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

Bureau of Primary Health Care (BPHC)

Health Center Quarterly Report (HCQR)

Reporting Manual

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HEALTH CENTER QUARTERLY REPORTING MANUAL

OVERVIEW

This manual supports submission of the **H**ealth **C**enter **Q**uarterly **R**eport (HCQR) for health centers receiving funding under the American Recovery and Reinvestment Act (ARRA). Grantees will be required to submit quarterly HCQRs that report programmatic progress on all health center ARRA funding received. The first HCQR will be due on July 10, 2009, and will include programmatic information on the New Access Point (NAP) and the Increased Demand for Services (IDS) awards. As Health Resources and Services Administration (HRSA) awards funding under the Capital Improvement Program (CIP) and the Facility Investment Program (FIP), quarterly reporting on these awards will be rolled into the HCQR to simplify filing and prevent duplication of information. The HCQR will include separate tables to report on each of these four health center ARRA funding opportunities. HRSA goal is to collect programmatic information on ARRA supported health center programs without duplicating information reported to the standard federal ARRA reporting system.

The ARRA (or the Recovery Act), signed into law February 17, 2009, provides approximately $500 million in grants to: support new health center sites and service areas; increase services and providers at existing sites; and address spikes in uninsured patients. It also provides $1.5 billion in grants to support health center construction, renovation and equipment, and the acquisition of health information technology systems. Integrated reporting on these capital funds will be addressed in later editions of this manual.

The Recovery Act was enacted to, among other goals:

- preserve and create jobs;
- promote economic recovery; and
- help people most impacted by the recession.

The ARRA grants awarded to health centers are designed to support efforts in all three of these national goal areas. All ARRA supported grantees (including health centers) are required to report quarterly on a standard set of elements that will be publicly displayed at the Recovery.gov web site. *In addition to these reports,* health centers will report separately, through the HCQR, on a limited number of health center program performance elements. These HCQRs will permit HRSA to report on and demonstrate the impact of health center activities funded under the ARRA.

HCQRs provide a *cumulative* profile of staff positions increased or retained; the number of *new* patients (and *new* uninsured patients) served; and the number of visits provided to these new patients. Grantees will be asked to report patients in both a "duplicated format" where the same patient may be counted as both a medical and a dental patient (for example) and in an "*unduplicated format"* where each new patient is counted only once. Unlike the Uniform Data System, which reports on a calendar year, the ARRA report covers the total project period of the ARRA funding and will be reported on a quarterly basis.

For the first quarter ending June 30, 2009, all grantees will submit program-specific information on activities included in their IDS grants. Those who also received a NAP grant will complete a second section of the HCQR covering the NAP grant. Later reports will capture information about the CIP and FIP grants as they are awarded. The HRSA's Electronic Handbook Book (EHB) will combine these reports into a summary report covering all ARRA funded activities.

INTRODUCTION

This is the first edition of the HRSA's HCQR User's Manual. **This Manual currently addresses the program specific reporting requirements for NAP and IDS activities funded under the ARRA and will be updated in the future to integrate the CIP and FIP funding opportunities. as additional awards are issued (CIP and FIP).** The most recent version of the HCQR manual will always be available at http://bphc.hrsa.gov/recovery/.

The Manual includes a brief introduction to the HCQR system, instructions for submitting the HCQR, definitions of terms as they are used in the HCQR, and detailed instructions for completing each table. Care should be taken in reviewing definitions as they are not necessarily the same as may be used in other BPHC activities.

The HCQR is an integrated reporting system used by all BPHC-supported health center grantees receiving support through the following ARRA programs:

- **Increased Demand for Services (IDS)**
- **New Access Point (NAP)**
- **Capital Improvement Program (CIP)** (to be included in a future edition of this manual)
- **Facility Investment Program (FIP)** (to be included in a future edition of this manual)

HRSA is collecting program-specific data on the ARRA grants to health centers to ensure compliance with legislative mandates and to report to Congress, OMB, and other policy makers on program accomplishments. To meet these objectives, HRSA requires grantees to report on a limited set of health center program performance elements consistent with the application guidances and awards. These data include:

- The number of jobs (measured in FTEs) that are created or retained as a result of the ARRA award.
- The number of new patients that received services as a result of the ARRA award.
- The number of visits that these new patients received.
- The number of new uninsured patients that received services as a result of the ARRA award.

