the computing systems that support clinical and administrative functions performed within the scope of the grant. Staff managing the hardware and software of an EHR/EMR system are reported on Line 30c, but design of medical forms, data entry, and analysis of EHR data are part of the medical functions reported on Lines 1 – 15.

- **Facility (Line 31)** – Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.

- **Patient Services Support Staff (Line 32)** – Intake staff and medical/patient records. Eligibility assistance workers are reported on Line 27a, not here.

NOTE: The Administration and Facility category for this report is more comprehensive than that used in some other program definitions and includes **all** personnel working in a BPHC-supported program, whether that individual's salary was supported by the BPHC grant or other funds included in the scope of project. Where appropriate, staff included in a grantee's overhead rate may be reported here.

NOTE ALSO: Table 8A has data relating to cost centers. Staff classifications should be consistent with cost classifications. The staffing on Table 5 is routinely compared to the costs on Table 8A during the review process. If there is a reason why such a comparison would look strange (e.g., volunteers on Table 5 resulting in no cost on Table 8A) be sure to include an explanatory note on Table 8A. The chart below illustrates the relationship between the two tables.

FTEs reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical providers and clinical support staff	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16 – 18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a – 20c: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists, etc.)	9: Other Professional
22a-22c: Vision (Ophthalmologist, Optometrist, Optometric Assistant, Other Vision Care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs/services (non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

CLINIC VISITS, COLUMN B

VISITS (Column B) – A visit is a documented, face-to-face contact between a patient and a provider who exercises their independent professional judgment in the provision of services to the patient. (See "Definitions of Visits, Providers, Patients, and FTE" section, page 6, for further details on the definition of visits). Grantees are to report visits which occurred during the reporting period which were rendered by staff identified in Column A, regardless of whether the staff are salaried, contracted or donated based on time worked. ***No*** visits are reported for personnel who are not "providers who exercise independent professional judgment" within the meaning of the definition above. In addition, the BPHC has chosen not to require reporting grantees to report on visits for certain other classes of staff, even if they *do* exercise professional judgment. In Column B, the cells applicable to these staff (e.g., laboratory, transportation, outreach, pharmacy etc.) are blocked out.

Visits that are purchased from non-staff providers on a fee-for-service basis are also counted in this column, even though no corresponding FTEs are included in Column A. To be counted, the service must meet the following criteria:

- the service was provided to a patient of the Grantee by a provider that is not part of the grantee's staff (neither salaried nor contracted on the basis of time worked),
- the service was paid for in full by the grantee, and
- the service otherwise meets the above definition of a visit.

This category ***does not include unpaid referrals, referrals where a third party will make the payment (e.g., the patient's insurance company) or referrals where only nominal amounts are paid***. Referrals for services that would not be counted as visits if performed by grantee's staff are similarly not counted if provided under some other arrangement.

PATIENTS, COLUMN C

PATIENTS (Column C) – A patient is an individual who has at least one visit during the reporting year. (See "Definitions of Visits, Providers, Patients, and FTE" section, page 7 for further details.) Report the number of patients for **each** of the seven separate services listed below. ***Within*** **each category, an individual can only be counted once as a patient. A person who receives multiple types of services should be counted once (and *only once)* *for each service*.**

For example, a person receiving only medical services is reported once (on Line 15 as a medical patient) regardless of the number of medical visits s/he may have had. A person receiving medical, dental and enabling services is reported once as a medical patient (Line 15), once as a dental patient (Line 19) and once as an enabling patient (Line 29), but is counted *only* once on each appropriate line in column C, regardless of the number of visits reported in column B. An individual patient may be counted once (and **only** once) in each of the following categories:

- Medical services patients (Line 15)
- Dental services patients (Line 19)
- Mental health services patients (Line 20)
- Substance abuse services patients (Line 21)
- Vision services patients (Line 22d)
- Patients receiving other professional services (Line 22)
- Enabling services patients (Line 29)

If you show visits in Column B for any of these seven categories, you are required to show the unduplicated number of patients who received these visits. Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Also, individuals who only receive services for which no visits are generated (e.g., laboratory, transportation, outreach) are not included in the patient count reported in Column C. For example, individuals who receive outreach or transportation services are not included in the total number of patients receiving enabling services in Column C; individuals who received flu shots but no other medical service are not counted as medical patients, etc.

QUESTIONS AND ANSWERS FOR TABLE 5

1. **Are there changes to this table?**
   No.

2. **How do I count participants in a group session?**
   If you have group treatment sessions for substance abuse, mental health, or behavioral health you must record the visit in each participant's chart. If a visit is not recorded in a participant's chart, that participant may not be counted as a patient. Each patient must be billed consistent with agency policy. If some patients/visits are billed and others are not billed, only those who are billed may be counted. *No group <u>medical</u> visits are counted on the UDS*. Though in some instances they may be billable, the UDS specifically does not count group medical activities as visits in such sessions.

3. **How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call the remaining 25 percent of his/her salary?**
   An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or hours spent on clinical committees, or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by a physician (for example) who does administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc., is not to be "adjusted off" – it is to be considered part of their time as a physician. The one exception to this rule is when a Medical Director is engaged in *corporate* administrative activities, in which case time can be allocated to administration. This does not, however, include *clinical* administrative activities such as chairing or attending meetings, supervising staff, writing clinical protocols, designing formularies, approving specialty referrals, etc. Note that the FQHC Medicare intermediary has different definitions for full time providers. These definitions are ***not*** to be used in reporting on the UDS.

4. **Our physicians work 35 hour weeks. Are they reported as 87.5% (35/40) FTEs?**
   No – they are each counted as 1.0 FTE. Grantees are not required by BPHC to have a 40 hour work week, but whatever workweek they have must be considered full time.

5. **Should the total number of patients reported on Table 3A be equal to the sum of the several types of service patients on Table 5?**
   Not unless the only service you provide is medical services. On Table 5, the grantee reports **patients for each type of service, with the patient counted once for <u>each</u> type of service received.** Thus a person who receives both medical and dental services would be counted once as a medical patient on Line 15 and once as a dental patient on Line 19. Because there are seven different types of patients identified on Table 5, a patient who is counted only once on Table 3A may be counted up to seven different places on Table 5.

6. **If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?**
   Yes. There should be a logical consistency between Table 5 and 8A. If a grantee reports that costs for case management services one would expect to see case managers reported on Table 5. Similarly, if there are staff on Table 5 we would expect costs on Table 8A unless all of the staff are volunteers.

7. **How are contracted providers and their activities reported on Table 5?**
   If the contracted provider is paid on the basis of time worked, the FTE is reported on Table 5 Column A as well as the visits and patients receiving services from this provider. If the contracted provider is paid on a fee-for-service basis, no FTE is reported on Table 5 Column A but visits and patients are reported.

8. **Where does "Behavioral Health" get reported?**
   "Behavioral Health" in some systems is just another name for mental health, and the staff and visits are reported on Lines 20a through 20c. But some grantees have merged the roles of "Mental Health Provider" and "Substance Abuse Provider" into a single role which they call "Behavioral Health Provider." In this instance, the grantee has two choices. The first (and probably easiest) is to assert that substance abuse problems are, indeed, mental health problems, and classify their Behavioral Health staff as Mental Health staff on the Lines 20a, a1, a2, b, or c. Another method would be to carefully record the time and activities of these dual function providers. In this case they will need to identify *each and every visit* as either a mental health visit or a substance abuse visit so that the patients and visits can be correctly classified. They must also keep track of their time so that their FTEs on Table 5 (and associated costs on Table 8A) can be accurately recorded.

9. **If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during a visit, how should this be counted?**
   Because "substance abuse" is also seen as a mental health diagnosis, it is permissible to count the visit as mental health. Under no circumstances would it be counted as "one of each." The provider will also need to be classified as mental health for this visit as must be the cost of the provider on Table 8A.

10. **Do I count the time of volunteers, interns or residents?**
    Yes. Volunteers, (some) interns and residents are licensed practitioners and their time is counted just like any other practitioner. Note, however, that most work shorter days because they are in educational sessions, often have more vacation time or other time off than other practitioners, or, in the case of volunteers do *not* have vacations or holidays. This would make them less than full time. See also the more complete discussion of counting Volunteers and of counting Interns and Residents in Appendix B.

11. **If I report patients and visits on my ARRA – HCQR, do I also count them on the UDS?**
    Yes – but please note that the cumulative ARRA report includes patients and visits from multiple years. The UDS counts **only those seen in the reporting year**.

12. **Do I count staff the same way on the UDS report as on the HCQR?**
    No – the UDS only counts FTE for the current program year and uses a slightly different methodology for counting staff (see section on reporting Full-Time Equivalent Employee above).

TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 - 7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Lines 9a - 10)**			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	**Total Medical (Lines 8 + 10a through 14)**			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	**Total Dental Services (Lines 16 - 18)**			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Total Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologist			
22b	Optometrist			
22c	Other Vision Care Staff			
22d	**Total Vision Services (Lines 22a-c)**			
23	**Pharmacy Personnel**			
24	Case Managers			
25	Patient/Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify___)			
29	**Total Enabling Services (Lines 24 - 28)**			
29a	**Other Programs/Services (specify___)**			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
34	**Grand Total Lines 15+19+20+21+22+22d+23+29+29a+30a through 32**			

INSTRUCTIONS FOR TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

This table reports data on two separate sets of data: selected *primary* diagnoses and selected services rendered. It is designed to provide this information using data maintained for billing purposes. As a *subset* of diagnoses and services, Table 6A is not expected to reflect the full range of diagnoses and services rendered by a grantee. The diagnoses and services selected represent those that are prevalent among BPHC patients or a sub-group of patients or are generally regarded as sentinel indicators of access to primary care or are of special interest to HRSA. Diagnoses reported on this table are those made by a medical, dental, mental health or substance abuse provider, ***only***, and are only the *primary diagnosis* provided at any given visit. Thus, if a case manager sees a diabetic patient, the visit is *not* to be reported on Table 6A; if a physician shows the primary diagnosis as hypertension and the secondary diagnosis as diabetes, the diabetes diagnosis is *not* reported on Table 6A.

The table is included in **both** the Universal Report and Grant Reports.

- The **Universal Report** reports on visits in the indicated diagnostic or service categories and a count of all individuals who had at least one visit in the indicated diagnostic or service category within the scope of any and all BPHC-supported projects included in the UDS.
- The **Grant Report** reports on only those visits provided to individuals served within the scope of the program being reported on.

Because the Grant Reports are sub-sets of the Universal Report, no cell on a grant report may exceed the comparable cell of the Universal Report.

Selected Primary Diagnoses – Lines 1 through 20d present the name and applicable ICD-9CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range of ICD-9CM codes is shown, grantees should report on all visits where the *primary diagnostic code* is included in the range/group. (NOTE: Many health centers are beginning to make the transition to ICD-10 codes. These codes are sufficiently different from the ICD-9 codes that they may not be used. They will need to be translated to ICD-9 codes for purposes of this report. Additional information is available on the conversion process at https://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp.)

Selected Tests/Screenings/Preventive Services – Lines 21 through 26d present the name and applicable ICD-9CM diagnostic and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served or of particular interest to HRSA. On several lines both CPT codes and ICD-9 codes are provided. Grantees may use *either* the CPT codes *or* the ICD-9 codes for any specific visit, *not both. Note that for this part of Table 6A, the concept of a "primary" code is neither relevant nor used. All* services are reported. A reported *service* may be in addition to another service, in addition to a reported primary *diagnosis* or may stem from a visit where there was no UDS-reportable diagnosis code.

NOTE: "V-Codes" for mammography and Pap test are listed to ensure capture of procedures which are done by the grantee, but coded with a different CPT code for State reimbursement under Title X or BCCCP. In some instances payors (especially governmental payors) ask grantees to use different codes for services which are included in the UDS. In these instances,

grantees should add these codes to the published list for reporting purposes.

Grantees must actually perform or pay for the test for it to be counted. Do not report referral for tests or procedures which are not performed by or paid for by the grantee.

Selected Dental Services – Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services may be performed *only by a dental provider who is reported on Lines 16 – 17.* Wherever appropriate, services have been grouped into code ranges. Note that for these lines, the concept of a "primary" code is neither relevant nor used. ***All*** services are reported.

PLEASE NOTE: Only services which are provided at a "countable" visit are reported on table 6A. Included in these would be services "attendant to" a countable visit. Thus, if a provider asks that a patient come back in 30 days for a flu shot, when that patient presents, the shot is counted because it is considered legally to be a part of the initial visit. Another person, walking in off the street for the same flu shot but without a specific referral from a prior visit would not have the interaction reported on Table 6A. Visits supported by the ARRA program ARE INCLUDED in this report as appropriate.

NUMBER OF VISITS, COLUMN A

LINES 1 – 20d: Diagnostic Data

Visits by Selected Primary Diagnoses (Lines 1-20d). Report the total number of visits during the reporting period where the indicated diagnosis is listed on the visit/billing records as the **primary** diagnosis **only**. If a visit has a primary diagnosis which is one of the many diagnoses not listed on Table 6A, it is not reported. While most visits ***are not*** *reported on this table*, those which ***are*** counted, are reported for only the primary diagnosis on Lines 1 through 20d. All visits are entered into clinic practice management/billing systems, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc. Any single visit may be counted a maximum of one time on Lines 1 – 20d regardless of the number of diagnoses listed for the visit.

LINES 21 – 34: Service Data

Visits by Selected Tests/Screenings/Preventive and Dental Services (Lines 21-34). Report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided. Note that codes for these services may either be diagnostic (ICD-9) codes or procedure (ADA or CPT-4) codes. *During one visit more than one test, screening or preventive service may be provided*, in which case, each would be counted.

- One visit may involve more than one of the identified services in which case each should be reported. For example, if during a visit both a Pap test and an HIV test were provided then a visit would be reported on both Lines 21 and 23.
- If a patient receives multiple immunizations at one visit, only one visit should be reported.
- Services may be reported ***in addition to*** diagnoses. A hypertensive patient who also receives an HIV test would be counted once on the hypertension Line 11 and once on Line 21, HIV test.
- If a patient had more than one tooth filled, only one visit for restorative services should be reported, not one per tooth.

NUMBER OF PATIENTS, COLUMN B

LINES 1 – 20d: Diagnostic Data

Patients by Primary Diagnosis (Lines 1-20d). For Column B report each individual who had one or more visits during the year where the primary diagnosis was the indicated diagnosis. A patient is counted once and only once regardless of the number of visits made for that specific diagnosis. Any patient may have visits with different primary diagnoses, for example, one for hypertension and one for diabetes, on different days. In this case, the patient would be reported once for each primary diagnosis used during the year. For example, a patient with one or more visits with a primary diagnosis of hypertension *and* one or more visits with a primary diagnosis of diabetes is counted once *and only once* as a patient on *both of* Lines 9 and 11, regardless of how many times they were seen.

LINES 21 – 26d: Services Data

Patients by Selected Diagnostic Tests/Screenings/Preventive Services (Lines 21-26d). Report patients who have had at least one visit during the reporting period where the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21-26d was provided. If a patient had a Pap test and contraceptive management during the same visit, this patient would be counted on both Lines 23 and 25 in Column B. Regardless of the number of times a patient receives a given service, they are counted once and only once on that line in Column B. For example, an infant who has an immunization at each of several well child visits in the year has each visit reported in Column A, but is counted only once in column B.

LINES 27 – 34: Dental Services Data

Patients by Selected Dental Services (Lines 27-34). Report patients who have had at least one visit with a dental professional during the reporting period for each of the selected dental services listed on Lines 27-34. (Services provided by persons other than a dentist or a dental hygienist may not be reported here.) If a patient had two teeth repaired and sealants applied during one visit, this patient would be counted once (only) on both Lines 30 and 32 in Column B.

QUESTIONS AND ANSWERS FOR TABLE 6A

1. **Are there changes to this table?**
   No.

2. **If a case manager or health educator serves a patient who is, for example, a diabetic, we often show that diagnostic code for the visit. Should this be reported on Table 6A?**
   No. Report only visits with medical, dental, mental health, and substance abuse providers on Table 6A. Note also that each should diagnose only in their own area. Thus, dentists may not diagnose hypertension, etc.

3. **The instructions call for diagnoses or services at visits. If we provide the service, but it is not counted as a visit (such as immunizations given at a health fair) should it be reported on this table?**
   Services given at health fairs are not counted, regardless of who provides the service or the level of documentation that is done. If a service is provided *as a result of a prescription or plan from an earlier visit that was counted* **it *is* counted**. For example, if a provider asked a woman to come back in four months for a mammogram that is done at the health center, it would be counted. But if the service is a self-referral where no clinical visit is necessary or provided (such as a blood pressure check at a health fair or a senior citizen coming in for a flu shot) **it *is not* counted**.

4. **Some diagnostic and/or procedure codes in my system are different from the codes listed. What do I do?**
   It is possible that information for Table 6A is not available using the codes shown because of idiosyncrasies in State or clinic billing systems. Generally, these involve situations where (a) the State uses unique billing codes, other than the normal CPT code, for State billing purposes (e.g., EPSDT) or (b) internal or State confidentiality rules mask certain diagnostic data. The following provides examples of problems and solutions.

Line #	Problem	Potential Solution
1	HIV diagnoses are kept confidential and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
23	Pap tests are charged to State BCCP program using a special code	Add these special codes to the other codes listed.
26	Well child visits are charged to the State EPSDT program using a special code (often starting with W, X, Y, or Z).	Add these special codes to the other codes listed and count all such visits as well. Do not count EPSDT follow-up visits in this category.

5. **The instructions specifically say that the source of information for Table 6A is "billing systems." There are some services for which I do not bill and/or for which there are no visits in my system. What do I do?**
   Referrals for which you do not pay (e.g., sending women to the County Health Department for a mammogram) are *not to be counted.* While grantees are only required to report data derived from billing systems, the reported data may understate services in the circumstances described below. In order to more accurately reflect your level of service,

grantees are encouraged to use other codes in their system to enable the tracking. For example, if a child is given a vaccination which the clinic does not charge for because they received it free from the Vaccine for Children program, the regular code with an extension may be used to indicate that it is not to be billed or the code may have a zero charge attached to it.

Line #	Problem	Potential Solution
21	HIV Tests are collected by us but processed and paid for by the State and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the correct code with a ".52" extension to indicate you did not do the technical component of the test.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the correct code with a ".52" extension to indicate you did not do the technical component of the test.
24	Flu shots and other vaccinations are not counted because the vaccines are obtained at no cost to the center.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the correct code with a ".52" extension to indicate you did not do the technical component of the test.
25	Contraceptive management is funded under Title X or a State family planning program and does not have a V-25 diagnosis attached to it.	Preferred: Add a "dummy code" you can map to the V-25 code. Alternative: Code with both the V-25 and the State mandated code but suppress printing of the V-25 code. Take care not to count the same visit twice.

Reporting Period: January 1, 2011 through December 31, 2011

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV , Asymptomatic HIV	042 , 079.53, V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32		
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71		
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx – 492.xx		
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11.	Hypertension	401.xx – 405.xx;		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx – 992.xx		
14a.	Overweight and obesity	ICD-9 : 278.0 – 278.02 or V85.xx excluding V85.0, V85.1, V85.51 V85.52		
Selected Childhood Conditions				
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
19a.	Tobacco use disorder	305.1		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3,309.81		
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx		
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)		

TABLE 6A – SELECTED SERVICES RENDERED

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	**CPT-4:** 86689; 86701-86703; 87390-87391		
21a.	Hepatitis B test	**CPT-4:** 86704, 86706, 87515-17		
21b.	Hepatitis C test	**CPT-4:** 86803-04, 87520-22		
22.	Mammogram	**CPT-4:** 77052, 77057 OR **ICD-9:** V76.11; V76.12		
23.	Pap test	**CPT-4:** 88141-88155; 88164-88167, 88174-88175 OR **ICD-9:** V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4:** 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24a.	Seasonal Flu vaccine	**CPT-4:** 90655 - 90662		

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
24b.	H1N1 Flu vaccine	**CPT-4:** 90663; 90470		
25.	Contraceptive management	**ICD-9:** V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99391-99393; 99381-99383;		
26a.	Childhood lead test screening (9 to 72 months)	**CPT-4:** 83655		
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408-99409		
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406 and 99407; S9075		
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

Service Category		Applicable ADA Code	Number of Visits (A)	Number of Patients (B)
Selected Dental Services				
27.	I. Emergency Services	**ADA :** D9110		
28.	II. Oral Exams	**ADA :** D0120, D0140, DO145, D0150, D0160, D0170, D0180		
29.	Prophylaxis – adult or child	**ADA :** D1110, D1120,		
30.	Sealants	**ADA :** D1351		
31.	Fluoride treatment – adult or child	**ADA :** D1203, D1204, D1206		
32.	III. Restorative Services	**ADA :** D21xx – D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA :** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA :** D3xxx, D4xxx, D5xxx , D6xxx, D8xxx		

Sources of codes:

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2011. American Medical Association.
- Current Procedural Terminology, (CPT) 2010/2011. American Medical Association.
- Current Dental Terminology, (CDT) 2010/2011. American Dental Association.

NOTE: x in a code denotes any number including the absence of a number in that place.

INSTRUCTIONS FOR TABLE 6B – QUALITY OF CARE INDICATORS

This table reports data on selected quality of care indicators. The quality of care indicators have historically been seen in the health care community as indicators of overall community health. More recently, they have become critical elements in the implementation of the national drive to implement Electronic Health Records (EHRs) and are defined as "meaningful use" elements in the implementing legislation. BPHC first implemented these measures in 2008 and has been updating and adding to them since then. As health centers continue to implement their EHRs, BPHC will continue to revise and expand these indicators. As a rule, indicators mirror "meaningful use" measures used by CMS.

