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

Bureau of Primary Health Care

UNIFORM DATA SYSTEM (UDS)
Calendar Year 2009

UDS Reporting Instructions for Section 330 Grantees

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

BUREAU OF PRIMARY HEALTH CARE

BPHC UNIFORM DATA SYSTEM MANUAL

For use to submit Calendar Year 2009 UDS Data

U.S. Department of Health and Human Services
Health Resources and Services Administration
BUREAU OF PRIMARY HEALTH CARE
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2009 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.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 62 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

INTRODUCTION

This 14th edition of the Bureau of Primary Health Care's User's Manual: Uniform Data System (UDS) 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 October 2009.**

The Manual includes a brief introduction to the Uniform Data System, instructions for submitting the UDS, definitions of terms as they are used in the UDS and detailed instructions for completing each table. Where relevant, the table-specific instructions also include a set of "Questions and Answers", addressing issues that are frequently raised when completing the tables. Three 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; and (C) provide sampling methodologies for manual chart reviews.

The UDS is an integrated reporting system used by all grantees of the following primary care programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration:

- **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.

In addition, since activities (patients, visits, income and expenses) which have been and/or are being supported by one or more element of the American Recovery and Reinvestment Act (ARRA) are integrated with other Section 330 funded activities, ARRA funded activities are reported in the UDS. BPHC collects data on its programs to ensure compliance with legislative mandates and to report to Congress, OMB, and other policy makers on program accomplishments. To meet these objectives, BPHC requires that grantees submit a core set of information annually that is appropriate for reviewing and evaluating performance and for reporting on annual trends. The UDS is the vehicle used by BPHC to obtain this information. (Note: Grantees are also required to report activities funded by ARRA in a separate Health Center Quarterly Report (HCQR). These instructions are included in the HCQR Reporting Manual and are not addressed in this manual).

The UDS includes two components:

- The **Universal Report** is completed by all grantees. The Universal Report consists of all 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** are completed by a sub-set of grantees **who receive multiple grants** from the BPHC health center program. The Grant Report consists of Tables 3A, 3B, 4, part of Table 5 and Table 6A, *only*. These 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 the Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *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 composed of 11 tables intended 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: Provides zip codes of patients served.
- Table 3A: Provides a profile of patients by age and gender.
- Table 3B: Provides a profile of patients by race, ethnicity and language.
- Table 4: Provides a profile of patients by income (% of poverty level) and third party medical insurance source. It also reports the number of targeted population patients receiving services.
- Table 5: Reports staffing full-time equivalents by position, and visits and patients by provider type and service type.
- Table 6A: Reports on primary diagnoses for medical visits and selected services provided.
- Table 6B: Reports findings on quality of care indicators.
- Table 7: Reports findings on health outcomes/disparities.
- Table 8: Details direct and indirect expenses by cost center.
- Table 9D: Reports full charges, collections and allowances by payor as well as sliding discounts and patient bad debt.
- Table 9E: Reports non patient-service income.

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.

Since 2006 persons served by BPHC-supported clinics are referred to in this manual 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 change the individuals who are being counted or reported on in the UDS process. All persons previously referred to and counted under any of these terms will continue to be counted in the UDS.*

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. The **grantee** is the direct recipient of one or more BPHC grants. All grantees that were funded before October 1, 2009 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. Grantees who are funded for the first time after October 1, 2009 and who received no other funds from BPHC during the year are not required to submit a 2009 UDS report.

DUE DATES AND REVISIONS TO REPORTS

Because of changes made to the UDS report and reporting process, submissions of all UDS reports for CY 2009 will be due by March 31, 2010. Grantees are advised, however, to complete their report well before that date to benefit from the new UDS pre-submission review process. To request assistance, please contact the UDS helpline at 1-866-UDS-HELP.

As of this submission, ***all data will be considered final when it is submitted on or before March 31. No post-submission editing or revisions will be permitted.***

HOW AND WHERE TO SUBMIT DATA

Starting with the CY 2008 UDS submission, reporting has been on-line making use of a web based data collection system that is completely integrated with the HRSA Electronic Handbooks (EHBs). Health Center users will use their EHB user name and password to log into the EHB in order to complete their UDS submission. Users will be able to submit the UDS report data using standard web browsers through a Section 508 compliant user interface. The system will present users with electronic forms that will clearly communicate what is required and will guide the users in completing their 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. The approach will continue to permit grantees to distribute the data entry responsibilities amongst multiple users if required. Note, however, that health center staff will be assigned either “view” or “edit” privileges for the *entire* UDS, not just specific tables. Automated edits will check for questionable quantitative and qualitative data to ensure that the data submitted are accurate.