HCQRs are *cumulative* and report on ARRA supported activities quarterly.

GENERAL INSTRUCTIONS

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

Who Submits Reports and Reporting Periods

Reports should be submitted directly by the health center **grantee** as the direct recipient of one or more HRSA/BPHC-ARRA grants. All ARRA supported health centers are required to submit HCQRs. Grantees will report on the entire ARRA service period, from the time they were first funded through the end date of their award.

How Many Reports are Submitted

Grantees will file only one HCQR per quarter. This report will have separate sections for each of the four potential ARRA funded programs and the HRSA's EHB will prompt a grantee to complete the appropriate reports based on the types of ARRA funding received. The EHB will automatically "roll up" the individual ARRA report sections into a single Universal Report which will summarize all ARRA supported activities for the grantee.

Due Dates and Revisions to Reports

HCQR reports may be worked on beginning the day after the close of the quarter, and are due ten days after the close of the quarter or, if that falls on a weekend or a holiday, the first business date after that day. Grantees should begin reporting on each separate ARRA grant beginning with the initial date of award in accordance with the following schedule:

Report Number	Period Covered	Due Date
1	Initial award – 6/30/09	7/10/09
2	Initial award – 9/30/09	10/12/09
3	Initial award – 12/31/09	1/11/10
4	Initial award – 3/31/10	4/12/10
5	Initial award – 6/30/10	7/12/10
6	Initial award – 9/31/10	10/11/10
7	Initial award – 12/31/10	1/10/11
8	Initial award – 3/31/11	4/11/11
9	Initial award – 6/30/11	7/11/11
10	Initial award – 9/30/11	10/10/11

All HCQR reports will be **final** when they are submitted. No revisions will be accepted after the due date. It should be noted, however, that reports are cumulative. In the event of mistaken reporting of program data, grantees may submit "corrected" cumulative data in the subsequent quarterly report.

How and Where to Submit Data

Reporting will be on-line using a web based data collection system that is completely integrated within the HRSA's EHBs. Health center grantees will use their EHB user name and password to log into the EHB in order to complete their HCQR submission. The system will present users with electronic forms that will guide them in completing the appropriate reports.

Users will be able to work on the forms in part, save them online, and return to complete them later in a collaborative manner. This approach will allow grantees to distribute the data entry among multiple users if required. Business rules that check for questionable quantitative and qualitative data will be applied to ensure that the data submitted meets legislative and programmatic requirements.

Training, Technical Assistance, and Additional Resources

HRSA will maintain the web site http://bphc.hrsa.gov/recovery/ which will be an ongoing, regularly updated, source for additional information about the BPHC ARRA supported programs. Included on this site will be frequently asked questions (FAQs) covering each of the ARRA funding programs and the reporting process, notification of training "webinars" that will be conducted to keep grantees updated, as well as the latest version of this manual and reporting forms.

- System Help Assistance about the HCQR and accessing the HRSA's EHB can be obtained from the BPHC Helpline at 301-443-7356 weekdays from 8:30AM to 6:00PM ET.

- Program specific reporting requirements assistance about HCQR can be obtained at 866-UDS-HELP from 8:30AM to 5:00PM ET.

Note: Extended hours for technical assistance support will be available as the deadline approaches. An email communication with be sent that will provide those dates and time.

COVER PAGE: FORM SF-PPR – PAGE 1

The HCQR includes a two-page form to be completed for *each* ARRA grant received. The grantee's EHB will automatically display those sections of the report (IDS, NAP, CIP, and/or FIP) which are to be completed, based on the types of ARRA funding received. While it is understood that the grantee will be integrating these four funding streams in a manner which optimizes services to the community *a separate section will be submitted for each grant*. Each section of the report should be capable of being read and reviewed as a whole and in isolation from the other sections. In general, the report will cover program specific data elements detailed in the application narrative and budget for the specific grant project, as reflected in the Notice of Grant Award (NGA).