These Quality of Care indicators are "process measures" which means that they document services which are thought to be correlated with and serve as a proxy for good long term health outcomes. We know that individuals who receive timely routine and preventive care are more likely to have improved health status. Thus, by increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, we can expect improved health status of the patient population in the future. Specifically:

- **Early entry into prenatal care:** *If* women enter care in their first trimester *then* the probability of adverse birth outcome will be reduced.
- **Childhood immunizations:** *If* children receive their vaccinations in a timely fashion *then* they will be less likely to contract vaccine preventable diseases or to suffer from the sequela of these diseases
- **Pap tests:** *If* women receive Pap tests as recommended *then* they can be treated earlier and will be less likely to suffer adverse outcomes from HPV and cervical cancer
- **Weight assessment and counseling for children and adolescents:** *If* clinicians ensure that their patients' Body Mass Indicator Percentile is recorded, and i*f* patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight) *then* the likelihood of obesity and its sequela will be reduced.
- **Adult Weight screening and follow-up:** *If* clinicians routinely calculate and record the BMI for their adult patients, and IF they identify patients with weight problems and developed a follow-up plan for overweight and underweight patients, *then* the likelihood of the debilitating sequela of serious weight problems can be reduced.
- **Tobacco use assessment:** *If* patients are routinely queried about their tobacco use (including smokeless tobacco) *then* providers will be able to intervene more quickly and effectively and reduce the incidence of cancer, asthma, emphysema, and other tobacco related illnesses.
- **Tobacco use intervention:** *If* tobacco users are provided with an effective mix of counseling and pharmacologic intervention *then* tobacco users will be more likely to quit smoking and will therefore have a lower incidence of cancer, asthma, emphysema, and other tobacco related illnesses.
- **Pharmacological treatment of asthmatics:** *If* patients identified with persistent asthma are provided with appropriate pharmacological intervention *then* they will be less likely to have asthma attacks, they will require fewer emergency room visits, and be less likely to develop complications related to asthma including death.

While the selected quality of care measures give a good overall description of the overall quality of primary care being provided at the center, it is clear that this is a *subset* of possible quality of care indicators. Individual health centers may use *additional* indicators for other purposes if

they choose to do so.

Table 6B is included only in the Universal Report, and includes patients and services supported by the ARRA program.

SECTIONS A AND B: DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

Only grantees that provide or assume primary responsibility for some or all of a patient's prenatal care, whether or not the grantee does the delivery, are required to complete Sections A and B. Grantees who do not provide prenatal care will indicate this by checking a box at the beginning of the table.

SECTION A: AGE OF PRENATAL CARE PATIENTS (Lines 1-6)

Report the total number of patients who received prenatal care services *at any time during the reporting period* by age group. Be sure to include all women receiving any prenatal care, including the delivery of her child, during the reporting year regardless of when that care was initiated, including women who began prenatal care during the previous reporting period and continued into this reporting period and women who began their care in this reporting period but will not/did not deliver until the next year. "Total prenatal patients" includes both patients who receive all their care from the grantee as well as patients who began care with another provider, patients who were transferred to another provider at some point during their prenatal care and patients who were delivered by another provider. To determine the appropriate age group, use the woman's age on June 30 of the reporting period. As many as half of all patients reported will have been reported in the prior year or will be reported in the next year.

SECTION B: TRIMESTER OF ENTRY INTO PRENATAL CARE (Lines 7-9)

All patients who received prenatal care including, but not limited to, the delivery of a child during the reporting period, are reported on Lines 7- 9. The trimester is determined by the trimester of pregnancy that the woman was in *when she began prenatal care* either at one of the grantee's service delivery locations or with another provider. A woman who begins her prenatal care with the grantee is reported once and only once in Column A. A woman who begins her prenatal care at another provider and then transfers to the grantee, is counted once and only once in Column B, and is *not* counted in Column A. Prenatal care is considered to have begun at the time the patient has her first visit with a physician or NP, PA, or CNM provider who initiates prenatal care with a complete physical exam. This visit is considered the "first visit" for UDS purposes. Prenatal care is *not* initiated when the prenatal patient registers for care at the center or has lab tests or psycho-social or nutritional assessments done. A woman is counted only once regardless of the number of trimesters during which she receives care. In those rare instances where a woman is in treatment for two separate perinatal courses of care in the same year, she is to be counted twice. (This can occur if a woman delivers, for example, in January and then becomes pregnant again in August.)

FIRST TRIMESTER (Line 7) Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be pregnant anytime through the end of the 13th week after

conception[3]. If the woman began prenatal care during the first trimester at the grantee's service delivery location, she is reported on Line 7 in Column A; if she received prenatal care from another provider during the first trimester before coming to the grantee's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with grantee.

SECOND TRIMESTER (Line 8) Includes women who received prenatal care during the reporting period whose "first visit" occurred when she was estimated to be between the start of the 14th week and through the 26th week after conception. If the woman began prenatal care during the second trimester at the grantee's service delivery location, she is reported on Line 8 in Column A; if she received prenatal care starting in the second trimester from another provider before coming to the grantee's service delivery location, she is reported on line 8 in Column B, regardless of when she begins care with grantee.

THIRD TRIMESTER (Line 9) Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be 27 weeks or more after conception. If the woman began prenatal care during the third trimester at the grantee's service delivery location, she is reported on Line 9 in Column A; if she received prenatal care from another provider starting the third trimester before coming to the grantee's service delivery location, she is reported on Line 9 in Column B, regardless of when she begins care with grantee.

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received perinatal care from the grantee during the calendar year, and is equal to the number reported on Line 6. All prenatal women must be reported here, regardless of when they entered care (this year or last year) or when they deliver (this year or next year).

SECTIONS C THROUGH H: OTHER QUALITY OF CARE INDICATORS

In these sections, grantees will report on the findings of their reviews of services provided to targeted populations of current medical patients (i.e., medical patients who had a medical visit at least once during the reporting period). These targeted populations are:

SECTION C: CHILDHOOD IMMUNIZATION (Line 10)
Children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, and who were first seen ever by the grantee prior to their second birthday are reported on Line 10. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 2009 and December 31, 2009.

SECTION D: PAP TESTS (Line 11)
Women aged 21 through 64 with at least one medical visit during the reporting period,

[3] Obstetricians commonly count time from last reported menstrual period (LMP). Since this is two weeks earlier than conception, the first trimester would be considered up through 15 weeks post-LMP. The second trimester is through 28 weeks post-LMP. Trimester may be based on other data if LMP data are not available.

who were first seen by the clinic at some point prior to their 65th birthday are reported on Line 11. For the purposes of this year's reporting this includes women whose date of birth is between January 1, 1947 and December 31, 1987. (NOTE: This is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 should be included in the calculation of this measure.)

SECTION E: WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS (Line 12)
Children and adolescents aged 2 through 17 with at least one medical visit during the reporting period, who had their third birthday during the reporting period, and who were first seen ever by the grantee prior to their 17th birthday are reported on Line 12. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 1994 and December 31, 2008.

SECTION F: ADULT WEIGHT SCREENING AND FOLLOWUP (Line 13)
Adults age 18 or older with at least one medical visit during the reporting period are reported on Line 13. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1993.

SECTION G1: TOBACCO USE ASSESSMENT (Line 14)
Adults age 18 or older, seen after 18th birthday, with at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 14. For the purposes of this year's reporting this includes all patients born on or before December 31, 1993.

SECTION G2: TOBACCO CESSATION INTERVENTION (Line 15)
Adults age 18 or older, seen after 18th birthday, who used tobacco products within the past 24 months who had at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 15. For the purposes of this year's reporting this includes all patients born on or before December 31, 1993.

SECTION H: ASTHMA PHARMACOLOGIC THERAPY (Line 16)
Patients age 5 through 40 with at least one medical visit during the reporting period, with a diagnosis of mild, moderate or severe persistent asthma are reported on Line 16. For the purposes of this year's reporting this includes all patients born between January 1, 1971 and December 31, 2006.

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates permit the recovery of all records for 100% of the patients which fit the criteria described below.

For each of the populations being surveyed, very rigid and specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings. (Special care must be taken since mistakes in this area may potentially portray a higher or lower quality of care than is actually the case.)

COLUMN INSTRUCTIONS

COLUMN a: NUMBER OF PATIENTS IN THE "UNIVERSE"

Enter the total number of health center patients who fit the detailed criteria defined below. Note that this will no doubt include a significant number of patients who have not received the specific service being measured. Because these populations are *initially* defined in terms of age (or age and gender), comparisons to the numbers on Table 3A will be made. But because *all* patients are counted on Table 3A, and only medical patients or medical patients with specific conditions are counted on Table 6B, and because Table 3A measures ages as of June 30th, the numbers *will not be equal to* those on Table 3A.

Column a will reflect the total number of patients meeting the criteria in the agency's total patient population including all sites and all programs.

COLUMN b: NUMBER OF CHARTS SAMPLED OR EHR TOTAL

Enter the total number of health center patients from the universe (Column a) for whom data have been reviewed. The number will either be *all patients* who fit the criteria (and hence the same number as the universe reported in column a) or a scientifically drawn *sample of 70 patients* selected from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire user population identified as the universe. Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that could result in over-sampling some group of patients.

If an EHR is present it *may* be used in lieu of a review of a sample of charts if and only if:

- The EHR *includes* every single clinic patient who meets the criteria described below for inclusion in the universe.
- The EHR *excludes* every single clinic patient who meets one or more exclusion criteria described below for exclusion from the universe.
- Every item in both the inclusion and the exclusion criteria is regularly recorded for all patients.
- The EHR has been in place long enough to be able to find the data required in prior year's activities. This means a minimum of three calendar years of full operation of the EHR before it can be used in lieu of chart audits for the immunizations, Pap test, and smoking measures. At least two full calendar years of operation of the EHR must be present for the adult and pediatric weight measures.

If the EHR is to be used in lieu of the chart audit, the number in Column b will be equal to the number in Column a.

COLUMN c: NUMBER OF CHARTS/RECORDS IN COMPLIANCE

Enter the total number of records which meet the requirement for compliance as discussed below.

DEFINING THE UNIVERSE: "CRITERIA" vs. "EXCLUSIONS" IN EHRs vs. CHART REVIEWS

Because the UDS follows the structure developed for meaningful use and other systems, a condition may sometimes be listed as a criteria and sometimes as an exclusion. They should be treated as described here to either constrain the universe of an EHR report or identify charts to be replaced in a chart review process.

In the discussion which follows the concepts of "conditions" or "criteria" are at times juxtaposed with "exclusions." This is partly because of the differing language and procedures in an EHR (or PMS) based report vs. a Chart Audit report. In an EHR or PMS review all criteria spelled out for a measure must be able to be found in the EHR and must be in the EHR for each and every patient at the health center. To the extent that it cannot be found, it will distort the findings, and should not be used. If, for example, the EHR cannot differentiate between a medical patient and a dental-only patient, then the EHR cannot be used to review the immunization of two year olds because we cannot limit the universe to medical patients.

In a sample chart review process, an item listed as a "criteria" below may be used as an "exclusion." Thus, we can ask that all two year old patients be listed but, if our sample includes someone who turns out to be a dental (only) patient, we can "exclude" that chart from the sample and replace it with another chart.

DETAILED INSTRUCTIONS FOR EACH CLINICAL MEASURE

What follows is a detailed discussion of each of the clinical measures. BPHC recognizes that some health centers may have different staff people working on each of the measures. Because of this, these pages have been designed so that the instructions for each of the measurers is complete in and of itself. As a result, instructions that apply to more than one measure will nonetheless be duplicated to permit extraction of that portion of the manual.

In this section, when conditions are linked with **"AND"** it means that each of the conditions must be met independently. If some, but not all of the conditions are met, the services for that patient are considered to have failed to meet the criteria and the case is considered to be out of compliance.

Note that some of the newer measures do not correspond directly with traditional ICD-9 or CPT codes. As a result, we have also included some CPT Category II codes (shown as CPT-II) which are specific to performance measures. These may be found in an appendix to most CPT manuals or on-line (starting on page 224) at http://www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes-alpha-listing-clinical-topics.pdf.

CHILDHOOD IMMUNIZATIONS (Line 10)

PERFORMANCE MEASURE: The performance measure is "Percentage of children with their 2nd birthday during the measurement year who are fully immunized on their second birthday." This is calculated as follows:

- **Numerator:** Number of children among those included in the denominator who were

fully immunized on or before their 2nd birthday[4]. A child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), 4 Pneumoccocal conjugate, 2 HepA, 2 or 3 RV (rotavirus) and 2 seasonal flu prior to or on their 2nd birthday.

- **Denominator:** Number of all children with at least one medical visit during the reporting period, who had their 2nd birthday during the reporting period or a sample of 70 of these children. For measurement year 2011, this includes all children with date of birth between January 1, 2009 and December 31, 2009. Children who were never seen by the clinic prior to their second birthday are to be excluded. There will no doubt be a number of children for whom no vaccination information is available and/or who were first seen at a point when there was simply not enough time to fully immunize them prior to their second birthday. They should still be included in the universe and thus in the denominator.

TOTAL NUMBER OF PATIENTS WITH 2ND BIRTHDAY DURING MEASUREMENT YEAR, COLUMN (a)

Enter number of children who:

- Were born between January 1, 2009 and December 31, 2009, *and*
- Had at least one medical visit during the reporting year, including children who were seen only for the treatment of an acute or chronic condition and those who were never seen for well child care *and*
- Were seen for the first time ever prior to their second birthday. (This could have been in 2009 or 2010.)

Include all children meeting this criterion regardless of whether they came to the clinic for well child services or other medical services which include vaccinations or they came for treatment of an injury or illness. *Note that children whose only service was receipt of a vaccination, and who never received other medical services, are not to be counted as patients on the demographic tables and are not included in the universe for this table.*

Children who had a contraindication for a specific vaccine should be included in the universe. In your review, they should be counted as being "compliant" for that specific vaccine and then reviewed for the administration of the rest of the vaccines. Contraindications should be looked for as far back as possible in the patient's history. The following may be used to identify contraindications which permit allowable vaccination-exclusions:

- **Any particular vaccine:** Allergic reaction to the vaccine or its components: ICD-9: 999.4.
- **DTaP:** Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine).
- **VZV, MMR, Rotavirus, and Flu:**
  - Immunodeficiency, including genetic (congenital) immunodeficiency syndromes ICD-9: 279.
  - HIV-infected or household contact with HIV infection ICD-9: Infection V08, symptomatic 042 or 079.53.

[4] This measure is *as of the second birthday*. Another commonly used measure looks at children before they turn three *and this measure is explicitly not to be used.* The vaccinations listed for this criteria are to be provided by the end of the 18th month. By establishing the date as the end of the 24th month there is a six month grace period built into the measure.

- ❖ Cancer of lymphoreticular or histiocytic tissue ICD-9: 200-202.
- ❖ Multiple myeloma ICD-9: 203. Leukemia ICD-9: 204-208.
- ❖ Allergic reaction to neomycin.

- **IPV:** Allergic reaction to streptomycin, polymyxin B, or neomycin.
- **Hib:** None.
- **Hepatitis B:** Allergic reaction to common baker's yeast.
- **Pneumococcal conjugate:** None.
- **Hepatitis A:** None.

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients from the universe (Column a) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column a) or a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. See discussion of sample size above on page 0.

NUMBER OF PATIENTS IMMUNIZED, COLUMN (c)
Enter in column c the number of children from column b who have received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), 4 Pneumoccocal conjugate, 2 HepA, 2 or 3 RV and 2 Flu prior to or on their 2nd birthday. Count any of the following as documenting compliance for a given vaccine: evidence of the antigen, contraindication for the vaccine, documented history of the illnesses, or a seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all the antigens.

- **DTaP/DT:** An initial DTaP vaccination followed by at least three DTaP, DT or individual diphtheria and tetanus shots, on or before the child's second birthday. Any vaccination administered prior to 42 days after birth cannot be counted. In States where the law allows an exception to a child who receives a pertussis vaccination, the child is compliant if he or she has four diphtheria and four tetanus vaccinations.

- **IPV:** At least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted.

- **MMR:** At least one measles, mumps and rubella (MMR) vaccination, with a date of service falling on or before the child's second birthday. (NOTE: CDC rules require that it be after the first birthday, but that is not required for the UDS.)

- **HIB:** Three H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted.

- **Hepatitis B:** Three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.

- **VZV (Varicella):** At least one chicken pox vaccination (VZV), with a date of service falling on or after the child's first birthday and on or before the child's second birthday.

- **Pneumococcal conjugate:** At least four pneumococcal conjugate vaccinations on or before the child's second birthday.

- **Hepatitus A:** At least two HepA vaccinations on or before the child's second birthday.

- **Rotavirus:** At least two rotavirus vaccinations (Rv) on or before the child's second birthday. RV administered prior to 42 days after birth cannot be counted.

- **Flu:** At least two influenza vaccinations on or before the child's second birthday. Flu shots administered prior to 180 days after birth cannot be counted.

  The following ICD-9 and/or CPT codes are evidence of compliance. NOTE: Additional vaccines for these diseases – especially combination vaccines – may have been approved and their CPT codes may be added by grantees to demonstrate compliance. Others listed here, especially those for single diseases covered by the MMR or MMRV vaccines may no longer be manufactured. NOTE ALSO: Many State and county entities participating in the Vaccines for Children (VFC) program assign their own unique codes to some or all of these vaccines. It is the intent of this report to include all such codes as well.

  DTaP: CPT (90698, 90700, 90701, 90720, 90721, 90723; ICD-9 (99.39)
  Diphtheria and tetanus: CPT (90702)
  Diphtheria: CPT (90719); ICD-9(VO2.4*, 032*, 99.36)
  Tetanus: CPT (90703); ICD-9 (037*, 99.38)
  Pertussis: ICD-9 (033*, 99.37)
  IPV: CPT (90698, 90713, 90723); ICD-9 (V12.02*, 045*, 99.41)
  MMR: CPT (90707, 90708, 90710); ICD-9 (055*, 99.45)
  Measles: CPT (90705, 90708); ICD-9 (055*, 99.45)
  Mumps: CPT (90704,90710); ICD-9 (072*, 99.46)
  Rubella: CPT (90706, 90707, 90708,90710); ICD-9 (056*, 99.47)
  Hib: CPT (90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748); ICD-9 (041.5*, 038.41*, 320.0*, 482.2*)
  Hepatitis B: CPT (90723, 90740, 90744, 90747, 90748); ICD-9 (VO2.61*, 070.2*, 070.3*) **VZV:** CPT (90710, 90716); ICD-9 (052*, 053*)
  Pneumococcal conjugate: CPT (90669,90670)
  Hepatitis A: CPT (90633, 90634); ICD-9 (070.0*, 070.1*)
  Rotavirus: CPT (90680, 90681); ICD-9 (008.61*)
  Seasonal Flu: CPT (90654, 90655, 90657. 90660-90662); ICD-9 (99.52 [5])

  * Indicates evidence of disease. A patient who has evidence of the disease prior to age two is compliant for the antigen.

For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from a note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized

[5] While 487.x is used for seasonal flu, the actual viruses involved change from year to year, and having been diagnosed with flu in the past is not sufficient to indicate current immunity.

health care provider or agency including the specific dates and types of immunizations administered. Immunization information may also be obtained from an immunization registry maintained by the State or other public body as long as it shows comparable information, but immunization registries typically cannot be used to identify compliance for the universe of patients.

For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday.

Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator for some immunizations. This applies only to those immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of immunization agents does not constitute sufficient evidence of immunization for this measure.

Also, good faith efforts to get a child immunized *which fail* remain "non-compliant" including:

- Parental failure to bring in the patient
- Parents who refuse for religious reasons
- Parents who refuse because of beliefs about vaccines

Similarly, "catch-up" schedules are not recognized for the purpose of this reporting.

PAP TESTS (Line 11)

PERFORMANCE MEASURE: The performance measure is "Percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer." (Note – this is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 should be included in the calculation of this measure.) This is calculated as follows:

- **Numerator:** Number of female patients 24 - 64 years of age receiving one or more documented Pap tests during the measurement year or during the two years prior to the measurement year among those women included in the denominator. Because of the difficulty in obtaining records from third parties, it is likely that a number of women will not be able to be counted as compliant, even though the grantee has referred the patient for services.
- **Denominator:** Number of all female patients age 24 - 64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women. For measurement year 2011, this includes patients with a date of birth between January 1, 1947 and December 31, 1987.

TOTAL NUMBER OF FEMALE PATIENTS 24 - 64 YEARS OF AGE, COLUMN (a)

Criteria: Enter the number of all female patients who:

- Were born between January 1, 1947 and December 31, 1987 *and*
- Were first seen by grantee prior to their 65th birthday *and*

- Had at least one medical visit in a clinical setting[6] during 2011.

Exclude women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient's history, through either administrative data or medical record review. Surgical codes for hysterectomy are: CPT (51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58551, 58552-58554, 58951, 58953-58954, 58956, 59135) and ICD-9-CM (68.4-68.8, 618.5) NOTE: Because very few Health Centers perform hysterectomies, the chance of finding these CPT codes is small. The record may, however, contain textual reference to the procedure, and should be searched for this in the event no current Pap test is identified.

If a system cannot determine exclusions from the universe, "excludable" women may be included in the universe and only later excluded from the sample, if identified. In these cases, a replacement record will be used[7].

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients from the universe (Column a) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column a), or a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. See discussion of sample size above on page 0.

If a woman in the random selection is found to meet the exclusion criteria, the record is excluded from the sample and another woman should be randomly selected to replace her. This can best be accomplished by selecting replacement cases at the same time that the random sample is identified.

NUMBER OF PATIENTS TESTED, COLUMN (c)
Enter the total number of female patients included in the sample who received one or more Pap tests in a three year period from 2009 through 2011. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. A patient is counted as having had a Pap test if a visit contains any one of the following codes or if a copy of a lab test performed by another provider is in the chart. A chart note which documents the name, date, and results from a test performed by another provider which is based on communications between the clinic and the provider is also acceptable. The following ICD-9

[6] The requirement of "in a medical setting" is explicitly designed to exclude from the universe women encountered by homeless or farmworker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit Pap tests to be conducted. Mobile clinics that are designated by the grantee as approved "sites" *are* considered to be clinical settings and women seen in these clinics *are* included in the universe.

[7] Since the universe for this measure will generally include thousands of women, the task of searching the charts of all non-compliant women would be problematic. If grantee chooses to use an EHR for this task which is not configured to identify surgical procedures provided outside of the clinic they will need to accept a slightly lower compliance rate.)

and/or CPT codes are evidence of compliance.

CPT (88141-88145, 88148, 88150, 88152-88155, 88164-88167, 88174-88175) ICD-9-CM (91.46)

Do not count as compliant, charts which note a referral to a third party but which do not include a copy of the lab report or a report of some form from the clinician/clinic that provided the test. Do not count as compliant unsubstantiated statements from patients which cannot be backed up with third party documentation.

WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS (Line 12)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 2[8] through 17 who had evidence of BMI *percentile* documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year." Note that this indicator is titled "2 through 17." Do not review the charts of any children who were not at least 3 years old during the measurement year. This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.
- **Denominator:** Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting year, and seen prior to their 17th birthday **OR** a sample of these patients. For measurement year 2011, this includes patients with a date of birth between January 1, 1994 and December 31, 2008.

TOTAL NUMBER OF PATIENTS 3 - 17 YEARS OF AGE, COLUMN (a)
Criteria: Enter the number of all patients who:

- Were born between January 1, 1994 and December 31, 2008 **AND**
- Were first seen ever by grantee prior to their 17th birthday **AND**
- Had at least one medical visit in a clinical setting[9] during 2011.

Exclusions: Pregnant patients.

[8] This measure commonly refers to patients who are *two* years old, however the specific compliance criteria is that they have the required services "within one year after reaching two years . . ." This means that a patient who is two (or two and a half) years old on December 31 and has not had the required counseling still has six months to a year to meet the criteria for compliance. Hence the use of "three years" as the criteria.

[9] The requirement of "in a medical setting" is explicitly designed to exclude from the universe children and adolescents whose only visits have been in homeless or farmworker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the grantee as approved "sites" *are* considered to be clinical settings and children and adolescents seen in these clinics *are* included in the universe.

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients included in the universe (Column a) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column a) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population. Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS WITH DOCUMENTED COUNSELING AND BMI PERCENTILE, COLUMN (c)
Enter the total number of patients identified in column b whose 2011 record demonstrates that their BMI percentile (not just height and weight or numeric BMI score from which the BMI percentile can be calculated) was documented during the measurement year **AND** that they received counseling on nutrition during the measurement year **AND** counseling on physical activity during the measurement year.

The following ICD-9 and/or CPT codes are evidence of compliance:

- Codes V85.5x are for recording BMI Percentile. Presence is sufficient, but not necessary.
- Codes 97802-97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary.
- ICD-9 code 65.41 is sufficient, but not necessary for physical activity counseling.

Do not count as compliant, charts which show *only* that a well child visit was scheduled, provided or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

ADULT WEIGHT SCREENING AND FOLLOW-UP (Line 13)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit **OR** within six months of the most recent visit **AND** if the most recent BMI is outside parameters, a follow-up plan is documented
  Denominator: Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, **OR** a sample of these patients. For measurement year 2011, this includes patients with a date of birth on or before December 31, 1993.

TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (a)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1993 **AND**
- Were last seen by grantee after their 18th birthday **AND**

- Had at least one medical visit in a clinical setting[10] during 2011.

Exclusions:
- Pregnant women
- Terminally ill patients

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients included in the universe (Column a) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column a) **OR** a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS WITH DOCUMENTED BMI AND COUNSELING IF WEIGHT IS OUTSIDE PARAMETERS, COLUMN (c)
Enter the total number of patients identified in Column b whose 2011 record demonstrates that their BMI (not just height and weight) was documented during their last visit or within six months prior to that visit, **AND** they received a follow-up plan to address their weight if they
- were under age 65 **AND** their BMI was over 25 **OR**
- were age 65 or older **AND** their BMI was over 30 **OR**
- were under age 65 **AND** their BMI was under 18.5 **OR**
- were age 65 or older **AND** their BMI was under 22

CPT / ICD-9: (CPT-II: 3008F = BMI documented)

Documentation in the medical record must show the actual BMI. Do not count as compliant, charts or templates which display *only* height and weight. The fact that an EHR is capable of calculating BMI does not replace the presence of the BMI itself.

TOBACCO USE ASSESSMENT (Line 14)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months." This is calculated as follows:
- **Numerator:** Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **OR** within 24 months of the most recent visit**.**
  Denominator: Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the

[10] The requirement of "in a medical/clinical setting" is explicitly designed to exclude from the universe patients whose *only* visits have been in homeless or farmworker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the grantee as approved "sites" *are* considered to be clinical settings and patients seen in these clinics *are* included in the universe.

reporting year, and with at least *two*[11] medical visits ever, **OR** a sample of these patients. For measurement year 2011, this includes patients with a date of birth on or before December 31, 1993.

TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (a)
Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1993 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit during 2011 **AND**
- Had at least two medical visits ever.

Exclusions:

- (None)

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients included in the universe (Column a) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column a) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS QUERIED ABOUT TOBACCO USE, COLUMN (c)
Enter the total number of patients identified in column b whose 2011 record demonstrates that they had been asked about their use of any and all forms of tobacco at their most recent visit or at a visit within 24 months of the last visit.

CPT / ICD-9: (CPT-II codes):

- 1000F = Tobacco use assessed
- 1034F = Current tobacco smoker
- 1035F = Current smokeless tobacco user (e.g., chew, snuff)
- 99406-07 = Smoking and tobacco use cessation counseling – sufficient, but not necessary
- 305.1, 649.00-649.04 = Tobacco use disorder – sufficient, but not necessary
- 1036F = Current tobacco non-user

TOBACCO CESSATION INTERVENTION (Line 15)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year (i.e., during 2010 or 2011) who received tobacco use intervention (cessation counseling and/or pharmacological intervention)." This is calculated as follows:

[11] Two visits are specified in order to ensure that the patient has a relationship with the grantee. The universe *may* be enlarged to include other patients whose relationship is demonstrated by having had a behavioral assessment, concomitant occupational therapy or concomitant mental health visits, however grantees are not expected to search for these patients.

- **Numerator:** Number of patients in the denominator who received tobacco cessation counseling or smoking cessation agents during their most recent visit **OR** within 24 months of the most recent visit**.**
  Denominator: Number of patients who were 18 years of age or older during the measurement year, seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty four months who had at least one medical visit during the reporting period, and at least *two*[12] medical visits ever, **OR** a sample of these patients. For measurement year 2011, this includes patients with a date of birth on or before December 31, 1993.

TOTAL NUMBER OF PATIENTS AGE 18 AND OVER, COLUMN (a)
Criteria: Enter the number of all patients who:
- Were born on or before December 31, 1993 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit during 2011 **AND**
- Had at least two medical visits ever **AND**
- Used any form of tobacco including smoked and smokeless tobacco

Exclusions:
- (None)

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)
Enter the total number of health center patients included in the universe (Column a) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column a) **OR** a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS WHO RECEIVED TOBACCO CESSATION INTERVENTION, COLUMN (c)
Enter the total number of patients identified in Column b whose 2011 record demonstrates that they had, within the past 24 months,
- Received tobacco use cessation **OR**
- Received an order for (a prescription or a recommendation to purchase) a smoking cessation medication. This medication may be a prescription or an OTC product. **OR**
- Been on (using) a smoking cessation agent.

CPT / ICD-9 (CPT-II codes):
- 1000F = Tobacco use assessed
- 1034F = Current tobacco smoker
- 305.1, 649.00-649.04 = Tobacco use disorder – sufficient, but not necessary
- 1035F = Current smokeless tobacco user (e.g., chew, snuff)

[12] Two visits are specified in order to ensure that the patient has a relationship with the grantee. The universe *may* be enlarged to include other patients whose relationship is demonstrated by having had a behavioral assessment or concomitant occupational therapy or concomitant mental health visits, however grantees are not expected to search for these patients.

- 1036F = Current tobacco non-user (indicative of patient to be excluded from universe)
- 4000F = Tobacco use cessation intervention counseling
- 99406-07 = Smoking and tobacco use cessation counseling – sufficient, but not necessary
- 4001F = Tobacco use cessation intervention – pharmacologic therapy

ASTHMA PHARMACOLOGIC THERAPY (Line 16)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication**.**
  Denominator: Number of patients who were between 5 and 40 years of age at some point during the measurement year, who have been seen at least twice in the practice and who had at least one medical visit during the reporting year, who had an active diagnosis of persistent asthma **OR** a sample of these patients. For measurement year 2011, this includes patients with a date of birth between January 1, 1971 and December 31, 2006.

TOTAL NUMBER OF PATIENTS AGE 5 THROUGH 40, COLUMN (a)

Criteria: Enter the number of all patients who:

- Were born on or after January 1, 1971 and on or before December 31, 2006 **AND**
- Were last seen by grantee while they were between 5 and 40 years of age **AND**
- Have been seen at least twice (not necessarily in the current year) **AND**
- Had at least one medical visit during 2011 **AND**
- Were diagnosed with *persistent*[13] asthma **OR** have persistent asthma as a current diagnosis on a chronic illness form or template.

Exclusions:

- Allergic reaction to asthma medications
- Individuals with a diagnosis of asthma who are discovered, upon review, to have intermittent mild asthma, not persistent asthma.

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN (b)

Enter the total number of health center patients included in the universe (Column a) for whom data have been reviewed. This will be **EITHER** all patients who fit the criteria (i.e., the same number as in Column a) **OR** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column

[13] It is the clear intent that the universe be limited to patients with *persistent* asthma and, specifically, that patients with mild intermittent asthma, for which no daily medication is needed, be excluded from the universe. But, while there are CPT Category II codes that differentiate between these conditions, there are no traditional ICD-9 codes which do so. Accordingly, a diagnosis of "asthma" (ICD-9 493.x) is permitted as an alternative criteria *or* as an initial screening methodology. Since the universe for this measure may include hundreds of patients, the task of searching the charts of all non-compliant patients may be very time consuming. If a grantee chooses to use an EHR for this task which is not configured to exclude intermittent asthma they will need to accept reporting a lower compliance rate.)

a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS WITH PERSISTENT ASTHMA WITH PHARMOCOLOGIC TREATMENT DOCUMENTED, COLUMN (c)

Enter the total number of patients identified in Column b whose 2011 record demonstrates that they had

- Received a prescription for or were using an inhaled corticosteroid **OR**
- Received a prescription for or were using an acceptable pharmacological agent, specifically: Cromolyn, a leukitriene modifier, nedocromil, or sustained release theophylline

CPT / ICD-9 (CPT-II codes):

- 493.x = Asthma
- 1038F = Persistent asthma (mild, moderate or severe)
- 1039F = Intermittent asthma (indicative of patient to be excluded from universe)
- 4015F = Persistent asthma, appropriate pharmacologic treatment prescribed

Do not count as compliant patients who are receiving a form of treatment other than pharmacologic treatment or whose only pharmacologic treatment is a short-acting bronchodilator for symptomatic relief.

QUESTIONS AND ANSWERS FOR TABLE 6B

1. **Are there any changes to the table this year?**
   Yes, five new preventive health care measures have been added and the vaccines included in the immunizations required by age two have changed.

2. **A child came in only once in 2011 for an injury and never returned for well child care. If her record is selected do we have to consider her chart to be out of compliance?**
   Yes. Once a patient enters a health center's system of medical care, the center is expected to be responsible for providing all needed preventive health care and/or document that they have received it.

3. **What if a woman we treat for hypertension and diabetes goes to an ObGyn in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not do Pap tests?**
   Once the patient has been seen in your clinic, you are responsible for providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to document Pap tests by contacting providers of Pap tests directly in order to obtain documentation by FAX, or by requesting that health center patients mail a copy of their test history, or through other appropriate means. The woman would be considered to be a part of your universe if she received ***any*** medical service(s) in 2011. If there is no copy of the results of her Pap test included in her chart, she would be considered out of compliance.

4. **If we pull a chart for a woman who we sent to the health department for her Pap test, but the results are not posted, can we call the health department, get the results, post them, and then count the chart as being in compliance?**
   The health center should obtain a copy of her test result to include in the patient's record for future care. However, the chart is still out of compliance for the reporting year (although the record may now be valid for successive years depending on when the test was performed).

5. **If we inform a parent of the importance of immunizations but they refuse to have their child immunized may we count the chart as being in compliance if the refusal is documented?**
   No. A child is fully immunized if and only if there is documentation the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, and history of illness for all required vaccines.

6. **Are parents required to bring to the health center documentation of childhood immunizations received from outside the health center?**
   Parents are encouraged to provide documentation of immunizations that their children receive elsewhere, but other mechanisms of obtaining this information are also acceptable. Health centers are encouraged to document childhood immunizations by contacting providers of immunizations directly in order to obtain documentation by FAX, or by requesting health center patients to mail a copy of their immunization history, or by finding the child in a state or county immunization registry or through other appropriate means. Health center patients should not be requested to return to the center merely to provide immunization documentation.

7. **Some of the immunization details are different than those used by CDC in the CASA or CO-CASA reviews of our clinic. May we use these CDC standards to report on the**

UDS?
No. In order to align the data from the UDS with data nationally, HRSA uses the vaccination specifics set forth by the National Quality Forum. Using a different set of standards will distort the data. Because data are being compared to Table 3A data, such misalignment may be detected in which case grantees will be asked to resample their data. A center *may* use a different set of standards for its own internal Quality Assurance program, but these may not be substituted for the HRSA rules defined for the UDS reporting on Table 6B.

8. **We want to use these reviews to compare our sites and our providers to one another. As a result we would like to use a larger universe. Is there any problem with this?**
Yes. First, all grantees using a sample must use 70 charts. This facilitates the development of State, national, and other roll-up reports. Second, and perhaps more important, any change in the sample size as described would bias the sample and provide distortions in the data set. A grantee *may* draw a larger random sample and use only the first 70 for the UDS, but the larger sample must be a random sample of the entire organization – it may not oversample specific sites or providers to facilitate internal QI activities.

9. **What happens if the CPT codes change again?**
The codes are reviewed annually by the UDS Help Line staff. If you think that there is a CPT code for a vaccine or a Pap test which is not being reflected in the list, contact the UDS Help Line. They will review the code with the BPHC and will incorporate approved changes to codes into the manual of future reporting.

10. **Is the Pap test review for women starting at age 21 or at age 24?**
For this measure you will look only at women who were 24 years or older (up to age 65) at some point in 2011. You will *not* look at any women who were 21, 22, or 23 years old at the end of 2011. Because the measure asks about Pap tests *administered* in 2011 *or* in 2010 or in 2009, it is possible that a 24 year old woman would have been 21 in 2009. If she received a Pap test in that year she would be considered to be in compliance. So we are looking only at women who are 24 through 64, but their qualifying test may have been received when they were 21 through 64. Grantees should take care to review charts *only* for women who were 24 through 64 in 2011 and should *not* select any charts for women who were younger.

11. **When the listing of CPT codes says "sufficient, but not necessary" what does this mean?**
The codes are generally for activities which, if undertaken, make it obvious that the criteria was met. But there are other ways to meet the criteria as well. For example, the code may be for "tobacco use disorder." If a provider codes this, it is clear that they have evaluated the patient for tobacco use and its presence in the chart is sufficient to document the evaluation. But this code is not necessary. The patient could have been evaluated for tobacco use without this diagnosis ever being made.

12. **Does "counseling for nutrition and . . . physical activity" have specific content that must be provided? Does it need to be provided if the child is well within the "normal" range?**
No – the counseling is tailored by the clinician given the patient's BMI percentile. Counseling is aimed at promoting routine physical activity and health eating for *all* children. Starting children off right is important in efforts to improve long-term health outcomes and quality of life.

13. **I have a patient who turned 2 in November of 2011. Should she be included in the Child and Adolescent weight measure? Does this measure start at age 2 or age 3?**
    No. The measure looks at children who were two, but allows the measurement to be recorded up to one year after her second birthday. Since she still has ten months for her BMI percentile to be charted and for her parents to receive counseling, she would not be included in the universe. For this measure you will look only at children who were 3 years or older (to age 17 – one year after 16th birthday) at some point in 2011. You will *not* look at any child who had not yet turned 3 or who was over 17 years old at the end of 2011. For children who are 3, the documentation for weight assessment and counseling may have been when they were 2.

14. **For adult patients, our protocol calls for a weight to be measured at every visit, but for height to be measured "at least once every two years." Is this acceptable?**
    BMI is calculated from current height and weight. Inasmuch as height in adults does not normally change more than a quarter of an inch in a two year period it is reasonable to follow such a protocol if it has been approved by your clinical staff.

15. **The indicator says that there must be effective intervention for tobacco users. Are there specific interventions that must be used in order to consider them effective?**
    No. This is at the discretion of the clinician and should be consistent with their assessment of the patient's level of tobacco use. As long as the clinician documents that they intervened and this intervention is consistent with the health center's own protocols, the treatment is in compliance for this measure.

16. **If our provider documents that they felt maintaining a dust free environment and a diet low in allergens coupled with a "rescue inhaler" is adequate to treat a persistent asthmatic, can we consider this patients treatment to be in compliance?**
    No. For persistent asthma one of the listed pharmacologic interventions is required. Rescue inhalers are not contraindicated, but they are not sufficient to meet the requirement of a pharmacologic intervention.

TABLE 6B – QUALITY OF CARE INDICATORS

(NO PRENATAL CARE PROVIDED? CHECK HERE: ☐)

SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS (GRANTEES WHO PROVIDE PRENATAL CARE ONLY)

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

	AGE	NUMBER OF PATIENTS (a)
1	LESS THAN 15 YEARS	
2	AGES 15-19	
3	AGES 20-24	
4	AGES 25-44	
5	AGES 45 AND OVER	
6	TOTAL PATIENTS (SUM LINES 1 – 5)	

SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE

	TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR	Women Having First Visit with Grantee (a)	Women Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

SECTION C – CHILDHOOD IMMUNIZATION

	CHILDHOOD IMMUNIZATION	TOTAL NUMBER PATIENTS WITH 2ND BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10	Children who have received age appropriate vaccines who had their 2nd birthday during measurement year (on or prior to 31 December)			

SECTION D – CERVICAL CANCER SCREENING

	PAP TESTS	TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11	Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

SECTION E – WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS

	CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING	TOTAL PATIENTS AGED 3 – 17 ON DECEMBER 31 (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12	Children and adolescents aged 3 - 17 with a BMI percentile, ***and*** counseling on nutrition and physical activity documented for the current year			

(NO PRENATAL CARE PROVIDED? CHECK HERE: ☐)				
SECTION F – ADULT WEIGHT SCREENING AND FOLLOW-UP				
ADULT WEIGHT SCREENING AND FOLLOW-UP		TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	Patients aged 18 and over with (1) BMI charted ***and*** (2) follow-up plan documented ***if*** patients are overweight or underweight			
SECTION G1 – TOBACCO USE ASSESSMENT				
TOBACCO ASSESSMENT		TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE (c)
14	Patients queried about tobacco use one or more times in the measurement year or prior year			
SECTION G2 – TOBACCO CESSATION INTERVENTION				
TOBACCO CESSATION INTERVENTION		TOTAL PATIENTS WITH DIAGNOSED TOBACCO DEPENDENCE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ADVISED TO QUIT (c)
15	Tobacco users aged 18 or older who have received cessation advice or medication			
SECTION H – ASTHMA PHARMACOLOGICAL THERAPY				
ASTHMA TREATMENT PLAN		TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16	Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

INSTRUCTIONS FOR TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

This table reports data on selected health outcome indicators by race and Hispanic/Latino ethnicity. The health outcome indicators are commonly seen in the health care community as indicators of overall community health. They are "intermediate outcome measures" which means that they document measurable outcomes of clinical intervention as a proxy for good long term health outcomes. Increasing the proportion of patients who have good intermediate health outcome, generally leads to improved health status of the patient population in the future. Specifically:

- Low Birthweight: *If* there are fewer low birthweight children born, *then* there will be fewer children who suffer the multiple negative sequela of low birthweight, such as delayed or diminished intellectual and/or physical development.
- Controlled Hypertension: *If* there is less uncontrolled hypertension, *then* there will be less cardiovascular damage, fewer heart attacks, less organ damage later in life.
- Controlled Diabetes: *If* there is less uncontrolled diabetes *then* there will be fewer amputations, less blindness, less organ damage later in life.

While the selected health outcome indicators give a good description of the overall quality of primary care being provided at the center, it is clear that this is a *subset* of possible health outcome indicators. Individual health centers may use other indicators in addition to these for their own internal QI program.

Table 7 reports health outcomes by race and Hispanic/Latino ethnicity to provide information on the extent to which health centers help reduce health disparities. Race and Hispanic/Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. *Note that using race and ethnicity data from the chart which is inconsistent with that in the registration data may result in errors in reporting!* Health centers who report on a sample of patients – and even those who report on their entire universe of patients – are cautioned against using their data to evaluate disparities given small sample sizes. However, on a state and national level, reported data will provide results which can be used to evaluate overall disparities for BPHC-funded programs.

The table is included only in the Universal Report.

HIV POSITIVE PREGNANT WOMEN, TOP LINE
All grantees are to report the total number of HIV positive pregnant women served by the health center on Line "0" *regardless of whether or not they provide prenatal care services*.

DELIVERIES PERFORMED BY GRANTEE PROVIDER (Line 2)
Report the total number of deliveries *performed by center clinicians* during the reporting period in Column i. (This line is not reported by the race or Hispanic/Latino ethnicity of the women delivered.) On this line ONLY, grantee is to include deliveries of women who were *not* part of the grantee's prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor's patients when the clinic provider participates in a call group and is on call at the time of delivery; emergency deliveries when the clinic

provider is on-call for the emergency room; and deliveries of patients who are assigned to the provider as a requirement for privileging at a hospital. Include as "health center clinicians" any clinician who is paid by the center while doing the delivery, regardless of the method of compensation. Do *not* include deliveries where a clinic doctor bills separately, receives, and retains payment for the delivery.