*Please note: The EHB will combine the information from the different grant-specific reports into an integrated data presentation. Employees, patients, and visits are to be credited to only **ONE** of the ARRA health center grants received so that adding the separate reports together will give an accurate picture of the grantee's total ARRA supported activities.*

Lines 1 – 7 and 9. Identification Section.

The first section of the Cover Page includes information identifying the grantee and the ARRA-supported grant(s) received. All of this information will be automatically transferred to the report from other sections of the EHB. Grantees will neither be required nor be able to enter data in these

fields. If there is a question about data in these fields, please call the BPHC Helpline at 301-443-7356.

Line 8. Final Report.

Grantees will indicate that the report is a "final report" *only* when they will no longer be performing activities associated with the ARRA grant or drawing down additional ARRA grant funds.

Line 10. Performance Narrative.

Describe key activities undertaken during the reporting period including information about any goals or objectives which were accomplished as well as the key factors which are contributing to or restricting the performance and success of the ARRA supported program. The narrative will be limited to 2000 characters (about 1 page.)

Please note: Since 2006 persons served by BPHC-supported clinics have been referred as "patients." Inconsistent language, referring to such persons as "clients", or "users" has led to some confusion in the past. There is no intent to exclude individuals who are referred to by a grantee as "clients" or "users". Also, reportable interactions between providers and patients are referred to as "visits." This term has the same meaning as "encounters" as defined in other BPHC reporting.

Line 10a. *Cumulative* New Unduplicated Patients.

For the purposes of reporting on this table, an ARRA supported new patient is an individual who has ***never*** been seen by the grantee prior to receipt of its ARRA funding, and who has subsequently had at least one visit as a result of ARRA funding. [Note: This table uses a more narrow definition of a new patient than in SF-PPR 2 discussed below.]

Line 10a reports *the total cumulative unduplicated new patients to date* seen by the grantee as a result of the ARRA funding. A new patient is counted only once for Line 10a, regardless of the number or frequency of services accessed. For example, a patient seen only once by a physician is counted once, and a patient seen by a physician, dentist, psychologist, and health educator a total of 25 times is also counted once.

Line 10a, as with all program-specific data elements in the HCQR, is cumulative. Therefore, a patient reported on this line will be included in the total count for all subsequent reporting for the entire two year period of the ARRA program.

*NOTE: If a grantee has multiple grant awards (e.g., a NAP and an IDS project) a new ARRA-supported patient may be counted under only **ONE** of the ARRA-supported grants.* Grantees should use the information (budget and narrative forms) submitted with their funded ARRA grants as a guide to determining whether a specific patient is to be counted under a particular ARRA grant.

> ***Special Instructions for ARRA-NAP projects only:*** NAP awards have been made to grantees who are receiving grant support from BPHC for the first time (new start), or to grantees which are adding a new site to their existing scope of project (satellite) with NAP grant support.
>
> - For ARRA NAP *new start grantees only,* all patients served by the health center are considered to be new patients because they are new to the Health Center Program as a result of ARRA funding.
> - For ARRA NAP *satellite grantees,* only those patients who are seen at the new site and *have not received services at another health center site* are considered to be new patients.

Line 10b. *Cumulative* New Unduplicated Uninsured Patients.