DELIVERIES AND LOW BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY, SECTION A (COLUMNS 1A – 1D)

Only grantees that provide, or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the grantee does the delivery, are required to complete Section A. All health center prenatal care patients who delivered during the reporting period, and all children born to them, are reported in Columns 1a – 1d. This table collects all the same data that prior iterations of the table have collected, but has been reformatted to improve ease of reading and ready understanding of the format.

PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Column 1a)

Report the total number of women who were enrolled in the grantee's prenatal care program in the reporting year or the prior year, who were known to have delivered during the reporting year. Grantees are responsible for reporting on these women even if the delivery was done by another provider. Grantees are required to follow up on women who are referred out, and to track and report their deliveries and birth outcomes. Include all women who had deliveries, regardless of the outcome, but do not include deliveries where you have no documentation that the delivery occurred (for example, for women who may have moved out of the area and/or who were lost to follow-up). This column collects data on "patients who delivered." Even if the delivery is of twins or triplets, the grantee is still to report *one* delivery.

BIRTHWEIGHT OF INFANTS BORN TO PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Columns 1b – 1d)

Report the total number of LIVE births during the reporting period for women who received prenatal care from the grantee or referral provider during the reporting period, according to the appropriate birthweight group. (Do not report still-births or miscarriages.)

> **NOTE:** Grantees must report birthweights for live children of **all** women who were in their prenatal care program and who delivered during the reporting period. *Data are reported regardless of whether the grantee did the delivery themselves, referred the delivery to another provider or the woman transferred to another provider on her own.*

The number of deliveries reported in Column 1a will normally not be the same as the total number of infants reported in Columns 1b – 1d because of multiple births and still births.

- **VERY LOW BIRTHWEIGHT (Column 1b) –** Report the total number of live children whose weight at birth was less than 1500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

- **LOW BIRTHWEIGHT (Column 1c) –** Report the total number of live children whose weight at birth was 1500 grams through 2499 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

- **NORMAL BIRTHWEIGHT (Column 1d) –** Report the total number of live children whose weight at birth was equal to or greater than 2500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

HYPERTENSION BY RACE AND HISPANIC/LATINO ETHNICITY, SECTION B (Columns 2a – 2c)

In this section, grantees report on findings from their reviews of current medical patients (i.e., medical patients who had at least two medical visits during the reporting period) who have been diagnosed as hypertensive at some point while they were a patient at the health center.

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates permit the recovery of 100% of the records of the patients which fit the sampling profile.

Very specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings.

Section B of Table 7 reports on all health center adult patients, 18 to 85 years of age, who have been diagnosed as hypertensive at any time before June 30 of the measurement year and who have been seen in the health center for medical services at least *twice* during the reporting year. (The diagnosis may have first been made in a year prior to the measurement year.)

PERFORMANCE MEASURE: The performance measure is "Proportion of patients born between January 1, 1921927 and December 31,1993 with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading." (NOTE: Many health centers use a different measure for their quality assurance process for their diabetic or dialysis patients. This may well be appropriate, but for the purposes of UDS reporting, the 140/90 measure must be used.) This is calculated as follows:

- **Numerator:** Number of patients in the denominator whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg.
- **Denominator:** All patients 18 to 85 years of age as of December 31 of the measurement year:
  - with a diagnosis of hypertension (HTN) and,
  - who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year,
  - and who have been seen for medical services at least *twice* during the reporting year
  - Or a statistically valid sample of 70 of these patients.

TOTAL PATIENTS AGED 18 TO 85 WITH HYPERTENSION, COLUMN 2a

Criteria: Enter the total number of patients by race and Hispanic/Latino ethnicity who meet all of the following criteria:

- Were born between January 1, 1927 and December 31, 1993 and,
- Have been seen at least twice during the reporting year for *any* medical service and,
- Have been diagnosed with hypertension (HTN) before June 30 of the measurement

year as evidenced by an ICD-9 code of 401.xx - 405.xx. It does not matter if hypertension was treated during the measurement year or is currently being treated. The notation of hypertension may appear during or prior to 2011. Hypertension may also be identified by finding any of the following statements in chart notes, however it is not assumed that all charts will be screened for these references:

- HTN
- High blood pressure (HBP)
- Elevated blood pressure
- Borderline HTN
- Intermittent HTN
- History of HTN

Statements such as "rule out hypertension," "possible hypertension," "white-coat hypertension," "questionable hypertension," and "consistent with hypertension" are not sufficient to confirm the diagnosis of hypertension if such statements are the *only references* to hypertension in the medical record.

Blood pressures (BP) that are **self-reported** by the patient such as when a patient calls in a blood pressure from home are generally not eligible unless a clinical management decision is made using that reading. If the patient is equipped with reliable technology and the provider is confident that the reading is reliable such that the provider is recording the automated BP reading and making prescription change or other decisions based on those readings, the health center can use the measurement.

Exclusions: Pregnant Patients, Patients with ESRD.

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN 2b

Enter the total number of hypertensive health center patients by race and Hispanic/Latino ethnicity (Column 2a) for whom data have been reviewed. This will ***either*** be all patients who fit the criteria ***or*** a scientifically drawn sample of 70 patients from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire universe identified in Column 2a. Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. The sampling method is described in Appendix C. If an EHR is present it may be used in lieu of a chart review of a sample of charts if and only if:

- The EHR includes every single clinic patient between the ages of 18 and 85 with diagnosed hypertension, regardless of whether or not they were specifically treated for hypertension.
- Blood pressure is regularly recorded in the EHR for all patients
- The EHR has been in place throughout the reporting year, and ideally for at least three years.

If the EHR is to be used, the number in Column 2b will be equal to the number in Column 2a. NOTE: Your PC-DEMS or PECS system may be used to report the universe ONLY IF it can be limited to a calendar year report and **only** if it includes all required data elements, e.g., it includes data for the required time frame for all hypertensive patients from all service sites.

PATIENTS WITH CONTROLLED BLOOD PRESSURE, COLUMN 2c

Hypertensive patients born between January 1, 1927 and December 31, 1993 whose charts

have been reviewed (those identified in Column 2b) whose systolic blood pressure measurement was less than 140 mm Hg *and* whose diastolic blood pressure was less than 90 mm Hg at the time of their last measurement in 2011 are reported in Column 2c by race and Hispanic/Latino ethnicity. (Patients who have not had their blood pressure tested during the reporting year will be counted as not meeting the performance measure.)

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS

1. Comparisons are made between the universe reported on Table 7, Column 2a, and the data reported on Table 3B. Under no circumstances may a grantee report more hypertensive Hispanic/Latinos or more hypertensive patients of any given race in Column 2a than are reported for that race or for the Hispanic/Latino ethnic group on Table 3B.

2. Under most circumstances persons with no reported race ***and*** no reported ethnicity (Row h) will be relatively small. Use Row h only if, when you ask a patient their race and whether or not they are Hispanic/Latino, they refuse to answer both questions. *Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.*

DIABETES BY RACE AND HISPANIC/LATINO ETHNICITY, SECTION C (Columns 3a – 3f)

In this section, grantees report on findings from their reviews of current medical patients (i.e., medical patients who had at least two medical visits during the reporting period) who have been diagnosed as Diabetic at some point while they were a patient at the health center:

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates permit the recovery of 100% of the records of the patients which fit the sampling profile.

Very specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in detail below and must be carefully followed to avoid misreporting findings.

This section of Table 7 reports on all health center patients 18 - 75 who have been diagnosed as diabetic at some point during their time as a patient at the health center.

PERFORMANCE MEASURE: The performance measure is "Proportion of adult patients born between January 1, 1937 and December 31, 1993, with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year." Grantees are to report results in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%. This is calculated as follows:

- **Numerator:** Number of adult patients whose most recent hemoglobin A1c level during the measurement year is $\leq$ 9% among those patients included in the denominator.
- **Denominator:** Number of adult patients aged 18 to 75 as of December 31 of the measurement year
  - with a diagnosis of Type I or II diabetes and,
  - who have been seen in the clinic for medical services at least *twice* during the reporting year,

- and do not meet any of the exclusion criteria whose chart was reviewed. Or a statistically valid sample of 70 of these patients

TOTAL PATIENTS AGED 18 - 75 WITH TYPE I OR II DIABETES, COLUMN 3a
Criteria: Enter the number of adult patients by race and Hispanic/Latino ethnicity who meet the following criteria:

- Were born between January 1, 1937 and December 31,1993 and,
- Have been seen at least *twice* for medical care during the reporting year,
- And have a diagnosis of diabetes. It does not matter if diabetes was treated or is currently being treated or when the diagnosis was made. The notation of diabetes may appear during or prior to the 2011 measurement year. To confirm the diagnosis of diabetes, one of the following must be found in the medical record:
  - ICD-9-CM Codes 250.xx, or 648.0, or
  - diabetic patients may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics.

Exclusions:
Exclude any patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year.[14] Note that patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0 or 251.8) reported during the measurement year are ***not*** to be included.

NUMBER OF CHARTS SAMPLED OR EHR TOTAL, COLUMN 3b
Enter the total number of diabetic health center patients by race and Hispanic/Latino ethnicity (Column 3a) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column 3a) or a scientifically drawn sample of 70 patients (using the methodology described in Appendix C) from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in Column 3a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients. If an EHR is present it may be used in lieu of a chart review of a sample of charts if and only if:

- The EHR includes every diabetic patient.
- Every item in the criteria is regularly recorded for all patients.
- The EHR has been in place throughout the performance year, and ideally for at least three years to permit identification of all diabetic patients.

If the EHR is to be used in lieu of the chart audit, the number in Column 3b will be equal to the number in Column 3a.

REPORTED HEMOGLOBIN A1c LEVELS, COLUMNS 3c through 3f
For this report, the last hemoglobin A1c (HbA1c) level taken in the measurement year as documented through laboratory data or medical record review, is reported. ***If there is no record of an HbA1c level being obtained during the measurement year, the chart will***

[14] If a search is made for pharmaceuticals that are used to treat diabetes, a person with these various conditions might be identified in error – hence this exclusion. If no search is done for pharmacy identification of patients, this can be ignored.

be reported in Column 3f: "greater than 9.0% or no test during the year." Patients with no test during the measurement year are included as non-compliant along with those who have poor HbA1c control.

- **Patients with HbA1c < 7% (Column 3c):** Number of patients included in Column 3b whose most recent HbA1c was less than 7%.
- **Patients with 7% ≤ HbA1c < 8% (Column 3d):** Number of patients included in Column 3b whose most recent HbA1c was greater than or equal to 7%, but less than 8%.
- **Patients with 8% ≤ HbA1c ≤ 9% (Column 3e):** Number of patients included in Column 3b whose most recent HbA1c was greater than or equal to 8% and less than or equal to 9%.
- **Patients with HbA1c > 9% or No Test During Year (Column 3f):** Number of patients included in Column 3b whose most recent HbA1c was greater than 9% ***and*** patients who did not receive an HbA1c test during the reporting year or whose test result is missing.

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS:

1. Comparisons are made between the universe reported on Table 7, Column 3a and the data reported on Table 3B. Under no circumstances may a grantee report more diabetic Hispanic/Latinos or more patients from any given race reported in Column 3a than are reported for that race or for the Hispanic/Latino ethnic group on Table 3B.

2. Under most circumstances persons with no reported race ***and*** no reported ethnicity (Row h) will be relatively small. Use Row h only if, when you asked a patient their race and whether or not they are Hispanic/Latino, they refused to answer both questions. *Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.*

QUESTIONS AND ANSWERS FOR TABLE 7

1. **Are there any changes to the table this year?**
   No change has been made to the content, however the columns and rows have been switched to permit display of the data in the same format as is used for Table 6B. In addition, the HbA1c levels to report have been expanded to include the ranges 7% $\leq$ HbA1c < 8% and 8% $\leq$ HbA1c $\leq$ 9%.

2. **When would we use Row h?**
   Row h will be used infrequently. It is to be used only in those instances where a patient refuses to provide their race and refuses to state whether or not they are Hispanic/Latino. Patients who provide a race, but do not answer affirmatively to a question about Hispanic/Latino ethnicity are to be classified as Non-Hispanic/Latino and reported on the appropriate Line 2a – 2g.

3. **Data are requested by race and Hispanic/Latino ethnicity. How are these to be coded?**
   Race and Hispanic/Latino ethnicity are coded on this table in the exact same manner that is used for coding on Table 3B. Refer to instructions for Table 3B for further information.

4. **Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**
   Patients are encouraged to provide documentation of HbA1c immunizations received elsewhere, but this is not required. Health centers are encouraged to document HbA1c tests by contacting providers of tests directly in order to obtain documentation by FAX, or by requesting health center patients to mail a copy of test results, or through other appropriate means. Health center patients should not be requested to return to the center merely to provide test documentation, however failure to document results means that the patient must be reported as out of compliance.

5. **We want to use these reviews to compare our sites and our providers to one another. As a result, we would like to use a larger universe. Is there any problem with this?**
   Yes. First, all grantees using a sample ***must use 70 random charts***. This facilitates the development of State, national, and other roll-up reports. Second, and perhaps more important, any change in the sample size as described would bias the sample and provide distortions in the data set.

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Section A: Deliveries and Birth Weight by Race and Hispanic/Latino Ethnicity

0	HIV Positive Pregnant Women	
2	Deliveries Performed by Grantee's Providers	

Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: =>2500 grams (1d)
Hispanic/Latino					
1a	Asian				
1b1	Native Hawaiian				
1b2	Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
Non-Hispanic/Latino					
2a	Asian				
2b1	Native Hawaiian				
2b2	Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
Unreported/Refused to Report Ethnicity					
h	Unreported/Refused to Report Race and Ethnicity				
i	***Total***				

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Section B: Hypertension By Race and Hispanic/Latino Ethnicity

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a	Asian			
1b1	Native Hawaiian			
1b2	Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic/Latino			
Non-Hispanic/Latino				
2a	Asian			
2b1	Native Hawaiian			
2b2	Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic/Latino			
Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity			
i	***Total***			

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Section C: Diabetes by Race and Hispanic/Latino Ethnicity

#	Race and Ethnicity	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%<= Hba1c <8% (3d)	Patients with 8%<= Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)
Hispanic/Latino							
1a	Asian						
1b1	Native Hawaiian						
1b2	Pacific Islander						
1c	Black/African American						
1d	American Indian/Alaska Native						
1e	White						
1f	More than One Race						
1g	Unreported/Refused to Report Race						
	Subtotal Hispanic/Latino						
Non-Hispanic/Latino							
2a	Asian						
2b1	Native Hawaiian						
2b2	Pacific Islander						
2c	Black/African American						
2d	American Indian/Alaska Native						
2e	White						
2f	More than One Race						
2g	Unreported/Refused to Report Race						
	Subtotal Non-Hispanic/Latino						
Unreported/Refused to Report Ethnicity							
h	Unreported/Refused to Report Race and Ethnicity						
i	***Total***						

INSTRUCTIONS FOR TABLE 8A – FINANCIAL COSTS

Table 8A must be completed by all BPHC grantees. It is included only in the Universal Report. The table covers the **total cost** of all activities which are within the scope of the project(s) supported, in whole or in part, by any of the four BPHC grant programs covered by the UDS including costs covered by an ARRA grant. All costs are to be reported on an accrual basis. These are the costs attributable to the reporting period, including depreciation, regardless of when actual payments were made. (Hence, only depreciation is reported for capital investments including ARRA – CIP or FIP grants.) Under UDS rules grantees do not report bad debts or the repayment of the principle of a loan on Table 8A, though they do show interest as an expense.

DIRECT, OVERHEAD, AND LOADED COSTS (COLUMN DEFINITIONS)

Column A: This column reports the accrued direct costs associated with each of the cost centers/services listed. See Line Definitions for costs to be included in each category. Column A also reports the total cost of overhead (administration and facility) separately on Lines 14 and 15.

Column B: This column shows the allocation of overhead costs (from Lines 14 and 15, Column A) to each of the direct cost centers.

- The total of facility and administration costs, reported in Column A, Lines 14 and 15, are to be distributed in Column B. The total amounts entered in Column B will thus equal the amount reported on Line 16, Column A. Lines 1 and 3 both refer to aspects of the medical practice. It is acceptable to report all medical overhead on Line 1 if a more appropriate allocation between Lines 1 and 3 is not available.
- *All* pharmacy overhead is to be allocated to the non-supply line (Line 8a). No overhead costs are reported on the pharmaceutical supplies line (Line 8b) which is blacked out in the reporting software.

The allocation of administration and facility costs should be done as follows, unless your center has a more accurate system:

FACILITY COSTS should be allocated based on the amount of square footage utilized for each of the cost centers including Medical, Lab and X-ray, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, Vision, Enabling, Other Program Related Services, and Administration. Square Footage refers to the portion of the grantee's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. Note that hallways and similar shared space *within a dedicated area* are assigned to that area. For example, the hallways inside of the medical suite that connects the exam rooms and the doctor's offices and the medical supply closets are considered medical space, not "common space."

For reporting purposes, the square footage associated with space owned by the grantee and leased or rented to other parties should not be included if it is considered to be outside of the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Program Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenue (Line 10).

Grantees who use an alternative allocation method that better allocates facility costs may use it, but should be sure to save back-up paperwork for review and explain the methods used in the table note. Alternative methods often include the allocation of the cost of each building separately – especially when the square foot costs of multiple buildings varies dramatically.

ADMINISTRATIVE COSTS should be allocated after facility costs have been allocated, and should include the facility costs allocated to administration. Administrative cost is allocated based on a straight line allocation method. The proportion of total cost (excluding facility cost) that is attributable to each service category should be used to allocate administrative cost. For example, if medical staff account for 50 percent of total cost (excluding administration) then 50 percent of administrative cost is allocated to medical staff. Grantees who use an alternative method that provides more accurate allocations may use it, but should be sure to save backup paperwork for review and explain the methods used in the table note.

Column C: This column shows the "fully loaded" cost of each of the cost centers listed on Lines 1 - 13. The fully loaded cost is the sum of the direct cost, reported in Column A, plus the allocation of overhead, reported in Column B. This calculation is now done automatically in the online reporting system. Column C also shows the value of any donated facilities, services and supplies on Line 18. These *non-cash* donations should be reported as a positive number, and are not included in any of the lines above. Note that this is the only place that the value of non-cash donations are shown. Non-cash donations are never reported on Table 9E. Line 19, Column C is the total cost including the value of donations. All UDS calculations which are based on "cost" are calculated based on total costs shown on Line 17 and exclude the value of donated services supplies or facilities.

BPHC MAJOR SERVICE CATEGORIES (LINE DEFINITIONS)

MEDICAL CARE SERVICES (Lines 1 - 4) – This category includes costs for medical care personnel; services provided under agreement; X-ray and laboratory; and other direct costs wholly attributable to medical care (e.g., staff recruitment, equipment depreciation, supplies, and professional dues and subscriptions). It does not include costs associated with pharmacy, dental care, substance abuse specialists, mental health (psychiatrists, clinical psychologists, clinical social workers, etc.), or vision care (ophthalmologists, optometrists, optometric assistants, etc.) services.

MEDICAL STAFF COSTS (Line 1) – Include all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, for medical care staff except lab and x-ray staff. The costs for staff dedicated to the operation of the EHR are also included on Line 1. The accrued cost (if any) of interns and residents who were paid or paid for, either directly or through a contract with their teaching institution, are reported on Line 1. The costs of intake, medical records, and billing and collections are considered administrative and should be included on Line 15 and then allocated in Column B. Include the cost for vouchered or contracted medical services on Line 1. Include the cost of any medical visit paid for directly by the center, such as at-risk specialty care from an HMO contract or other specialty care on Line 1.

Beginning in 2011 grantee providers will become eligible for the Meaningful Use EHR Incentive Payments. In the event a health center opts to permit one or more provider

to retain these payments, the amounts retained should be shown on this line as well. The income received from Medicare or Medicaid is reported on Table 9E Line 3a.

MEDICAL LAB AND X-RAY COSTS (Line 2) – Include all costs for medical lab and x-ray, including salaries and fringe benefits for personnel supported directly or under contract, for lab and x-ray staff; and all other direct costs including, but not limited to, supplies, equipment depreciation, related travel, contracted or vouchered lab and x-ray services, etc. The costs of intake, medical records, billing, and collections are considered administrative and should be included on Line 15 and allocated in Column B. Note that dental lab and x-ray costs are reported on the dental line, Line 5.

OTHER DIRECT MEDICAL COSTS (Line 3) – Include all other direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, CME registration and travel, laundering of uniforms, recruitment, membership in professional societies, books, and journal subscriptions, etc. The cost of EHR are reported on Line 3 including but not limited to the depreciation on the software and hardware, training costs, licensing fees, etc.

TOTAL MEDICAL (Line 4) – The sum of Lines 1 + 2 + 3.

OTHER CLINICAL SERVICES (Lines 5 - 10) – This category includes staff and related costs for dental, mental health, substance abuse services, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, and podiatrists).

DENTAL (Line 5) – Report all costs for the provision of dental services including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, dental lab services and dental x-ray. Corporate administrative costs and facility costs should be shown first on Line 15 Column A and then allocated to dental in Column B.

MENTAL HEALTH (Line 6) – Report all direct costs for the provision of mental health services, *other than substance abuse services,* including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology. Corporate administrative costs and facility costs should be shown first on Line 15 Column A and then allocated to Mental Health in Column B. (See also Q & A discussion for Table 5 on page 42.)

SUBSTANCE ABUSE (Line 7) – Report all direct costs for the provision of substance abuse services including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs, as should associated staff on Table 5. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology. Corporate administrative costs and facility costs should be shown first on Line 15 Column A and then allocated to Substance Abuse in Column B. (See also Q & A discussion for Table 5 on page 42.)

PHARMACY (NOT INCLUDING PHARMACEUTICALS) (Line 8a) – Report all direct costs for the provision of pharmacy services including but not limited to staff, fringe

benefits, non-pharmaceutical supplies, equipment depreciation, related travel, contracted purchasing services, etc., *but excluding the cost of pharmaceuticals*. All corporate administrative costs and facility costs for *both* Lines 8a and 8b should be shown first on Line 15 Column A and then allocated to Pharmacy on line 8a Column B. Include 100% of the cost of clinical pharmacists on this line.

PHARMACEUTICALS (Line 8b) – Report all direct costs for the purchase of pharmaceuticals, including the cost of vaccines and other injectable drugs. Do not include other supplies. Do **not** include the value of donated pharmaceutical supplies (these **are** recorded on Line 18, Column C). No space is provided to report the overhead costs associated with the purchase of pharmaceuticals. To the extent that there are such costs (they may well be lower than what would otherwise be calculated) they are combined with pharmacy costs and reported on Line 8a.

OTHER PROFESSIONAL (Line 9) – Report all direct costs for the provision of other professional and ancillary health care services including but not limited to: podiatry, chiropractic, acupuncture, naturopathy, speech, occupational and physical therapy, etc. (A more complete list appears at Appendix A.) (Note that vision care, which had previously been included on this line, is now reported separately on Line 9a below.) Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative costs and facility costs should be shown first on Line 15 Column A and then allocated to "Other Professional" in Column B. Note that there is a cell to "specify" the other professional costs reported on this line.

VISION (Line 9a) – Report all direct costs for the provision of vision services including optometry, ophthalmology, and vision support staff. Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative costs and facility costs should be shown first on Line 15 Column A and then allocated to "Vision" in Column B.

TOTAL OTHER CLINICAL (Line 10) – The sum of Lines 5 + 6 + 7 + 8a + 8b + 9 + 9a.

ENABLING AND OTHER PROGRAM RELATED SERVICES (Lines 11 - 13) – This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, eligibility assistance — including pharmacy assistance program eligibility, environmental risk reduction, and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. It also includes the cost of staff and related costs for other program related services such as WIC, day care, adult day health care, job training, delinquency prevention, and other activities not included in other BPHC categories.

ENABLING (Line 11) – Enabling services include a wide range of services which support and assist primary medical care and facilitate patient access to care. Line 11 is calculated automatically as the total of the detail lines. It includes all direct costs for the provision of enabling services including but not limited to costs such as staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative costs and facility costs should be reported first on Line 15 Column A and then allocated to enabling in Column B.

Lines 11a – 11g provide room to detail six specific types of enabling services as well as an

"other" category for all other forms of enabling services:

- Case Management (11a)
- Transportation (11b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (including pharmacy program eligibility) (11e)
- Translation/Interpretation Services (11f)
- Other (11g)

If the "other" category is used, there is room to “specify” the other forms of enabling services included on this line.

OTHER PROGRAM RELATED (Line 12) – Report all direct costs for the provision of services not included in any other category here. This includes services such as WIC, childcare centers, adult day healthcare centers, and training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel and contracted services. (Staff for these programs are reported on Line 29a of Table 5.) Corporate administrative and facility costs should be reported first on Line 15 Column A and then allocated in Column B to other program related costs. Grantees are asked to describe the program costs in the “specify” field provided.

TOTAL ENABLING AND OTHER PROGRAM RELATED SERVICES (Line 13) – The sum of Lines 11 + 12.

FACILITY AND ADMINISTRATIVE COSTS (Lines 14 - 16) – This includes all traditional overhead costs that are later allocated to other cost centers. Specifically:

FACILITY COSTS (Line 14) – Facility costs include rent or depreciation, facility (mortgage) interest payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs.

ADMINISTRATIVE COSTS (Line 15) – Administrative costs include the cost of all corporate administrative staff, billing and collections staff, medical records and intake staff, and the costs associated with them including, but not limited to, supplies, equipment depreciation, travel, etc. In addition, include other corporate costs (e.g., purchase of insurance, audits, legal fees, interest payments on non-facility loans, Board of Directors' costs, etc.). The cost of all patient support services (e.g., medical records and intake) should be included in Administrative Costs. Note that the "cost" of bad debts is **NOT** to be included in administrative costs or shown on this table in any way. Instead, the UDS reduces gross income by the amount of patient bad debt on table 9D.

NOTE: Some grant programs have limitations on the proportion of **grant funds** that may be used for administration. **Limits on administrative costs for those programs is not to be considered in completing Lines 14 and 15.** The Administration and Facility categories for this report includes **all** administrative costs and personnel working in a BPHC-supported program, whether or not that cost was identified as administrative in any specific grant application.

TOTAL OVERHEAD (Line 16) – The sum of lines 14 + 15.

TOTAL ACCRUED COST (Line 17) – It is the sum of Lines 4 + 10 +13 + 16.

VALUE OF DONATED FACILITIES, SERVICES, AND SUPPLIES (Line 18) – Include here the total imputed value of all in-kind and donated services, facilities, and supplies applicable to the reporting period that are within your scope of project, using the methodology discussed below. In-kind services and donations include all services (generally volunteers, but sometimes paid staff donated to the grantee by another organization), supplies, equipment, space, etc., that are necessary and prudent to the operation of your program that you do not pay for directly and which you included in your budget as donated. Line 18 reports the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment. The value of these services should not be included in Column a on the lines above.

The estimated reasonable acquisition cost should be calculated according to the cost that would be required to obtain similar services, supplies, equipment,or facilities within the immediate area at the time of the donation. Donated pharmaceuticals, for example, would be shown at the price that would be paid under the Federal drug pricing program, not the manufacturer's suggested retail price. Donated value should only be recognized when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the grantee's operation.

If the grantee is not paying NHSC for assignees, the full market value of National Health Service Corps (NHSC) Federal assignee(s), including "ready responders," should also be included in this category. NHSC-furnished equipment, including dental operatories, should be capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expense should be shown in this category for the reporting period.

Grantees are asked to describe the donated items using the “specify” field provided.

TOTAL WITH DONATIONS (LINE 19) – It is the sum of Lines 17 and 18, Column C.

NOTE: As staff make up 70%+ of the cost of most health centers, there is a direct relationship between the staffing included on Table 5 and expenses on Table 8A. Report as follows:

FTEs reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical providers and clinical support staff	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16 – 18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a – 20c: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists, etc.)	9: Other Professional
22a-22c: Vision Services (Ophthalmologist, Optometrist, Optometric Assistant, Other Vision Care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs/services (e.g., non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

CONVERSION FROM FISCAL TO CALENDAR YEAR

Grantees whose cost allocation system permits them to provide accurate accrued cost data should use that system. Grantees whose fiscal year does not correspond to the calendar year and whose accounting system is unable to provide accurate accrued cost data may calculate calendar year costs, using the following straight-line allocation methodology:

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. EXAMPLE: A grantee whose fiscal year ends March 31, 2011, allocates 25 percent of costs in each cost category to the 2011 calendar year.

Step 2: Using the trial balance for the end of December, determine the total cost for the remainder of the calendar year for each column. For example, a grantee whose fiscal year ends March 31, 2011 would use the nine-month trial balance for December 31. (NOTE: Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.)

Step 3: Sum results of Steps 1 and 2 and enter the total in Column A.

QUESTIONS AND ANSWERS FOR TABLE 8A

1. **Are there any changes to this table?**
   There is one minor technical change for 2011. Prior to this year vision services were included in the "other professional" cost center (Line 9). This year a new line (9a) has been provided to show the cost of vision services and their direct and indirect costs should be moved here.

2. **My auditor says that the cost of bad debts must be reflected in my financial statement as a cost. Where do I show it on Table 8A?**
   Your auditor is correctly explaining *audit rules*. The UDS report does not follow all FASBI and GAAP accounting rules and this is an example of one of those rules which is treated differently. Bad debt is not shown as a cost. Instead, it is shown (accounted for) on Table 9D where it is viewed by BPHC as an adjustment to income.

3. **How are donated services accounted for?**
   If a provider comes to your health center and renders a service to your patients, you show both the FTE (on Table 5) and the value, which is determined by "what a reasonable person would pay" *for the time (not the service),* on Table 8A, Line 18. For example, if an Optometrist sees five patients in a two hour period, the amount shown is what you would pay an Optometrist for two hours of work, not the total charges for the five visits. *However,* if you refer a patient for a service to a provider outside of your site who donates these services *neither the charge nor the value of the time or service is reported on the UDS.* For example, if you refer a patient to the county hospital for a hip replacement which is provided to your patient at no cost to you or the patient, neither the time of the surgical team nor the UCR charge for the service is reported on the UDS. The same would be true of mammograms done at the County Health Department.

4. **How are donated drugs accounted for?**
   If drugs are donated directly to the health center which then dispenses them to a patient, the value of the drugs is *calculated at what a reasonable payor would pay for them* and is reported on Table 8A, Line 18. This is NOT the retail cost of the drug, it is the 340(b) price of the drug – an amount which is generally 40% - 60% of the average wholesale price (AWP). *Technically* if the drug is donated directly to the patient, even though it may be sent to the health center, this is not a donation to the center and need not be accounted for or reported. But since we are interested in knowing the total value of supplies provided to you *directly or indirectly,* grantees are encouraged to include the value of such drugs on Line 18 as well.

5. **We get most of our vaccines through Vaccines For Children (VFC) or other State and county programs. Are these considered to be donated drugs and accounted for here?**
   Yes. The value of donated drugs that are used in the clinic, such as vaccines, should also be reported on Table 8A, Line 18, again at the reasonable cost.

6. **What part of my ARRA grant is reported on Table 8A?**
   Table 8A reports on your total accrued costs including all costs supported by ARRA. But, because it is an accrual process, it will generally *not* include the cash outlays for capital expenses supported by your ARRA CIP and/or FIP grants. It *will* include the 2011 depreciation on those capital projects which have been placed in use, consistent with the health center's usual depreciation rules. Do *not* include the new funds received from the ACA CHC fund to offset the expiration of the ARRA support of NAP or IDS funds. These

new funds are reported on Line 3a of Table 9E.

7. **My doctors were paid the EHR Incentive Payments directly by CMS. If I let them keep some or all of these dollars are they reported anywhere on Table 8a?**
   Yes. Health centers are expected to establish reporting mechanisms for their providers to inform them of payments received and to account for all of these funds. If providers are permitted to retain some or all of these funds they are to be reported on Table 9e Line 3a.

TABLE 8A – FINANCIAL COSTS

		Accrued Cost (a)	Allocation of Facility and Administration (b)	Total Cost After Allocation of Facility and Administration (c)
Financial Costs for Medical Care				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 Through 3)			
Financial Costs for Other Clinical Services				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify _____)			
9a	Vision			
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9a)			
Financial Costs of Enabling and Other Program Related Services				
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11 f.	Interpretation Services			
11g.	Other Enabling Services (specify: _____)			
11.	Total Enabling Services Cost (Sum Lines 11a through 11g)			
12.	Other Related Services (specify:_____)			
13.	**TOTAL ENABLING AND OTHER SERVICES (Sum Lines 11 and 12)**			
Overhead and Totals				
14.	Facility			
15.	Administration			
16.	**TOTAL OVERHEAD** (Sum lines 14 and 15)			
17.	**TOTAL ACCRUED COSTS** (Sum Lines 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services, and Supplies (specify: _____)			
19.	**TOTAL WITH DONATIONS** (Sum Lines 17 and 18)			

INSTRUCTIONS FOR TABLE 9D – PATIENT RELATED REVENUE

Table 9D must be completed by all BPHC grantees covered by the UDS. It is included only in the Universal Report. This table collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off. The statute requires that ***all*** health centers have a fee schedule and that they charge patients and/or their third party payors. This does not preclude the center from discounting these fees (see discussion regarding Sliding Discounts below, page 100) but there must be charges.

ROWS: PAYOR CATEGORIES AND FORM OF PAYMENT

Five payor categories are listed: Medicaid, Medicare, Other Public, Private, and Self Pay. Except for Self Pay, each category has three sub-groupings: non-managed care, capitated managed care, and fee-for-service managed care.

MEDICAID – LINES 1 - 3. Grantees should report as **"Medicaid"** all services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. For example, in States with a capitated Medicaid program, where the grantee has a contract with a private plan like Blue Cross, the payor would be considered to be Medicaid, even though the actual payment may have come from Blue Cross. Note that EPSDT (the childhood Early and Periodic Screening, Diagnosis and Treatment program), which has various names in different States, is a part of Title XIX and is included in the numbers reported here – almost always on Line 1. Note also that CHIP (or CHIP-RA), the Children's Health Insurance Program, which also has many different names in different States, is sometimes paid through Medicaid. If this is the case, it should be included in the numbers reported here. Also included here will be a portion of the charges for "cross-over" services that are reclassified to Medicaid after being initially submitted to Medicare. In a small number of cases Medicaid patients are enrolled in a “share of cost” program where they pay some portion of the fee as a co-payment or a deductible. In this case, the patient’s share of the cost is reclassified to self pay.

MEDICARE – LINES 4 - 6. Grantees should report as **"Medicare"** all services billed to and paid for by Medicare (Title XVIII) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. Specifically, for patients enrolled in a capitated Medicare program, including Medicare Advantage, where the grantee has a contract with a private plan like Blue Cross, the payor is Medicare, even though the actual payment may have come from Blue Cross. If a patient is covered by both Medicare and Medicaid, or by Medicare and a private payor, some portion of the charge will be reclassified to these other payment sources, and patient co-payments will be reclassified to “self pay.”

OTHER PUBLIC – LINES 7 - 9. Grantees should report as **"Other Public"** all services billed to and paid for by State or local governments through programs *other than indigent care programs.* The most common of these would be CHIP, the Children's Health Insurance Program, which has many different names in different States, *when it is paid for through commercial carriers.* (See above if CHIP is paid through Medicaid.) Other Public also includes family planning programs including but not limited to Title X

programs, BCCCP (Breast and Cervical Cancer Control Programs with various State names), and other dedicated State or local programs. With the implementation of health reform, we also anticipate a potential growth in State insurance plans, which will join plans such as Washington's Basic Health Plan or Massachusetts' Commonwealth Plan. **Other Public does not include State or local indigent care programs.** Patients whose only payment source is one of these State or local indigent care programs are reported as "uninsured" on Table 4 and their charges, collections, etc., are reported on the self-pay line, Line 13.

NOTE: Reporting on State or local indigent care programs that subsidize services rendered to the uninsured is as follows:

- Report all charges for these services and collections from patients as "self-pay" (Line 13 Columns a and b of this table);
- Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on Line 13 Columns e and f of this table; and
- Report collections from the associated State and local indigent care programs on Table 9E and specify the program paying for the services. State/local indigent care programs are reported on Line 6a on that table.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program or with the UDS Help line.

PRIVATE – LINES 10 - 12. Grantees should report as "**Private**" all services billed to and paid for by commercial insurance companies or by other third party payors. Specifically, *do not* include any services that fall into one of the other categories. As noted above, charges etc., for Medicaid, Medicare, and CHIP programs which use commercial programs as intermediaries are classified elsewhere. Private insurance *includes* insurance purchased for public employees or retirees such as Tricare, Trigon, and the Federal Employees Insurance Program, as well as Workers Compensation. Private may also include contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis such as a Head Start program that pays for annual physical exams at a contracted rate, or a school, jail or large company that pays for provision of medical care at a per-session or negotiated rate.

SELF PAY – LINE 13. Grantees should report as "**Self Pay**" all services and charges where the responsible party is the patient, *including charges for indigent care programs* as discussed above under "other public." **NOTE: This includes the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals which become the patient's personal responsibility.**

COLUMNS: CHARGES, PAYMENTS, AND ADJUSTMENTS RELATED TO SERVICES DELIVERED (REPORTED ON A CASH BASIS)

FULL CHARGES THIS PERIOD – COLUMN A. Record in Column A the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category. Charges should only be recorded for services that are billed to **AND** covered in whole or in part by a payor, or the patient, even if some of the latter are written off with sliding discounts. Full gross charges should always be reported. The difference between these and contracted payments are then adjusted as "contractual allowances" (see below). Some patients have more than one source of payment for their services. In these instances, a charge

will initially be made to one carrier, who may deny some or all of the charge. The unpaid portion will then be moved to the secondary payor, and to a tertiary payor if one exists and, eventually, to the patient as a self-pay charge.

Charges that are generally not billable or covered by traditional third-party payors should not be included on this table. For example, a charge for parking or for job training would not normally be included. WIC services are not billable charges. Charges for transportation and similar enabling services would not generally be included in Column A, except where the payor (e.g., Medicaid) accepts billing and **pays** for these services.

Charges for eyeglasses, pharmaceuticals, durable medical equipment, and other similar supply items must be included. Charges for pharmaceuticals, including vaccines, which are donated to the clinic or directly to a patient through the clinic should not be included since the clinic may not legally charge for these drugs. Charges for dispensing these pharmaceuticals, may, however, be included.

Charges which are not accepted by a payor and which need to be reclassified (including deductibles and co-insurance) should be reversed as negative charges if your MIS system does not reclassify them automatically. Reclassifying these charges by utilizing an *adjustment* and rebilling to another category is an incorrect procedure since it will result in overstatement by including the charges twice as well as the adjustments and payments.

NOTE: Under no circumstances should the actual amount paid by Medicaid or Medicare (such as FQHC rates) or the amount paid by any other payor be used as the actual charges. Charges *must* come from the grantee's CPT based fee schedule.

AMOUNT COLLECTED THIS PERIOD – COLUMN B. Record in Column b the gross receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered. *This includes the FQHC reconciliations, managed care pool distributions, court settlements, and other payments recorded in columns c1, c2, c3, and/or c4*. Note: Charges and collections for deductibles and co-payments which are charged to, paid by, and/or due from patients are recorded as "self pay" on Line 13.

RETROACTIVE SETTLEMENTS, RECEIPTS, OR PAYBACKS – COLUMNS C1-C4. *IN ADDITION TO INCLUDING THEM IN COLUMN b*, details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns c1-c4.

COLLECTION OF RECONCILIATION/WRAP AROUND, CURRENT YEAR – COLUMN C1. Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level – most common in managed care programs) from Medicare, Medicaid, or Other Public payors that cover services provided during the current reporting period.

COLLECTION OF RECONCILIATION/WRAP AROUND, PREVIOUS YEARS – COLUMN C2. Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level – most common in managed

care programs) from Medicare, Medicaid, or Other Public payors that cover services provided during previous reporting periods. Include multi-year settlements here.

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOLS, INCENTIVES, AND WITHHOLDS – COLUMN C3. Enter other cash payments including managed care risk pool redistribution, incentives including "pay for performance" incentives, and withholds, from any payor. Include settlements which may result from a court decision which requires a payor to make a settlement including a multi-year settlement. These payments may apply to either a managed care or non-managed care payor.

NOTE: Do *not* include EHR Incentive payments from Medicaid or Medicare in this column. These payments are recorded separately on Table 9E, Line 3a.

PENALTY/PAYBACK – COLUMN C4. Enter payments made to FQHC payors because of overpayments collected earlier. Also enter "penalty" payments made to managed care plans for over-utilization of the inpatient or specialty pool funds. (This is now a rare occurrence.)

NOTE: If a center arranges to have their "repayment" deducted from their monthly payment checks, the amount deducted should be shown in Column (c4) *as if it had actually been paid in cash during the year* and should be added to the amount received in Column b.

ALLOWANCES – COLUMN D. Allowances are granted as part of an agreement with a third-party payor. Virtually all insurance companies, for example, have a maximum amount they pay, and the center agrees to write off the difference between what they charge and what they receive. These amounts are reported in Column d. *Allowances must be reduced by the net amount of retroactive settlements and receipts (reported in the Columns c1, c2, c3, c4), including current and prior year FQHC reconciliations, managed care pool distributions and other payments. This will often result in a negative number being reported as the allowance in Column d.*

If, as a result of a contract or agreement, Medicaid, Medicare, other third-parties, or other public payors reimburse less than the grantee's full charge, and the grantee cannot bill the patient for the remainder, the remainder or reduction on the appropriate payor line is entered in Column d at the time the Explanation of Benefits (EOB) is received and the amount is written off.

EXAMPLE: The State Title XIX Agency has paid $40 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column a as a full charge to Medicaid. After payment was made, the $40 payment is recorded on Line 1 Column b. The $35 reduction is reported as a positive allowance (+$35) on Line 1 Column d.

Under FQHC programs, where the grantee is paid based on cost, it is possible that the cash payment will be greater than the charge. In this case, the adjustment recorded in Column d would be a negative adjustment. (Financial adjustments received under FQHC are reported in Columns c1 and c2.)

EXAMPLE: The State Title XIX Agency has paid grantee's negotiated FQHC rate of $113 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column a as a full charge to Medicaid. After payment was made, the

$113 payment is recorded on Line 1 Column b. The $38 payment over the actual charge is reported as a negative allowance (-$38) on Line 1 Column d.

NOTE: Amounts for which another third party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payors for co-payments) are not considered adjustments and should be recorded or reclassified as full charges due from the secondary source of payment. These amounts will only be classified as adjustments when all sources of payment have been exhausted and further collection is not anticipated and/or possible.

Because capitated plans typically pay on a per-member per-month basis only, and make this payment in the current month of enrollment, these plans typically don't carry any receivables. For Capitated Plans (Lines 2a, 5a, 8a, and 11a **ONLY**) the allowance column should be the arithmetic difference between the charge recorded in Column a and the collection in Column b unless there were early or late capitation payments (received in a month other than when they were earned) and which span the beginning or end of the calendar year.

Also note that Line 13 Column d is blanked out because up-front allowances given to self-pay patients based on their income and family size are recorded as sliding discounts and valid self-pay receivables that are not paid should be recorded as self pay bad debt.