Grantees will report the number of new uninsured individuals who are served by the health center as a result of the ARRA grant. It is recognized that patients may be uninsured for some or all of the time that they are receiving services at the health center. Therefore, the definition of an uninsured patient is a person who is uninsured for some or all of the two year+ period of the ARRA-supported program. For reporting purposes on Line 10b, a patient is considered uninsured if they meet one of the following three criteria:

- New patients (as defined above) who are uninsured – specifically, uninsured means that they do not have ***medical*** insurance at the first time they receive services. Once they have been counted as uninsured they remain in the cumulative count.
- New patients (as defined above) who are insured when they first receive services but who subsequently ***become*** uninsured. Once they have been counted as uninsured they remain in the cumulative count.
- Existing insured patients (i.e., a patient who had been seen by the grantee as an insured patient prior to initial ARRA grant support) who subsequently lost their insurance (on or after February 17, 2009) and were seen at the health center as an uninsured patient. Once they have been counted as uninsured they remain in the cumulative count.

The definition specifically *excludes* the following:

- A patient who has medical insurance but who is seen exclusively in the dental clinic for services which are not covered by insurance; and
- A patient who is *underinsured*, even if they pay for the care themselves.

Line 10b reports *the total unduplicated **uninsured** ARRA-supported patients seen to date* by the grantee. A new uninsured patient is counted only once on Line 10b, regardless of the number or frequency of services accessed. For example, a patient seen only once by a physician is counted once and a patient seen by a physician, dentist, psychologist, and health educator a total of 25 times is also counted just once. Line 10b is cumulative. Therefore, once a patient is reported as uninsured, the patient is subsequently included in all the cumulative reporting on this element.

Line 10c. Designated Point of Contact.

The Cover Page identifies the name and contact information for the individual responsible for the HCQR submission. This person may or may not be the person who is the "Certified Authorizing Official" for the program. This is the person that BPHC will contact if there are any questions relating to the HCQR submission. Because this person and/or their contact information may change over the life of the project, grantees will be required to enter/validate this information for each HCQR.

Line 11. Other Attachments.

You may, at your own discretion, add additional information that helps to "tell the story" of the impact of the ARRA-supported program by attaching additional documents. This may include descriptions of activities undertaken, of how individual patients were served by the program (while maintaining patient confidentiality protections), or how the grant impacted the lives of individual providers or employees. Copies of newspaper stories or other documents may be included if they are first scanned into a PDF format. Attachments *may not be used* to extend the required narrative in section 10.

Line 12. Certification.

The Certified Authorizing Official must separately certify the accuracy of the HCQR as the final step in the submission process. This is done by entering the EHB using their logon and password and

checking the box indicating that they have read and approve the submission. Until this is done the report is not officially “submitted.”

DETAILED ARRA-SUPPORTED ACTIVITIES: FORM SF-PPR PAGE 2

Staffing and Utilization

Personnel by Major Service Category: Lines 1 through 34.

The lines on this form correspond to the same lines that are used in the BPHC-HRSA UDS report. Personnel are allocated to positions based on the work they perform, and not necessarily their job title. Thus, an RN may be the health educator for the program and will be counted as a health educator, not a nurse. See the UDS manual for further discussion of this topic.

Cumulative Full Time Equivalents (FTEs): COLUMN A.

This table includes FTE staffing information on all individuals who were either hired with ARRA funds (and associated income) or who were retained as a result of these funds. Do not include new staff who are hired to fill an existing position as a result of normal staff turnover and where that position had not specifically been targeted for elimination prior to ARRA.

- **Column A - left: New FTEs.** A "new" FTE position for purposes of the HCQR includes all individuals who: (1) were not employed by the grantee prior to the ARRA grant; and (2) whose costs are covered in whole or in part by the ARRA funds received from BPHC *or from income generated as a result of receipt of ARRA funds.* This includes positions created and those previously unfulfilled that are filled as a result of ARRA funding.

  In the event that an existing part time position is expanded to include more hours or to become full time, *that portion of the FTE which was added with ARRA related support* will be considered to be "new." Thus, an RN who was working half time whose position is expanded to full time will be considered to be a 0.5 FTE *new* staff person for purposes of HCQR (See below for more information).

- **Column A - right: Retained FTEs.** A "retained" FTE is one that had been proposed for elimination or which would have been cut – in whole or in part – if it were not for the ARRA funds and associated income. The definition includes existing FTEs that were scheduled for termination as well as those that would have been eliminated through attrition.