SLIDING DISCOUNTS – COLUMN E. In this column, enter reductions to patient charges based on the patient's ability to pay, as determined by the grantee's sliding discount schedule. This would include discounts to required co-payments, as applicable.

NOTE: Only self-pay patients may be granted a sliding discount based on their ability to pay. Column e is blanked out on all other lines. When a charge originally made to a third party such as Medicare or a private insurance company has a co-payment or deductible written off, THE CHARGE MUST FIRST BE RECLASSIFIED TO SELF-PAY. To reclassify, first reduce the third-party charge by the amount due from the patient and then increase the self-pay charges by this same amount.

BAD DEBT WRITE OFF – COLUMN F. Any payor responsible for a bill may default on a payment due from it. **In the UDS, only self pay bad debts are recorded.** In order to keep responsible financial records, centers are required to write off bad debts on a routine basis. (It is recommended that this be done no less than annually.) In some systems this is accomplished by posting an allowance for bad debts rather than actually writing off specific named accounts. Amounts removed from the center's self-pay receivables through either (but not both) mechanism are recorded here.

Reductions to the collectable amount for the Self-Pay category based on the patient's income and family size should be made on Line 13, Column e. Bad debt write off (Line 13, Column f) may occur due to the grantee's inability to locate persons, a patient's refusal to pay, or a patient's inability to pay even after the sliding fee discount is granted.

Under no circumstances are bad debts to be reclassified as sliding discounts, even if the write off to bad debt is occasioned by a patient's inability to pay the remaining amount due. For example, a patient eligible for a sliding discount is supposed to pay 50 percent of full charges for a visit. If the patient does not pay, even if he or she later qualifies for a 100 percent discount, the amount written off must still be reported as bad debt, not sliding

discount. At the time of the visit, it was a valid collectable from the patient.

Only bad-debts from patients are recorded on this table. While some insurance companies do, in fact, default on legitimate debts as they go bankrupt, centers are not asked to report these data.

OTHER WRITE OFFS. Some health centers use additional write offs. In some cases a private, local or State grant permits writing off charges to a certain class of individuals. In other cases a cash discount is provided for pre-payment or payment at time of service. Some providers claim the right to grant “courtesy discounts” to patients. These discounts are not recorded on the UDS. In any such case the full charge is shown in Column a, the amount collected is reported in Column b, and the amount of the other write-off is not reported.

If the current clinic record shows that the patient would be entitled to a sliding discount, the write off may be shown as such (Column e). But if they would otherwise be ineligible, the write off *must not be reported as a sliding discount.* This situation occurs most frequently when a source of funds permits a discount to persons whose income exceeds 200% of poverty. By law, the discount may not be shown as a sliding discount, but this does not preclude the agency from writing off the charges.

TOTAL PATIENT RELATED INCOME (Line 14). Enter the sum of Lines 3, 6, 9, 12, and 13. Be sure to include only these "subtotal" lines and not the detail for each of the subtotals.

QUESTIONS AND ANSWERS FOR TABLE 9D

1. **Are there any changes to this table?**
   Yes. A minor change to column c3 now permits health centers to report other types of retroactive payments such as those received in settlement of litigation over rates and payments. Column c3 is now open on all lines except the self-pay line.

2. **How are charges and collections for patients enrolled in an indigent care program handled?**
   Such charges are reported on the self-pay Line 13, Column a. Payments received from State or local indigent care programs subsidizing services rendered to the uninsured are not reported on this table. All such payments, whether made on a per visit basis or as a lump sum for services rendered, shall be recorded on Table 9E, Line 6a. See Table 9E for specific instructions. Grantees receiving payments from State/local indigent care programs that subsidize services rendered to the uninsured should:
   - Report all charges for these services (Column a) and the collections from patients as "self-pay" (Column b) (Line 13 of this table);
   - Report all amounts not collected from the patient as sliding discounts (Column e) or bad debt (Column f), as appropriate, on Line 13 of this table;
     NOTE: Report as bad debt only the amount the patient was responsible for and failed to pay.
   - Report collections from the State/local indigent care programs on Table 9E, Line 6a.

3. **Are the data on this table cash or accrual based?**
   Table 9D is essentially a "cash" table. Entries represent gross charges and adjustments for the reporting calendar year and actual cash receipts for the year.

4. **Should the lines of the table "balance?"**
   No. Because the table is on a "cash" basis, the columns for amount collected and for allowances will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will be remaining in accounts receivable at the end of the year. The one exception is on the capitated lines (Lines 2a, 5a, 8a, and 11a) where allowances are the difference between charges and collections by definition, provided there are no early or late capitation payments that cross the calendar year change.

5. **If we have not received any reconciliation payments for the reporting period what do we show in Column c1 (current year reconciliations)?**
   If you have not received a reconciliation payment during this reporting period for current year services, enter zero (0) in Column c1.

6. **We regularly apply our sliding discount program to write off the co-payment portion of the Medicare charge for our certified low-income patients. The sliding discount column (Column e) is blanked out for Medicare. How do we record this write off?**
   The amount of the co-payment needs to be removed from the charge column of the Medicare line (Lines 4 - 6 as appropriate) and then added into the self-pay line (Line 13). It can then be written off as a sliding discount on Line 13. The same process would be used for any other co-payment or deductible write-off.

7. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Must we, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**
   Yes – regardless of whether or not it is done automatically by your PMS the UDS report must reflect this reclassification of all charges that end up being the responsibility of a party other than the initial party.

TABLE 9D (Part I of II) – PATIENT RELATED REVENUE (Scope of Project Only)

PAYOR CATEGORY		FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
				COLLECTION OF RECONCILIATION/ WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)									
3.	**TOTAL MEDICAID** (LINES 1+ 2A + 2B)									
4.	Medicare Non-Managed Care									
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**TOTAL MEDICARE** (LINES 4 + 5A+ 5B)									
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)									

TABLE 9D (Part II of II) – PATIENT RELATED REVENUE (Scope of Project Only)

PAYOR CATEGORY		FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
				COLLECTION OF RECONCILIATION/ WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**TOTAL OTHER PUBLIC** (LINES 7+ 8A +8B)									
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	**TOTAL PRIVATE** (LINES 10 + 11A + 11B)									
13.	Self Pay									
14.	**TOTAL** (LINES 3 + 6 + 9 + 12 + 13)									

INSTRUCTIONS FOR TABLE 9E – OTHER REVENUE

Table 9E must be completed by all BPHC grantees covered by the UDS. It is included only in the Universal Report. This table collects information on non-patient income received during the reporting period that supported activities described in the scope of project(s) covered by any of the four BPHC grant programs. Income received is reported on a "cash basis" and includes all funds received during the calendar year which supported a Federally-approved project even if the revenue was accrued during the previous year or was received in advance and considered "unearned revenue" in the center's books on December 31.

The UDS uses the **"last party rule"** to report grant revenues. The "last party rule" means that *grant and contract funds should always be reported based on the entity from which the grantee received them, regardless of their original origin*. For example, funds awarded by the State for maternal and child health services usually include a mixture of Federal funds such as Title V and State funds. These should be reported as State grants because they are awarded by the State. Similarly, WIC funds are totally provided by the Federal Department of Agriculture, but are always passed through the State, and are reported on Line 6 as State funds, not on Line 3 as Federal. The one exception to the rule is for the Medicare and Medicaid EHR Incentive Grants received for eligible providers (Line 3a). These payments are generally made directly to the clinic's providers. It is presumed that, as employees, these funds will be turned over to the clinic. The dollars are reported on this line even though the payment may come from the provider and not directly from the CMS.

BPHC GRANTS

LINES 1a THROUGH LINE 1e – Enter draw-downs during the reporting period for all BPHC section 330 grants in the primary care cluster. These include the four primary care programs included in the UDS. Note that Lines 1d and 1f no longer are reported. Amounts should be consistent with the PMS-272 report.

During 2011, ARRA funds for Increased Demand for Services (IDS) and for certain new access points (both "new starts" and "expansions") came to an end. At that point BPHC awarded funds out of the ACA CHC fund to continue those programs. That part of IDS and new-start funds received during the year from the ACA are to be reported on Lines 1a through 1e as 330 funds. The portion received from ARRA funds will be included below on Lines 4 and 4a.

TOTAL HEALTH CENTER CLUSTER (Line 1g) – Enter the total of Lines 1a through 1e.

CAPITAL IMPROVEMENT PROGRAM GRANTS (Line 1j) – Enter the amount of Capital Improvement Program grant dollars drawn down. This is a legacy program which is all but extinct at this time. Do not use this line unless you are certain you have some of these funds. ***DO NOT INCLUDE ARRA CAPITAL IMPROVEMENT GRANTS ON THIS LINE. They are to be reported on Line 4a.***

CAPITAL DEVELOPMENT GRANTS (Line 1k) – Enter the amount of Affordable Care Act (ACA) Capital Development grant dollars drawn down.

TOTAL BPHC GRANTS (Line 1) – Enter the total of Lines 1g (Total Health Center Cluster), 1j (*non-ARRA* Capital Improvement Program Grants), and1k (Capital Development Grants). Be sure that all BPHC section 330 grant funds drawn down during the year are included on Line 1. The amounts shown on the BPHC Grant Lines should reflect **direct funding** only. They should not include BPHC funds passed through to you from another BPHC grantee nor should they be reduced by money that you passed through to other centers. Note again that ARRA funds are *not* 330 funds and are included only on line 4 and 4a as discussed below.

OTHER FEDERAL GRANTS

RYAN WHITE Part C HIV EARLY INTERVENTION (Line 2) – Enter the amount of the Ryan White Part C funds drawn down during the reporting period. NOTE: Ryan White Part A, Impacted Area, grants come from County or City governments and are reported on Line 7 (unless they are first sent to a third party in which case the funds are reported on Line 8). Part B grants come from the State and are reported on Line 6, unless they are first sent to a County or City government (in which case they are reported on Line 7) or to a third party (in which case the funds are reported on Line 8). SPRANS grants are generally direct Federal grants, and are reported on Line 3.

OTHER FEDERAL GRANTS (Line 3) – Enter the amount and source of any other Federal grant revenue received during the reporting period which falls within the scope of the project(s). These grants include only those funds received directly by the center from the U.S. Treasury. Do not include Federal funds which are first received by a State or Local government or other agency and then passed on to the grantee such as WIC or Part A or Part B Ryan White funds. These are included below on Lines 6 through 8. Grantees are asked to describe the programs so the UDS reviewer can make sure that the classification of the program as a Federal grant is appropriate.

MEDICARE AND MEDICAID EHR INCENTIVE GRANTS FOR ELIGIBLE PROVIDERS (Line 3a) – the Medicare and Medicaid Electronic Health Record Incentive Program grants are funded through the American Recovery and Reinvestment Act of 2009 (ARRA). They provide incentives to Eligible Providers (as defined under ARRA) for the adoption, implementation, upgrading, and meaningful use of certified electronic health records. Unless modifications to the program are made, these payments are made directly to the clinic's providers. It is presumed that, as employees, these funds will be turned over to the clinic. They are reported on this line *even though the payment may come from the provider and not directly from the CMS.* This is an exception to the "Last Party" rule. In the event the provider is permitted to retain these grants as part of their compensation, *the amount should still be recorded on this line and an equal amount should be shown on Table 8A, Line 1 as staff compensation.*

ARRA NAP, IDS, CIP and FIP GRANT FUNDS (Lines 4 and 4a) – Enter the amount of American Recovery and Reinvestment Act (ARRA) New Access Point and/or Increased Demand for Services (IDS) grant funds which were drawn down in 2011 on Line 4. Enter the amount of ARRA Capital Improvement and/or Facility Investment grant funds which were drawn down in 2011 on Line 4a. Note that ARRA grants were given for a multi-year period. It is not expected that the amount reported will equal the amount awarded. Please review your PMS-272 forms to determine the draw-down amount.

During 2011, ARRA funds for Increased Demand for Services (IDS) and for certain

new access points (both “new starts” and “expansions”) came to an end. At that point BPHC awarded funds out of the ACA CHC fund to continue those programs. The final drawdowns of IDS and new-start funds received during 2011 are recorded on this line. (The new ACA funds are to be reported on Lines 1a through 1e as 330 funds.) It is anticipated that this line will be eliminated in the 2013 UDS Report.

TOTAL OTHER FEDERAL GRANTS (Line 5) – Enter the total of Line 2 + Line 3 + Line 3a + Line 4 + Line 4a.

NON-FEDERAL GRANTS OR CONTRACTS

“Grants and Contracts" are defined as amounts received on a line item or similar basis which are not tied to the delivery of services.

STATE GOVERNMENT GRANTS AND CONTRACTS (Line 6) – Enter the amount of funds received under State government grants or contracts. They do NOT include funds from State indigent care programs. When a State grant or contract program *other than an indigent care program* pays a grantee based on the amount of health care services provided or on a negotiated fee for service or fee per visit, the charges, collections and allowances are reported on Table 9D as "Other Public" services, not here on Table 9E. Grantees are asked to describe the programs so the UDS reviewer can make sure that the classification of the program as a State grant is appropriate.

STATE/LOCAL INDIGENT CARE PROGRAMS (Line 6a) – Enter the amount of funds received from State/local indigent care programs that subsidize services rendered to the uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California Expanded Access to Primary Care Program, Tobacco Tax programs in Arizona and New Mexico, and the Colorado Indigent Care Program). Grantees are asked to describe the programs so the UDS reviewer can make sure that the classification of the program as a State/local indigent care program is appropriate. This line should not be used for any program not listed above without specific instructions provided at a State or regional UDS training program, the UDS help line, or in communications with the UDS reviewer.

> NOTE: Payments received from State or local indigent care programs subsidizing services rendered to the uninsured should be reported on Line 6a of this table whether on not the actual payment to the grantee is made on a per visit basis or as a lump sum for services rendered. **Patients covered by these programs are reported as uninsured on Table 4 and all of** the associated charges, sliding discounts, and bad debt write-offs are reported on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D.

LOCAL GOVERNMENT GRANTS AND CONTRACTS (Line 7) – Report the amount received from local governments during the reporting period that covers costs included in the scope of the grantee's project(s). They do NOT include funds from local indigent care programs. When a local grant or contract *other than an indigent care program* pays a grantee based on the amount of health care services provided or on a negotiated fee for service or fee per visit, the charges, collections, and allowances are reported on Table 9D as "Other Public" services, not here on Table 9E. Grantees are

asked to describe the programs so the UDS reviewer can make sure that the classification of the program as a local grant is appropriate.

FOUNDATION/PRIVATE GRANTS AND CONTRACTS (Line 8) – Report the amount received during the reporting period that covers costs included within the scope of the project(s). Funds which are transferred from another grantee or another community service provider are considered "private grants and contracts" and included on this line. Grantees are asked to describe the programs so the UDS reviewer can make sure that the classification of the program as a foundation/private grant is appropriate.

TOTAL NON-FEDERAL GRANTS AND CONTRACTS (Line 9) – Enter the total of Lines 6, 6a, 7, and 8.

OTHER REVENUE (Line 10) – Other Revenue refers to other receipts included in the Federally approved scope of project that are not related to charge-based services. This may include fund-raising, interest income, rent from tenants, etc. Grantees are asked to describe these sources of "other revenue." *Do not* enter the value of in-kind or other donations made to the grantee – these are shown only on Table 8A, Line 18. Also, *do not* show the proceeds of any loan received, either for operations or in the form of a mortgage.

TOTAL REVENUE (Line 11) – Enter the total of Lines 1, 5, 9, and 10 for total other revenues/income.

QUESTIONS AND ANSWERS FOR TABLE 9E

1. **Are there any changes to this table?**
   Yes. It is anticipated that this will be the last year that ARRA New Access Point (NAP) and Increased Demand for Services (IDS) funds will be reported on Line 4. As health centers close out these grants and move to the new ACA CHC fund dollars, these new dollars will be reported as 330 funds on Lines 1a – 1e.

   A new line, Line 3a, has been added to this table. Grantees will report EHR Incentive Payments received on this line. It is currently anticipated that the dollars will go directly to the providers and that they will then be turned over to the health centers by the providers or in some other manner accounted for by the health center. The full amount of the incentive payments received during the calendar year are expected to be reported on this line, *even if the provider is permitted to retain some or all of these payments.*

2. **Are there any important issues to keep in mind for this table?**
   This table collects information on cash receipts for the reporting period that supported activities described in the scope of project covered by any of the four BPHC grant programs. Only cash receipts received during the calendar year should be reported. In the case of a grant, this amount equals the cash amount received during the year not the full award amount unless the full award was paid during the year.

3. **How should indigent care funds be reported on the UDS?**
   Payments received from State or local indigent care programs subsidizing services rendered to the uninsured should be reported on Line 6a of Table 9E whether on not the actual payment to the grantee is made on a per visit or visit basis or as a lump sum for services rendered. **Patients covered by these programs are reported as uninsured on Table 4** and all of their charges, collections, sliding discounts, and bad debt write-offs are reported on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D.

TABLE 9E – OTHER REVENUES

	SOURCE	AMOUNT (a)
BPHC GRANTS (ENTER AMOUNT DRAWN DOWN – CONSISTENT WITH PMS-272)		
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	**TOTAL HEALTH CENTER CLUSTER** (SUM LINES 1A THROUGH 1E)	
1j.	Capital Improvement Program Grants (excluding ARRA and ACA)	
1k.	Affordable Care Act (ACA) Capital Development Grants	
1.	**TOTAL BPHC GRANTS** (SUM LINES 1G + 1J + 1K)	
OTHER FEDERAL GRANTS		
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify:_____)	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
4.	American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS)	
4a.	American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investment Program (FIP)	
5.	**TOTAL OTHER FEDERAL GRANTS** (SUM LINES 2 – 4A)	
NON-FEDERAL GRANTS OR CONTRACTS		
6.	State Government Grants and Contracts (specify:_____)	
6a.	State/Local Indigent Care Programs (specify:_____)	
7.	Local Government Grants and Contracts (specify:_____)	
8.	Foundation/Private Grants and Contracts (specify: _____)	
9.	**TOTAL NON-FEDERAL GRANTS AND CONTRACTS** (SUM LINES 6 +6A + 7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:_____)	
11.	**TOTAL REVENUE** (LINES 1+5+9+10)	

APPENDIX A: LISTING OF PERSONNEL

(ALL line numbers in the following table refer to Table 5.
Note that a "provider" may also deliver services which are not counted as visits.)

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
PHYSICIANS		
Family Practitioners (Line 1)	X	
General Practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetrician/Gynecologists (Line 4)	X	
Pediatrician (Line 5)	X	
OTHER SPECIALIST PHYSICIANS (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other Specialists and Sub-Specialists	X	
NURSE PRACTITIONERS (Line 9a)	X	
PHYSICIANS ASSISTANTS (Line 9b)	X	
CERTIFIED NURSE MIDWIVES (Line 10)	X	
NURSES (Line 11)		
Clinical Nurse Specialists	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurse	X	
Licensed Practical Nurse/Licensed Vocational Nurse	X	
OTHER MEDICAL PERSONNEL (Line 12)		
Nurse Aide/Assistant (Certified And Uncertified)		X
Clinic Aide/Medical Assistant (Certified and Uncertified Medical Technologists)		X
Quality Assurance/EHR design and operation staff		X
LABORATORY PERSONNEL (Line 13)		
Pathologists		X
Medical Technologists		X
Laboratory Technicians		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Laboratory Assistants		X
Phlebotomists		X
X-RAY PERSONNEL (Line 14)		
Radiologists		X
X-Ray Technologists		X
X-Ray Technician		X
Radiology Assistants		X
DENTISTS (Line 16)		
General Practitioners	X	
Oral Surgeons	X	
Periodontists	X	
Endodontists	X	
OTHER DENTAL		
Dental Hygienists (Line 17)	X	
Dental Assistant (Line 18)		X
Dental Technician (Line 18)		X
Dental Aide (Line 18)		X
MENTAL HEALTH (Line 20) & **SUBSTANCE ABUSE** (Line 21)		
Psychiatrists (Line 20a)	X	
Psychologists (Line 20a1)	X	
Social Workers - Clinical (Line 20a2 or 21)	X	
Social Workers - Psychiatric (Line 20b or 21)	X	
Family Therapists (Line 20b or 21)	X	
Psychiatric Nurse Practitioners (Line 20b)	X	
Nurses - Psychiatric and Mental Health (Line 20b)	X	
Unlicensed Mental Health Providers including trainees interns or residents) and “Certified” staff	X	
Alcohol And Drug Abuse Counselors (Line 21)	X	
Nurse Counselor (Line 20b)	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Herbalists	X	
Massage Therapists	X	
Naturopaths	X	
Occupational Therapists	X	

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Podiatrists	X	
Physical Therapists	X	
Respiratory Therapists	X	
Speech Therapists/Pathologists	X	
Traditional Healers	X	
Nutritionists/Dietitians	X	
Community Health Aides and Practitioners	X	
VISION SERVICES PERSONNEL (Line 22a-22d)		
Ophthalmologists (Line 22a)	X	
Optometrists (Line 22b)	X	
Ophthalmologist/Optometric Assistant (Line 22c)		X
Ophthalmologist/Optometric Aide (Line 22c)		X
Ophthalmologist/Optometric Technician (Line 22c)		X
PHARMACY PERSONNEL (Line 23)		
Pharmacist, Clinical Pharmacist		X
Pharmacy Technician		X
Pharmacist Assistant		X
Pharmacy Clerk		X
ENABLING SERVICES (Line 29)		
CASE MANAGERS (Line 24)		
Case Managers	X	
Care/Referral Coordinators	X	
Patient Advocates	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses	X	
HEALTH EDUCATORS (Line 25)		
Family Planning Counselors	X	
Health Educators	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Registered Nurses	X	
Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
Patient Transportation Coordinator		X
Driver		X
ELIGIBILITY ASSISTANCE WORKERS (Line 27a)		
Benefits Assistance Workers		X
Pharmacy Assistance Program Eligibility Workers		X
Eligibility Workers		X
Patient Navigators		X
Patient Advocates		X
Registration Clerks		X
INTERPRETATION (Line 27b)		
Interpreters		X
Translators		X
OTHER ENABLING SERVICES PERSONNEL (LINE 28)		X
OTHER RELATED SERVICES STAFF (Line 29a)		
WIC Workers		X
Head Start Workers		X
Housing Assistance Workers		X
Child Care Workers		X
Food Bank/Meal Delivery Workers		X
Employment/Educational Counselors		X
Exercise Trainers/Fitness Center staff		X
Adult Day HealthCare, Frail Elderly Support staff		X
MANAGEMENT AND SUPPORT STAFF (Line 30a)		
Project Director		X
Chief Executive Officer/Executive Director		X
Chief Financial Officer		X
Chief Information Officer		X
Chief Medical Officer		X
Secretary		X
Administrator		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Director of Planning And Evaluation		X
Clerk Typist		X
Personnel Director		X
Receptionist		X
Director of Marketing		X
Marketing Representative		X
Enrollment/Service Representative		X
FISCAL AND BILLING STAFF (Line 30b)		
Finance Director		X
Accountant		X
Bookkeeper		X
Billing Clerk		X
Cashier		X
Data Entry Clerk		X
IT STAFF (Line 30c)		
Director of Data Processing		X
Programmer		X
IT Help Technician		X
Data Entry Clerk		X
FACILITY (Line 31)		
Janitor/Custodian		X
Security Guard		X
Groundskeeper		X
Equipment Maintenance Personnel		X
Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
Medical And Dental Team Clerks		X
Medical And Dental Team Secretaries		X
Medical And Dental Appointment Clerks		X
Medical And Dental Patient Records Clerks		X
Patient Records Supervisor		X
Patient Records Technician		X
Patient Records Clerk		X
Patient Records Transcriptionist		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Registration Clerk		X
Appointments Clerk		X

APPENDIX B: SPECIAL MULTI-TABLE SITUATIONS

Several conditions require special consideration in the UDS because they impact multiple tables which must then be reconciled to each other. This Appendix presents some of these special situations along with instructions on how to deal with them. Currently addressed in this section are the following issues:

- Contracted care (specialty, dental, mental health, etc.) which is paid for by the reporting grantee
- Services provided by a volunteer provider
- Interns and Residents
- WIC
- In-house pharmacy or dispensary services for grantee's patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Donated drugs
- Clinical dispensing of drugs
- Adult Day Health Care (ADHC)
- Medi-Medi cross-overs
- Certain grant supported clinical care programs (BCCCP, Title X, etc.)
- State or local safety net programs
- Workers Compensation
- Tricare, Trigon, Public Employees Insurance, etc.
- Contract sites
- CHIP
- Carved-out services
- Migrant voucher programs and other voucher programs
- Incarcerated patients

ISSUE	TABLES AFFECTED	TREATMENT
Contracted Care (Specialty, dental, mental health, etc.) *(Service must be paid for by grantee.)*	5	**Providers (Column A)** are counted if the contract is for a portion of an FTE (e.g., one day a week OB = 0.20 FTE). Providers are *not* counted if contract is for a service (e.g., $X per visit or $55 per RBRVU). **Visits (Column B)** are *always* counted, regardless of method of provider payment or location of service (grantee's site or contract provider's office).
	6	Grantee receives encounter form or equivalent from contract provider, counts primary diagnosis and/or services provided as applicable.
	8A	**Column A: Net Cost.** Cost of provider/service is reported on applicable line. **Column B: Overhead.** Grantee will generally use a lower "overhead rate" for off-site services.
	9D	**Charge (Column A)** is grantee's UCR charge if on-site; is contractor's UCR charge if off site. **Collection (Column B)** is the amount received by *either* grantee *or* contractor from first or third parties. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12) **Sliding Discount (Column E)** if applicable, is the amount written off for eligible patients per center's fiscal policies (Line 13). Calculated as UCR charge minus amount collected from patient, minus amount owed by patient as their share of payment.
Services provided by a volunteer provider *(Service are not paid for by grantee.)*	Description	Volunteer staff (including AmeriCorps/HealthCorps, but not National Health Service Corps) who provide services on behalf of the grantee where there is a basis for determining their hours can be included in the UDS report.
	5	**Providers (Column A)** are counted if the service is provided on site at grantee's clinic. FTE is calculated by using hours volunteered as the numerator. Because volunteers do not receive benefits, the denominator is the number of hours that a comparable *employee* spends performing their job. This means, most specifically, that a full time of 2080 hours (for example) will be reduced by vacation, sick leave, holidays and continuing education normally provided to employees. As a rule, the equation will be hours worked divided by a number somewhere around 1800. Providers *are not counted* if their services are provided at their own offices. **Visits (Column B)** are counted only if the service is provided at a site in the grantee's scope of service and under the grantee's control.

ISSUE	TABLES AFFECTED	TREATMENT
	6	Grantee counts primary diagnosis and/or services provided on site, as applicable.
	9D	If the provider is on-site, the charges for their services are treated exactly the same as for staff. Do not include charges for volunteer providers who are off-site.
Interns and Residents	Description	Health centers often make use of individuals who are in training, referred to variously as interns or residents, depending on their field and their licensing. Medical Residents and some mental health interns are generally licensed practitioners who are training for a higher level of certification or licensing.
	Table 5	**Column A:** Licensed interns and residents are counted in the category of credentialing that the provider is *working toward*. Thus, a family practice resident is shown on Line 1 as Family Physician, etc. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the grantee) or like a volunteer (if they are *not* being paid). See volunteer providers, immediately above. **Column B:** Visits between a medical resident and a patient are recorded as visits *to that resident or intern. Under no circumstances are the visits credited to the supervisor of the resident or intern*. Visits of a *licensed* mental health provider will be counted on Lines 20a, 20a1, 20a2, or 20b. If the provider is not licensed, they will be counted on Line 20c.
	Table 8A	*If the intern or resident is paid by the grantee* ***or*** their cost is being paid through a contract which pays a third party for the interns or residents, the cost is shown in column a on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the intern or resident *is not being paid by the grantee* and the grantee is not paying a third party, then the *value of the donated time* is reported on Line 18. Be sure to describe the nature of the donation on the table at this line.
WIC	3A, 3B, 4	Clients whose only contact with the grantee is for WIC services and who do not receive another form of service counted on Table 5 from providers outside of the WIC program *are not counted as patients on any of these tables*. Do not count as patients because of nutritional, health education, or enabling services provided by WIC.
	5	**Staff (Column A)** are counted on Line 29a. **Visits and patients (Columns B and C)** are *never* reported unless otherwise justified.

ISSUE	TABLES AFFECTED	TREATMENT
	8A	**Column A: Net costs.** Total cost of program reported on Line 12 in Column a. **Column B: Overhead.** Since much of the administrative cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
	9D	Nothing associated with the WIC program is to be reported on this table.
	9E	Income for WIC programs, though originally Federal, comes to grantees from the State. Unless the grantee *is* a State government, the grant/contract funds received are reported on Line 6.
In-house pharmacy or dispensary services for grantee's patients *(including only that part of pharmacy that is paid for by the grantee and dispensed by in-house staff.)* [see below for other situations].	5	**Column A: Staff.** Pharmacy staff are normally reported on Line 23. To the extent that the pharmacy staff have only an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs (PAPs), they are included on Line 23. Staff (generally not including pharmacists) who spend a readily identifiable portion of their time with PAP programs should be counted on Line 27a, Eligibility Assistance. **Column B: Visits.** The UDS does not require the counting or reporting of visits with pharmacy whether it is for filling prescriptions or associated education or other patient/provider support.
	8A	**Line 8b, Column A: Pharmaceutical Direct Costs.** The actual cost of drugs purchased by the pharmacy is placed on Line 8b. The value of donated drugs is *not* reported here. These costs *are* reported on Line 18 in Column c. **Line 8a, Column A: Other Pharmacy Direct Costs.** All other operating costs of the pharmacy are shown on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. **Line 11e, Column A: Eligibility Assistance Direct Costs.** Show the cost of staff (full-time, part-time, or allocated time) assisting patients to become eligible for PAPs and all related supplies, equipment depreciation, etc. **Column B: Facility and Administration.** All overhead costs associated with Line 8a and 8b are reported on Line 8a. While there may be some overhead cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. **Column C, Line 18:** Show the value of donated drugs (generally calculated at 340(b) rates) on this line *only.*

ISSUE	TABLES AFFECTED	TREATMENT
	9D	**Charge (Column A)** is grantee's full retail charge for the drugs dispensed. **Collection (Column B)** is the amount received from patients or insurance companies. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12). **Sliding Discount (Column E)** is amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge minus amount collected from patient, minus amount owed by patient as their share of payment.
	9E	The value of donated drugs is ***not*** reported on this table – it is reported on Table 8A. (See above.) The charges for drugs dispensed to patients are to be reflected on Table 9D, not this table.
In-house pharmacy for community (i.e., for non-patients)	Description	Many CHCs which own licensed pharmacies also provide services to members of the community at large who are *not* CHC patients. Careful records are required to be kept at these pharmacies to ensure that drugs purchased under section 340(b) provisions are not dispensed to non-patients. Some of these pharmacies are totally in-scope, while others have their "public" portion out of scope. If the public aspect is "out of scope," none of its activities are reported on the UDS. If it is in scope, the public portion should be considered an "other activity" and treated as follows:
	5	**Column A: Staff.** Report allocated public portion of staff on Line 29a: Other Programs and Services.
	8A	Report all related costs, including cost of pharmaceuticals, on Line 12: Other Related Services.
	9E	Report all income from public pharmacy on Line 10: Other, and specify that it is from "Public Pharmacy."

ISSUE	TABLES AFFECTED	TREATMENT
Contract Pharmacy **Dispensing to clinic patients, generally using 340(b) purchased drugs**	5	No staff, visits, or patients are reported. PAP staff all go to enabling services.
	8A	If the pharmacy is charging one amount for "managing" the program and/or an amount for "dispensing" the drugs; and another amount for the drugs themselves, the former charge is reported on Line 8a, the latter on Line 8b. If the CHC is purchasing the drugs directly [because of 340(b) regulations] the full amount it spends on purchasing goes on Line 8b, and any administrative or dispensing costs charged by the pharmacy go on Line 8a. If the pharmacy is reporting a flat amount for services including both pharmaceuticals and their services, *and there is no reasonable way to separate the amounts* report all costs on Line 8b. Associated administrative costs will go on Line 8a in Column B, even though Line 8a Column A is blank. If prepackaged drugs are being purchased, *and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs* report all costs on Line 8b. Associated administrative costs will go on Line 8a in Column B, even though Line 8a Column A is blank.
	9D	**Charge (Column A)** is grantee's full retail charge for the drugs dispensed or the amount charged by the pharmacy/pre-packager if retail is not known. **Collection (Column B)** is the amount received from patients or insurance companies or, under certain circumstances, the pharmacy. (NOTE: most CHCs have this arrangement only for their uninsured patients.) **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12). **Sliding Discount (Column E)** is amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge (or pharmacy charge) minus amount collected from patient (by pharmacy or CHC), minus amount owed by patient as their share of payment.
	9E	No income would be reported on Table 9E. Do not use Table 9E to show net income from Pharmacy. Actual income must be reported on Table 9D.

ISSUE	TABLES AFFECTED	TREATMENT
Donated Drugs	8A	*If the drugs are donated to the CHC and then dispensed to patients* show their value [generally calculated at 340(b) rates] on Line 18, Column C. *If the drugs are donated directly to the patient* grantee is not *required* to report the value of the drugs however it is preferred that the value be included for a better understanding of the program.
	9D	If a dispensing fee is charged to the patient, show this amount (only) and its collection/write-off.
	9E	Do not show any amount, even though GAAP might suggest another treatment for the value.
Clinical dispensing of drugs	Description	Many pharmaceuticals, ranging from vaccines to allergy shots to family planning shots or pills, are dispensed in the clinic area of the CHC. This dispensing is often considered to be a service attendant to the visit where it was ordered or, in the case of vaccinations, to be a community service. In most instances it is appropriate to charge for these services, though they are not considered to be visits.
	3A/3B/4	If this is the only service the individual has received during the year, they are not counted as patients.
	5	These services are not counted as separate visits.
	6a	Because these are not visits, they are not counted on Table 6a.
	8A	Costs are reported on Line 8b – pharmaceuticals (*not* on Line 3, other medical costs). In the case of vaccines obtained at no cost through Vaccines For Children or other State or local programs, the value must be reported on Line 18 – donated services and supplies.
	9D	Full charges, collections, allowances, and discounts are reported as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated, though an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
	9E	Do not show any amount, even though GAAP might suggest another treatment for the value.
Adult Day Health Care (ADHC)	Description	ADHC programs are often recognized by Medicare, Medicaid, and certain other third party payors. They involve caring for an infirm, frail elderly patient during the day to permit family members to work, and to avoid the institutionalization of and preserve the health of the patient. They are quite expensive and may involve extraordinary PMPM capitation payments, though are thought to be cost effective compared to institutionalization. If patients are covered by both Medicare and Medicaid treat as in Medi-Medi, below.
	5	When a provider does a formal, separately billable, examination of a patient at the ADHC facility, it is treated as any other medical visit. The nursing, observation, monitoring, and dispensing of medication services which are bundled together to form an ADHC service are *not* counted as a visit for the purposes of reporting on this table. Staff are included on Line 29a.

ISSUE	TABLES AFFECTED	TREATMENT
	8A	If there are separate medical services being provided and billed separate from the ADHC charge the associated costs are on Lines 1 – 3. All other costs are reported on Line 12.
	9D	ADHC charges and collections are reported. Because of Medicaid FQHC procedures it is possible that there will also be significant positive or negative allowances. See also Medi-Medi below.
Medi-Medi Cross-Over	Description	Some individuals are eligible for both Medicare and Medicaid coverage. In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC) fee, the remainder is billed to Medicaid which pays the difference based on policy which varies from State to State.
	4	Patients are reported on Line 9, Medicare. *Do not* report as Medicaid.
	9D	While initially the entire charge shows as a Medicare charge, after Medicare makes its payment, the remaining allowable amount is re-classified to Medicaid. This means that *eventually* the charges and collections will be the same, though for any given twelve month period the cash positions will probably not net out. In most cases a significant portion of the total charge will transfer to Medicaid where it will be received and/or written off as an allowance.
Certain grant supported clinical care programs: BCCCP, Title X, etc. (These are fee-for service or fee-per-visit programs only)	Description	Some programs pay providers on a fee-for-service or fee-per visit basis under a contract which may or may not also have a cap on total payments per year. They cover a very narrow range of services. Breast and Cervical Cancer Control and Family Planning programs are the most common, but there are others.
	4	These are *not* insurance programs. They pay for a service, but the patient is to be classified according to their primary health insurance carrier. Most of these programs do not serve insured patients, so most of the patients are reported on Line 7 as uninsured.
	9D	While the patient is uninsured, there *is* an "other public" payor for the service. The clinic's usual and customary charge for the service (**not** the negotiated fee paid by the public entity) is reported on Line 7 in Column A, and the payment is reported in Column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in Column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.
State or local safety net programs	Description	These are programs which pay for a wide range of clinical services for uninsured patients, generally those under some income limit set by the program. They may pay based on a negotiated fee-for-service, or fee-per-visit. They may also pay "cents on the dollar" based on a cost report, in which case they are generally referred to as an "uncompensated care" program.
	4	While patients may need to qualify for eligibility, these programs are not considered to be public insurance. Patients served are almost always to be counted on Line 7 as uninsured.

ISSUE	TABLES AFFECTED	TREATMENT
	9D	The charges are to be considered charges directly to the patient (reported on Line 13, Column A). If the patient pays any co-payment, it is reported in Column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it collected or is written off as a bad-debt in Column f. All the rest of the charge (or all of the charge if there is no required co-payment) is reported as a sliding discount in Column E.
	9E	The total amount received during the calendar year is reported on Line 6a.
Workers Compensation	4	Workers Compensation is a form of *liability insurance for employers*, not a *health insurance for employees*. Patient's whose bills are being paid by Workers Compensation should have a related insurance and that is what is reported on Table 4 (even if it is not being billed or cannot be billed by the CHC.) In general, if they had an employer paid/work-place based health insurance plan they would be reported on Line 11. If they do not have *any* health insurance, they are reported on Line 7.
	9D	Charges, collections and allowances for Workers Compensation covered services are reported on Line 10.
Tricare, Trigon, Veterans Administration, Public Employees Insurance, etc.	4	While there are many individuals whose insurance premium is paid for by a government, ranging from military and dependents to school teachers to congressmen and HRSA staff, these are all considered to be private insurances. They are reported on Line 11, *not on Line 10a.*
	9D	Charges, collections, and allowances are reported on Lines 10 – 12, *not on Lines 7 – 9.*
Contract sites ***(In-scope sites in schools, workplaces, jails, etc.)***	Description	Some CHCs have <u>included in their scope of service</u> a site in a school a workplace, a jail, or some other location where they are contracted to provide services to (students/employees/inmates/etc.) at a flat rate per session or other similar rate *which is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third parties.
	4	**Lines 1-6 – income:** In general, income should be obtained from the patients. In prisons, it may be assumed that all are below poverty (Line 1). In schools, income should be that of the parent or unknown or, in the case of minor consent services, below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). **Lines 7-12 – insurance:** Record the actual form of insurance the patient has, regardless of the clinic's ability to bill that source. (Children in school based clinics are often covered by a Medicaid program, but assigned to another provider. They are still shown as Medicaid patients.) Do not consider the agency with whom the clinic is contracted to be an insurer. (Schools and jails are not "other public" insurance.)

ISSUE	TABLES AFFECTED	TREATMENT
	5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
	8A	Costs will generally be considered as medical (Lines 1-3) unless other services (mental health, case management, etc.) are being provided. *Do not report on Line 12—"other related services."*
	9D	*Unless the visit is being charged to a third party such as Medicaid* the clinic's usual and customary charges will appear on Line 10, Column A. The amount paid by the contractor is shown in Column B. The difference (positive or negative) is reported in Column D.
	9E	*Contract revenue is not reported on Table 9E.*
CHIP (CHIP-RA)	4	**Medicaid:** If CHIP is handled through Medicaid and the enrollees are identifiable, they are reported on Line 8b. *If it is not possible to differentiate CHIP from regular Medicaid,* the enrollees are reported on Line 8a with all other Medicaid patients. **Non-Medicaid:** CHIP enrollees in States which do not use Medicaid are reported as "Other Public CHIP" on Line 10b. Note that, even if the plan is administered through a commercial insurance plan, the enrollees are *not reported on Line 11.*
	9D	**Medicaid:** Report on Lines 1 – 3 as appropriate. **Non-Medicaid:** Report on Lines 7 – 9 as appropriate. *Do not report on Lines 10 – 12 even if the plan is administered by a commercial insurance company.*
Carve-outs	Description	**Relevant to capitated managed care only.** Grantee has a capitated contract with an HMO which stipulates that one set of CPT codes will be covered by the capitation regardless of how often the service is accessed, and another set of codes (or all other codes) the HMO will pay for on a fee-for-service basis whenever it is appropriate. Most common carve-outs involve mental health, lab, radiology and pharmacy, but specific specialty care or diagnoses (e.g., perinatal care or HIV) may also be carved out.
	4	**Patient Member Months:** Member months are reported on Line 13a in the appropriate column, regardless of whether or not the patient made use of services in any or all of those months. *No entry is made on Line 13b ("Fee-for-service managed care member months") for the carved out services, even if payments were received for these services.*
	9D	**Lines 2a/b, 5a/b, 8a/b, 11a/b.** Capitation payments are reported on the "a" lines, carve out payments are reported on the "b" lines.

ISSUE	TABLES AFFECTED	TREATMENT
Incarcerated Patients	Description	Some grantees contract with jails and prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.
	4	Income must be presumed to be below poverty. Individuals receiving health services under this contract are not considered to have insurance. The patient must be classified according to their primary health insurance carrier regardless of whether the services will be billed to the insurer, but are almost always uninsured.
	9D	The patient's services are paid for by the jail/prison. The clinic's usual and customary charge for the service is reported on Line 10 in Column A, and the payment is reported in Column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in Column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.
(Migrant) Vouchers	Description	**Voucher Programs** have traditionally been an exclusive part of the Migrant and Seasonal Farmworker program, though in recent years some Homeless and even CHC programs have made use of the mechanism. In this system, the center identifies services that are needed by its patients which cannot be provided by their in-house staff. Vouchers are written to authorize a third party provider to deliver the services, and voucher is returned to the grantee for payment. Payment is generally at less than the providers full fee, but is consistent with other payors such as Medicaid.
	3a, 3b, 4	**Patients are counted** even if the only service that they receive is a paid vouchered service, provided that these services would make the patient eligible for inclusion if the center provided them. Thus a vouchered taxi ride would *not* make the patient "countable" because transportation services are not counted on Table 5.
	5	**Column A:** There is no way to account for the time of the voucher providers. As a result, zero FTEs are reported with regard to these services. If there is a provider who works *at* the center, the FTE of *that* provider *is* counted. For example, the one-day-a-week family practitioner would be reported as 0.20 FTEs on Line 1. But the 125 vouchered visits to FPs would not result in an additional count on Line 1. **Column B:** Count all visits that are paid for by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (i.e., a "voucher" to a doctor who donates five visits per week does NOT generate a visit that is counted on Table 5).