  "Retained" positions may include **"restored"** positions. If a position was reduced to .5 FTE from 1.0 FTE and, as a result of ARRA funding is restored to 1.0 FTE, the restored .5 FTE would be included in the count of retained positions (See below for more information).

Overall, the requirement for reporting jobs is based on a simple calculation used to avoid overstating the number of other than full-time permanent jobs. This calculation converts part-time or temporary jobs into "full time equivalent" (FTE) jobs. In order to perform the calculations, a recipient will need the total number of paid hours that are funded by the Recovery Act. The recipient will also need the number of paid hours in a full-time schedule for a quarter. The formula for reporting can be represented as:

$$\frac{\text{Cumulative Recovery Act Funded Hours Paid (Qtr 1 . . . n)}}{\text{Cumulative Hours in a full-time Schedule (Qtr 1 … n)}}$$

Example:
Assume that a recipient is preparing its first quarterly report and that the recipient's Recovery Act funded work required two full-time employees and one part-time employee working half days for the quarter. Also assume that the recipient's full time schedule for the quarter is 520 hours (2080 hours in a work year divided by 4 – actual hours may be used instead). To convert worked hours to number of FTE for the first quarterly report, aggregate all hours paid and divide by the number of

hours in a full time schedule for the quarter. In this example, full-time hours paid (520 hrs x 2 employees = 1040 hrs) + part time hours paid (260 hrs) / number of hours in a full time schedule for the quarter (520 hrs) = 2.5 FTE reported in the first quarterly report. Because the jobs are reported cumulatively each quarter, this same number of FTEs would be report for the second quarter if the same number of employees worked the same number of hours.

Reporting is cumulative across the project lifecycle, and will not reset at the beginning of each calendar or fiscal year. In the example above, the 2.5 FTE reported in the first quarterly report will stay the same through the project lifecycle, assuming the same number of employees are paid for the same number of hours. The table below shows the FTE calculations through the life cycle of an 18 month project that uses full-time, part-time, and temporary workers.

Period	3rd qtr	4th qtr	1st qtr	2nd qtr	3rd qtr	4th qtr
Full time schedule	520	1040	1560	2080	2600	3120
Full time employee 1 (e.g. Physician)	520	1040	1560	2080	2600	3120
Full time employee 2 (e.g. Nurse Practitioner)	520	1040	1560	2080	2600	3120
Part time (1/2 time) employee 3 (e.g. RN)	260	520	780	1040	1300	1560
Temp employee (650 hrs) (e.g. Administrative)	0	0	130	390	650	650
Total hours worked	1300	2600	4030	5590	7150	8450
Quarterly FTE	2.5	2.5	2.58	2.69	2.75	2.71

***Cumulative* Visits by Service Provided: COLUMN B.**

A visit is a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. *All visits that are generated as a result of ARRA funding* are to be reported, *including those that are generated by providers that weren't hired/retained as a result of the ARRA funding but have increased capacity that is filled with new patients as a result of the ARRA funding.* (A complete, comprehensive definition of a visit is included as Appendix A.)

For the purpose of this table, grantees are to report on the number of visits made by all new patients (as defined in SF-PPR1 – Line 10a) AND those current health center patients that have received a NEW SERVICE as a result of ARRA funding over the two year project period. [Note: This table uses a broader definition of a new patient than on Line 10a of SF-PPR 1 discussed above to account for the expansion of services supported through ARRA.] For example:

- If a grantee hires a pediatrician who assumes part of the existing case load of a family practitioner, the visits for a new patient seen by the family practitioner would be counted.
- If a grantee extends the hours of service at site A to include evenings and Saturdays and as a result, *existing* patients are served during the extended hours while *new* patients are seen during normal hours, the visits for these new patients would be counted, but not the visits of the existing patients.

- If a grantee expands their dental services with ARRA support and a medical patient who never had dental care before now begins to receive this care, they will be counted as a new dental patient and their *dental visits* (but *not* their medical visits) will be reported.

In those cases where a comprehensive collection of data is overly costly or burdensome and thus disrupts the grantees ability to effectively implement the underlying mission of the program, grantees may consider reporting on new patients, services provided, and visits for only those patients who had not been seen at the health center prior to receipt of ARRA funding.

Visits that are purchased from non-staff providers on a fee-for-service basis *using ARRA funds* are also counted in this column, even though no corresponding FTEs are included in Column A. To be counted in this column, these purchased services 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 (or in part) by the grantee using ARRA funds or funds generated from ARRA supported services, and
- the service otherwise meets the above definition of a visit.

This category ***does not include unpaid referrals, or referrals where only nominal amounts are paid,*** or referrals for services that would otherwise not be counted as visits.

Visits reported in this column are *cumulative* from the initial ARRA grant award. Thus, all visits reported for the first time in one quarter *will also be included* in visits reported in subsequent quarters. Eventually, the report will include the visits for the entire ARRA-supported grant period.

***Cumulative* Patients by Service Provided: COLUMN C.**

For the purpose of this table, grantees are to report on the number of NEW patients served (as defined in SF-PPR1 – Line 10a) AND those CURRENT health center patients that have received a NEW SERVICE as a result of ARRA funding over the two year project period. [Note: This table uses a broader definition of a new patient than for Line 10a of SF-PPR 1 discussed above, to account for the expansion of services supported through ARRA.]

ARRA-supported new patients are reported in Column C *only once* within each category of service (e.g., medical), regardless of the number of visits generated. For example, a patient who receives multiple types of services (e.g., medical and dental) *should* be counted under each category of service but *only once for each category*. Thus, a new patient receiving only medical services is reported once on Line 15 (as a medical patient) regardless of the number of medical visits. A new patient 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.

A current health center patient that is accessing a new services as a result of the ARRA funding, should be reported as a new patient only once under the category of new service accessed (e.g., medical) regardless of the number of visits the patient generates in accessing that new service. For example, if a “medical-only” patient at the health center is now seen for the first time in the newly expanded dental program as a result of ARRA funding, that patient *would be counted as a new dental patient and their dental visits (only) would be reported.* Also, individuals who only receive services for which no visits are generated (e.g., laboratory tests, transportation, health education or smoking cessation classes, immunizations, flu shots) are not included in the patient count reported in Column C.

An individual patient may be counted **only** once in each of the following categories:

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

Grantees reporting visits in Column B for any of these six categories are required to identify the unduplicated number of patients who received this type of visit in Column C. Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

In those cases where a comprehensive collection of data is overly costly or burdensome and thus disrupts the grantees ability to effectively implement the underlying mission of the program, grantees may consider reporting on new patients, services provided, and visits for only those patients who had not been seen at the health center prior to receipt of ARRA funding.

HEALTH CENTER QUARTERLY PERFORMANCE PROGRESS REPORT
SF-PPR – Page 1

HRSA OFFICE USE ONLY (*Pre-populated by system)*

1. Federal Agency and Organization Element to which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency	3a. DUNS Number 3b. EIN
4. Recipient Organization (Name and complete address including zip code)		5. Recipient Identifying Number or Account Number

6. Project/Grant Period 6a. Project Title: Start Date (mm/dd/yyyy): / End Date (mm/dd/yyyy):	7. Reporting Period End Date (mm/dd/yyyy)	9. Reporting Frequency [] Annual [] Semi-annual [] quarterly [] other (If other, describe: _____)

GRANTEE USE ONLY *(Reported by Grantee for each ARRA Award received)*

8. Final Report? [ ] Yes [ ] No

10. Performance Narrative (attach performance narrative as instructed by the awarding Federal Agency)

10a. Total New Patients (Unduplicated)	10b. Total New Uninsured Patients	
10c. Name and Title of Designated Point of Contact	Telephone	Fax
	Email Address	

11. Other Attachments (attach other documents as needed or as instructed by the awarding Federal Agency)
<< File name: *This will indicate name of the file that was attached if any* >>