ISSUE	TABLES AFFECTED	TREATMENT
	6	**Diagnoses/Services.** The Voucher program is expected to receive from the provider a bill similar to a HCFA-1500 which lists the services and diagnoses. These are to be tracked by the center and reported on Table 6.
	8A	**Cost of Vouchered Services.** The costs are reported on the appropriate line. Medical vouchers are reported on Line 1, not Line 3. Report *only* those costs paid directly by the grantee. **Discounts.** Virtually all clinical providers are paid less than their full fee. Some grantees like to report the amount of these discounts as "donated services." *While this is not required,* grantees may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on Line 18, Column D.
	9D	**Column A: Charges.** Report the full charge that the provider shows on their HCFA-1500 as the charge on Line 13 – self pay. Do not use the voucher amount as the full charge. **Column B: Collections.** If the patient paid the voucher program a nominal or other fee, show this in column B. **Column E: Sliding Discounts.** Show the difference between the full charge and the amount that the patient was *supposed to pay* in Column E. Do not show the full amount in Column E if the patient was supposed to make a payment to the center and failed to do so. **Column F: Bad Debt.** Show any amount (such as a nominal fee) that the patient was supposed to pay but failed to pay. Bad debts are recognized consistent with the center's financial policies. Amounts not paid may be considered a bad debt in 30 days or in a year – whatever is the center's policy.

APPENDIX C: SAMPLING METHODODOLOGY FOR MANUAL CHART REVIEWS

INTRODUCTION

For each measure discussed on Table 6B and 7 (with the exception of the perinatal measures), health centers have the option of reporting on their entire patient population as a universe or to select a scientifically drawn random sample to review. To report on the universe, the data source such as an Electronic Health Record must include ***all*** medical patients from ***all*** service delivery sites and grant funded programs (e.g., CHC, HCH, MHC, PH) in the defined universe. In addition, the data source must cover the period of time to be reviewed (e.g., three years for pap tests, etc.) and include information to assess compliance with the clinical measure as well as to evaluate exclusions. Reporting on the universe is more accurate (i.e., it reports on 100% of patients) and can be easier (if queries are automated). If the health center cannot report on the universe (or chooses not to), a random sample must be used to report. Note that the health center can report on the universe for some measures while using a sample to report others. It is not necessary that all measures be reported using the same method.

RANDOM SAMPLE

A random sample is defined as a part of a universe where each member of the universe has the exact same chance of being selected as every other member of the universe.

Thus, a true random sample will generate outcomes which are similar to outcomes reported for the universe of patients because the sample is "representative" of the universe.

STEP BY STEP PROCESS FOR REPORTING CLINICAL MEASURES USING A RANDOM SAMPLE

For each measure, perform each of the following steps.

STEP 1: Identify the patient population to be sampled (the universe)

Define the universe for each condition.

- Including ***all*** active (measurement year) medical patients
- Including ***all*** sites in the scope of project
- Including contracted medical services

Identify the number of patients who fit, or who initially appear to fit, the criteria for that measure. Create a list and number each member of the patient population in the universe. The list may be in any sequence since randomization will remove any order bias.

STEP 2: Determine the sample size for manual chart review

BPHC has mandated that, if a sample is to be used, it must be a sample of 70.

STEP 3: Select the random sample

Using one of the two recommended sampling methodologies, identify the sample of 70 charts.

STEP 4: Review the sample of records to determine compliance with the clinical measure

For each measure, review available data sources to identify any automated sources to simplify data collection. Since these data sources will be augmented by the paper record, they do not need to be available for all patients. Examples of data sources include:

- Electronic health records
- PECs databases
- State immunization registries for vaccine histories
- Logs
- Practice management system

For each patient in the sample, determine whether sufficient information is available in these alternative resources to confirm compliance. If compliance cannot be confirmed from the alternative source, pull the paper record to retrieve required information.

STEP 5: Replacing patients that should be excluded from the sample.

Best practices would dictate that the methodology used to select the sample (or the universe) should be able to test for each and every required criteria. Some criteria (such as the age of the patient) will almost always be easily implemented. Others, such as whether or not the patient had two medical visits during the year may be more difficult to add to a query. Others, such as whether a woman has ever had a hysterectomy, may not be available. When criteria cannot be used to screen the universe, it may be used to exclude patients from a sample. If, upon inspection, it is determined that one or more criteria used to identify the universe or sample was not met, the case (chart) would be removed. If the review is of a sample of charts, than another chart is selected to replace the chart that was originally selected.

If a patient is selected that should be excluded from the sample, the patient will be replaced with a substitute. Use the replacement methodology described for the sampling methodology selected. Any criteria which was missed in selecting a chart (e.g., not noting that the two year old was first seen after their second birthday) may be used to exclude a chart. Some specific criteria which may be used to exclude a patient/chart include:

- All measures – not a medical patient
- Childhood immunizations – none
- Pap tests – women who have had a hysterectomy
- Controlled hypertension – Pregnant patients, end stage renal disease
- Controlled diabetes – patients with a diagnosis of polycystic ovaries that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year; gestational diabetes (ICD-9-CM Code 648.8); or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year
- Weight related measures – pregnancy or imminent demise
- Asthma – allergic response to asthma medication
- Tobacco use – patient is no longer a tobacco user

METHODOLOGY FOR OBTAINING A RANDOM SAMPLE

Two methods are approved for generating a random sample and a sample of replacements for excluded patients:

- Work with a list of random numbers generated for your total patient population.
- Select a random starting point and use a calculated interval to find each next member of the sample.

Either method can be used to create a "replacement list" used to replace patients who are excluded.

Option #1: Random Number List

The preferred method for selecting a random sample is to use a random number list. An individualized list of random numbers can be created at the Web site http://www.randomizer.org/form.htm.

The Web site requires no password or subscription to access. To obtain a list of random numbers, complete the questions as documented below. Request **1** list of **70** numbers. Complete the "Number Range" by entering the **1** as the first number and the **total number of patients** in the universe for the particular measure under consideration as "n." For example, if there are 628 children who turn two in the reporting year in the universe, enter 628 as **N**. It is often helpful, *but not necessary* to sort the selected random numbers.

Then click on the button, "Randomize Now!" A list of randomly generated numbers will be created. These numbers correspond with the numbered list of patients in the universe prepared in Step 1, above.

Identifying a Replacement

To create a "sample" of patients to substitute for patients who should be excluded from the sample, follow the instructions for creating a list of random numbers for a replacement sample. Rather than selecting 70 numbers for the set, select a smaller sample of 5 to 10 charts. In this instance, the list *should not be sorted* since doing so will "bias" the replacement sample toward the lower numbers on the list.

If, upon review, it is determined that a patient should be excluded from the original random sample of 70, replace that patient with one of the patients from the replacement sample. Because of the need to replace ineligible charts, more than 70 patients may be need to be evaluated for compliance for a particular measure but the final sample will include 70 patients who meet all the selection criteria.

Input	Initial Sample	Replacements
Set of Numbers	1	1
Number per set	70	At least 5 or as many as needed
Number range = 1-"n"	Last sequence number in list	Last sequence number in list
Unique numbers	Yes	Yes

Sort numbers	Yes, least to greatest	No

Option #2: Interval

A second method uses the same numbered list of patients in the universe created in Step 1, above. To generate the sample:

1. Calculate sampling interval (SI) by dividing number of patients in the universe by 70:

   Sample Interval Size (SI) = Population size (number in universe) / Sample size (70)

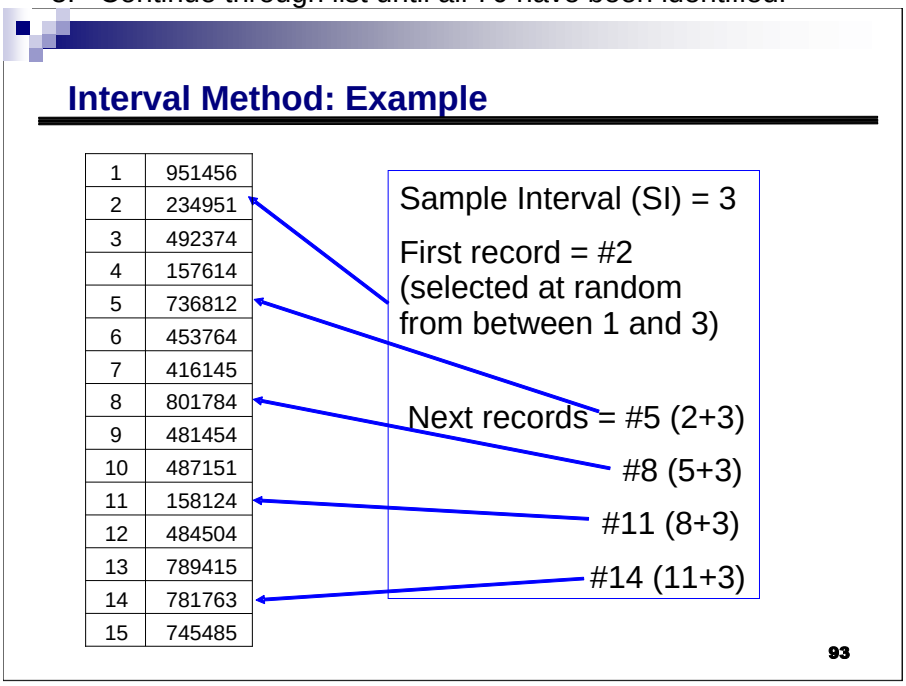
2. Randomly pick a patient from the first sampling interval. For example, if the sampling interval is 10, the first sampling interval includes patients no.1 through no.10. Randomly select one patient from this interval.

3. That will be your first record sequence number

4. Then, select every nth patient based on the sampling interval until you reach the desired sample size. In our example, if the first patient selected is number 8, and the sampling interval is 10, then the remaining patients to be selected are no.18, 28, 38, etc.

   first sequence # + SI = second #

5. Continue through list until all 70 have been identified.



Identifying a Replacement
If a selected patient should be excluded from the sample, return to the original list and substitute the next patient on the list for the excluded patient. If that patient should be excluded select the next patient on the list until an eligible patient is selected. Resume selection using the next chart you had pre-selected for the sample. (If you run out of patients, continue your count back at the beginning of the universe.) In this manner, more than 70 patients may be evaluated for compliance for a particular measure but the final sample will include 70 patients who meet all the selection criteria.

Achieving a Sample of 70 Patients
Under certain situations, a larger number of charts may need to be pulled to achieve a total of 70 charts. Specifically for CY 2011, for users unable to determine a universe for the two tobacco measures using existing systems, alternative instructions for determining a universe and determining compliance are provided:

Tobacco Assessment

1. Prepare a list of all patients born on or before 12/31/1993; with at least one medical visit in clinic setting; who have been seen at least twice ever. This list is the universe for tobacco assessment reported on Table 6B Line 14 column a.

2. Randomly order entire list. If using the Randomizer set the "Numbers in set" to be equal to the total number of cases. Do not sort from least to greatest.

3. Pull the first 70 charts from the randomly ordered list. These are the 70 charts that will be used to assess compliance for tobacco assessment. Enter 70 in Table 6B Line 14 Column b.

4. Review the 70 charts for documentation that patient was queried about tobacco use any time within 24 months of their last visit. Report the number of charts found to be in compliance on Line 14 Column c. NOTE: you can look for documentation of tobacco assessment at any visit, regardless of the category of service.

Tobacco Cessation Intervention

5. Continue to pull charts from the randomly ordered list until you have the charts of 70 tobacco users. Keep track of how many charts you had to review in the list to obtain 70 tobacco users. Divide 70 by the total number of charts that were reviewed to achieve 70 tobacco users. This percentage will be used as the percent of the adult population who are tobacco users. Multiple this percentage by the total universe on Table 6B Line 14 Column a - this is the universe of tobacco users for the cessation measure (Table 6B Line 15 col a).

6. Review the charts of the 70 tobacco users to get the compliance rate for tobacco users with documented cessation intervention. Report 70 on Table 6B Line 15 Column b and the number of compliant charts on Line 15 Column c.

APPENDIX D: GRANTEE ELECTRONIC HEALTH RECORD (EHR) CAPABILITIES

INSTRUCTIONS

INSTALLED EHR 1. Does your Center currently have an Electronic Health Record (EHR) system installed and in use?

Question 1 seeks to determine whether or not an EHR has been installed by the grantee as of December 31, 2011 and, if so, which product is in use, how broad is access to the system, and what features are available and being used. While they can often produce much of the UDS data, do not include practice management systems or other billing systems. If the grantee has *purchased* an EHR, but had not yet placed it into use, answer question 1 "No." If it has been installed, indicate if it was being used, as of December 31, 2011, by:

a. All sites and all providers. For the purposes of this response, "providers" means all *medical* providers including physicians, nurse practitioners, physician assistants and certified nurse midwives. While some or all of the dental, mental health or other providers may also be using the system, as may medical support staff, this is not required to choose response 'a.' For the purposes of this response, "all sites" means all *permanent* sites where medical providers serve health center *medical* patients and *does not* include administrative only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis.
b. At some sites or for some providers. Select option b if one or more permanent site did not have the EHR installed or in use (even if this is planned) or if one or more medical providers (as defined above) does not yet use the system. When determining if all providers have access to the system, the grantee *should* consider part time and locum providers who serve clinic patients. D*o not* select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.
c. No. Select "no" if no EHR was in use on December 31, 2011, even if the system had been installed and staff were training on how to use the system.

If a system is in use (i.e., if a or b has been selected above), identify from the lists provided which Office of the National Coordinator – Authorized Testing and Certification Bodies (ONC-ATCB) certified systems have been installed and indicate in the blank the version number or name. (For more information on ONC-ATCB, please see http://onc-chpl.force.com/ehrcert.) If your system is not listed or if you have installed a non-certified system, select "other" and then identify the system you have installed. You may select only one EHR from the list.

If b: "some sites or some providers" is selected identify how many sites have the EHR in use *and* how many (medical) providers are using it. Please enter the number of sites (as defined above) where the EHR is in use, and the number of providers who use the system (at any site). Include part time and locum *medical* providers who serve clinic patients. A provider who has separate log in identities at more than one site is still counted as just one provider.

MEANINGFUL USE 2. Does your Electronic Health Record (EHR) provide the following Meaningful Use functions and are you using them?

With reference to your EHR, BPHC would like to know if your system has each of the specified capabilities which relate to the CMS Meaningful Use criteria for EHRs and if you are using them. (For more information on meaningful use, see https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.) For each capability, indicate:

"yes," if your system has this capability and it is being used by your medical providers,

(1) "yes, but turned off or not used," if your system has the capability, but the function is either turned off or is not currently in use,
(2) "no," if your system does not have the capability, or
(3) "unknown," if you do not know if the capability is built in and/or if your medical providers are using it.

Select (1) (has the capability and it is being used) if the software is able to perform the function and some or all of your medical providers are making use of it. It is not necessary for all providers to be using a specific capability in order to select (1).

Select (2) or (3) if the capability is not present in the software *or* if the capability is present, but the function has not been turned on or if it is not currently in use by any medical providers at your center. Select (2) or (3) only if *none* of the providers are making use of the function.

UDS USE 3. Do you use your EHR to compile the data for your clinical UDS reporting (Table 6B and 7)?

This question applies strictly to UDS Tables 6B and 7. Answer Yes if you use your EHR to do all of the following for at least one clinical measure:

1. Identify all patients who are in the universe.
2. Identify all patients who may have an exclusion.
3. Determine the compliance status of every single patient in the universe.

Answer No if you use the EHR only to identify the sample and manually pull charts to identify compliance rates.

QUESTIONS

The following questions will be presented on a screen in the Electronic Handbook to be completed before the UDS Report is submitted. The instructions for the EHR questions can be found in EHB as you are completing the questions.

Question 1 determines whether a grantee is using any EHR system, and if so which one and by how many providers. Question 2 covers the 'Core' requirements and the 'Core Quality Measure' elements of Meaningful Use. We believe that this set is a reasonable baseline for assessing grantee progress on implementing EHRs. Question 3 will serve as an indicator to whether grantees are using the capabilities of their EHR to respond to the UDS report. Grantees who respond that they do not have an EHR in Question 1 will not be asked Questions 2 or 3.

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?
    a. Yes, at all sites and for all providers
    b. Yes, but only at some sites or for some providers

c. No
    i. Pop-up if (a) OR (b)
        1. Please select your vendor from the list of certified systems below and indicate the version number or name. If "other", please specify:
            a. Allscripts Version (_____)
            b. GE Centricity Version (_____)
            c. eClinical Works Version (_____)
            d. e-MDs Version (_____)
            e. Epic Version (_____)
            f. Greenway Version (_____)
            g. CompuGroup (Health Port) Version (_____)
            h. IMS Version (_____)
            i. Logician Version (_____)
            j. McKesson Version (_____)
            k. Medinformatix Version (_____)
            l. Medinotes Version (_____)
            m. MicroMD Version (_____)
            n. NextGen Version (_____)
            o. Resource Patient Management System (RPMS) Version (_____)
            p. Sage Version (_____)
            q. Sevocity Version (_____)
            r. SuccessEHS Version (_____)
            s. VistA/ WorldVistA Version (_____)
            t. <Other – Specify: _____ Version (_____)

    ii. Pop-up if (b)
        1. How many sites have the EHR in use?
        2. How many providers use the EHR system?

2. For each of the core Meaningful Use criteria for computerized capabilities below, please indicate whether your practice has and uses this capability, does not have the capability, or does have the capability but the function is turned off such that it is not used:

Yes/Yes, but turned off or not used/No/Unknown

1. Patient history and demographic information?
    If yes, does this include a patient problem list?
    If yes, does it record and chart changes in vital signs?
    If yes, does it record weight screening and follow-up?

2. Clinical notes?
    If yes, do they include a list of the medications that the patient is taking?

If yes, does this include a comprehensive list of the patient's allergies (including allergies to medications)?

3. Computerized provider order entry (CPOE)?
   For lab tests?
   For radiology tests?
      If yes, are orders sent electronically?
      If yes, are results incorporated into EHR?
      If yes, are out of range levels highlighted?

4. Electronic entry of prescriptions?
   If yes, are warnings of drug allergies, interactions or contraindications provided?
   If yes, are prescriptions sent electronically to the pharmacy?

5. Reminders for guideline-based interventions or screening tests?
   If yes, does it record smoking status?
   If yes, does it prompt for and record the tobacco cessation intervention?

6. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically?

7. Notifiable diseases sent electronically?

8. Reporting to immunization registries done electronically?

9. Capability to provide patients with an electronic copy of their health information upon request?

10. Capacity to provide clinical summaries for patients for each office visit?

11. Does the system protect electronic health information?

3. Do you use your EHR to compile the data for your clinical UDS reporting (Table 6B and 7)?

APPENDIX E: FQHC LOOK-ALIKE DESIGNEE REPORTING

Federally Qualified Health Center Look-Alikes are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

HRSA is enhancing the Federally Qualified Health Center (FQHC) Look-Alike Program by streamlining and simplifying its application and data reporting processes through integration into the HRSA Electronic Handbooks (EHB), further described in Program Assistance Letters (PALs) 2010-02, 2010-09, 2010-10, and 2011-10. Beginning in January 2012, Look-Alikes will be required to submit UDS data to HRSA through the EHB rather than through paper applications. This will allow HRSA to bring together data and information used to monitor FQHC Look-Alikes, record program changes, and track program performance in one centralized system.

Where an entire agency is designated as an FQHC Look-Alike, the Look-Alike reporting will cover the activities of the entire agency. However, when only a portion of an agency (e.g., one of a number of sites or the outpatient department of a hospital) is designated, the Look-Alike report must accurately reflect this partial designation such that Look-Alike data represent *only that portion of their agency that is designated as an FQHC Look-Alike.* Special care should be taken in allocating only a part of the administrative and/or facility costs where these are shared between the LAL and the overall corporation or agency.

Special care must also be taken by the limited number of "dually designated" agencies. "Dual status" occurs when an organization receives a grant under section 330 as well as maintains a FQHC Look-Alike designation. In such a case, a health center receives grant funding under section 330 for sites in the grant's approved scope of project and, at the same time, operates other sites under a FQHC Look-Alike designation. The organization must maintain separate and distinct scopes of project for the FQHC Look-Alike designation and section 330 grant funds. Administrative costs must be allocated when reporting on both the 330 UDS and the Look-Alike (LAL) UDS. *Under no circumstances can the same cost be included in both the Look-Alike and Grantee reports.*

Data will be reported by Look-Alikes using the definitions and rules in this manual. General exceptions to the reporting for designees from the grantee reporting outlined in this manual are: Look-Alikes do not complete Table 6A.

- Look-Alikes complete only a Universal Report.
- Discussion of grant tables is not applicable.
- Look-Alikes will not have assigned UDS reviewers.
- Once in the UDS, Look-Alikes will see modified versions of BPHC Grantee tables with grayed-out fields for elements that do not apply or for which Look-Alikes are not required to report.

Modifications made to the Look-Alike version of the UDS tables are designed to minimize burden on and reduce the total effort of Look-Alikes. These modifications are summarized in the table below. When reviewing UDS tables in this manual, Look-Alikes should note that they are the unmodified BPHC Grantee tables. The Look-Alike UDS tables displayed in EHB will reflect the modifications described above and specified below.

TABLE		Modification (if any)
SERVICE AREA		
Grantee Profile	Patients by ZIP code	<none>
PATIENT PROFILE		
Table 3A	Patients by Age and Gender	<none>
Table 3B	Patients by Hispanic/Latino Ethnicity and Race; Patients best served in a language other than English	<none>
Table 4	Selected Patient Characteristics	Lines 13a-c: Managed care utilization is not reported. Lines 14 – 15 and 17 – 22: No details are reported on farmworkers or homeless patients.
STAFFING AND UTILIZATION		
Table 5	Staffing and Utilization	<none>
CLINICAL		
Table 6B	Quality of Care Indicators	<none>
Table 7	Health Outcomes and Disparities	Race/ethnicity data are not reported. Only total patients are reported for each health outcome. NOTE: Race/ethnicity data will be reported in 2013 for Calendar Year 2012.
FINANCIAL		
Table 8A	Costs	None
Table 9D	Patient Related Revenue	Managed care detail and details of retroactive payments are not reported.
Table 9E	Other Revenue	Data on BPHC 330 and ARRA grants are not reported.
OTHER FORMS		
Appendix D	EHR Capabilities	<none>