ELECTRONIC CONFIRMATION (*Auto-filled by system)*

12. Certification: I certify that to the best of my knowledge and belief that this report is correct and complete for the performance of activities for the purposes set forth in the award documents

12a. Name and Title of Authorized Certifying Official	12c. Telephone 12d. Email Address
12b. Signature of Authorized Certifying Official	12e. Date Report Submitted (mm/dd/yyyy)

OMB Approval Number: 0970-0334

DETAILED ARRA-SUPPORTED ACTIVITIES
SF-PPR - Page 2 Staffing and Utilization

Personnel by Major Service Category	Staff FTE(s) (a)		Visits (b)	Patients (c)
	New	Retained		
Medical Care Services				
1. Family Physicians				
2. General Practitioners				
3. Internists				
4. Obstetrician/Gynecologists				
5. Pediatricians				
7. Other Specialty Physicians				
8. Total Physicians (Sum lines 1-7)				
9a. Nurse Practitioners				
9b. Physician Assistants				
10. Certified Nurse Midwives				
10a. Total Mid-Levels (Sum lines 9a-10)				
11. Nurses				
12. Other Medical Personnel				
13. Laboratory Personnel				
14. X-Ray Personnel				
15. Total Medical (Sum lines 8+10a through 14)				
Dental Services				
16. Dentists				
17. Dental Hygienists				
18. Dental Assistance, Aides, Techs				
19. Total Dental Services (Sum lines 16-18)				
Mental Health Services				
20a. Psychiatrists				
20a1. Licensed Clinical Psychologists				
20a2. Licensed Clinical Social Workers				
20b. Other Licensed Mental Health Providers				
20c. Other Mental Health Staff				
20. Mental Health (Sum lines 20a-20c)				
Substance Abuse Services				
21. Substance Abuse Services				
Other Professional Services				
22. Other Professional Services Please specify 'Other' Professional Services below (max 5 lines)				
Pharmacy Personnel				
23. Pharmacy Personnel				
Enabling Services				
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				
29. Total Enabling Services (Sum lines 24-28)				
Other Programs/Services				
29a. Other Programs/Services Specify:				
Administration and Facility				
30a. Management and Support Staff				
30b. Fiscal and Billing Staff				
30c. IT Staff				
30 Subtotal Administrative Staff (Sum lines 30a-30c)				
31. Facility Staff				
32. Patient Support Staff				
33. Total Administrative & Facility (Sum lines 30-32)				
Grand Total				
34. Grand Total (Sum lines 15+19+20+21+22+23+29+29a+33)				

OMB Approval Number: 0970-0334

APPENDIX A: VISIT

Visit definitions are needed both to determine who is counted as a patient and to report visits by type of service. **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.** 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 HCQR to the extent that they meet all other criteria. In these instances, a summary of the visit may appear in the grantee's charts.

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

1. To meet the criterion for "independent professional judgment," 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 **is not** 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.

2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. 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. Screenings 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 renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of services 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. 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 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. 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. A reporting entity may not count more than one inpatient visit per patient per day.

5. Such services as drawing blood, collecting urine specimens, performing laboratory tests, 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. Each patient may have, at a maximum:
   - One medical visit (physician, nurse practitioner, physicians 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, optometrist, etc.).
   - 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 HCQR. 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 HCQR is up to the grantee. Internally, the grantee may follow any protocol it wishes in terms of crediting providers with visits.*

7. A 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 some states prohibit an LVN or an LPN to exercise 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 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.

SUBSTANCE ABUSE VISIT – A visit between a substance abuse provider (e.g., a mental health provider or a credentialed substance abuse counselor, rehabilitation therapist, psychologist) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

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 in 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, and specific diseases). Participants in health education classes are not considered to have had visits. Some individuals trained as pharmacists now work as health educators and perform health education work. They should be classified as health educators and have those services counted as health education visits. This *does not include* the normal education that is a required part of the dispensing of any medicine in a pharmacy.