The EHB will provide users with a summary of which tables are complete.

DEFINITIONS OF VISITS, PROVIDERS, PATIENTS AND FTES

This section provides definitions which are critical for consistent reporting of UDS data across grantees.

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). **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.

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 (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 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. An 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. 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. Such services 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. 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 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) to be seen later in the same day at the grantee's fixed clinic site.

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. (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) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, 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.)

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.

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) 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.

PATIENT

Patients are individuals who have at least one visit *during the reporting year*[1], 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 provided UDS-countable visits.

The **Universal Report** includes all patients who have at least one visit during the year within the scope of activities supported by **any** BPHC grant covered by the UDS. On tables 3A, 3B, 4 and 6A of the Universal Report, each patient is 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.

[1] 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.

Persons who only receive services from large-scale 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 are not counted as patients.

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 include, but are not limited to, persons whose only contact is:

- 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 means that the person worked full-time for one year. Each agency defines the number of hours for "full-time" work. For example, if a physician is hired full-time and works 36 hours per week, she is a 1.0 FTE. The full-time equivalent is based on employment contracts for clinicians and 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 hours weeks. FTE is also based on the number of months 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 and residents 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 multiple BPHC grants**. These reports repeat all or part of the elements of five of the Universal Report tables. They 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 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 multiply funded 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**.

For **Grant Reports,** grantees provide data on the patients and activities within that part of their program which is **funded under a particular grant**. Because a patient can receive services through more than one type of BPHC grant, 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 only one BPHC grant are required to complete only the Universal Report. Agencies with multiple BPHC grants, 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 has a Health Care for the Homeless grant (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) grants, completes a Universal Report, a Grant Report for the Homeless grant, and a grant report for the Migrant grant.
- 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 the Universal or Grant Report is left blank.

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 Identity 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	

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 overlap.

It is the BPHC's goal to identify residence by zip code for all patients served, but it is understood that residence information may not be available for all 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.

- Migrant Patients: Many Migrant Farm Workers may 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.

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 small number of patients from a large number of zip codes. To ease the burden of reporting, *zip codes with less than ten patients* should be aggregated and reported in an "Other" category.

QUESTIONS AND ANSWERS FOR ZIP CODE REPORTING

1. **Are there any changes to this table?**
   Information previously reported on the "Cover Sheet," other than zip code information, is no longer reported.

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 small number of patients from a large number of zip-codes. To ease the burden of reporting, zip codes with less than 10 patients should 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 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 TABLES 3A AND 3B – PATIENTS BY AGE AND GENDER AND PATIENTS BY HISPANIC or LATINO IDENTITY / RACE / LANGUAGE

Tables 3A and 3B provide demographic data on patients of 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 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: ethnicity and race 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.

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 tables 6B and 7, age is essentially defined as age on December 31st, thus providing a cross check on the selection of the universe. The numbers on Table 3A will *not* be the same as those on Tables 6B and 7, though they will be reasonably close.

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

NOTE: Line numbers on this table have changed. Be sure you report on the correct line.

Table 3B now displays the race and ethnicity of the patient population in a matrix format. This permits the racial identification of the Hispanic/Latino population. Race and ethnicity continue to be defined as in the past:

HISPANIC/LATINO IDENTITY:

- This table collects information on whether or not patients consider themselves to be of Hispanic/Latino identity *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, based on 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 identity data.
- Column C (Unreported / Refused to Report): Only one cell is available in this column. Report only those patients who left the entire race and Hispanic/Latino Identity part of the intake form totally blank on line 7, column C.

- 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/Latino". Patients who self-report race but do not separately identify if Hispanic/Latino 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, 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 having origins in 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".

Note: Grantees are required to report race *and* ethnicity for all patients; however, 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/Hispanic or Latino identity.

LANGUAGE:

- Report on line 12 the number of patients who are best served in a language other than English or with sign language.
- Include those patients who were served 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 race data changed?**
   No. 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 addition of the race classification, 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 should patients of Hispanic/Latino ethnicity now be reported?**
   In 2008, we divided the table into two sections. In 2009, the table has been revised to show race and ethnicity data in a matrix. Patients who were once reported as Hispanic / Latino independent of race will now be reported in Column A as Hispanic/Latino. Patients are to be reported on lines 1 through 7 depending on their race. If "Hispanic/Latino" is the only identity recorded in the center's files, these patients will be reported in column A on line 7 as having an "Unreported" racial identification.

3. **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, 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 not to be counted as patients or reported on Table 3A or 3B.

4. **Do 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 Identity 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).

5. **Does race *and* Hispanic/Latino identify of all our patients need to be collected and reported?**
   Yes. The UDS requires the classification of race and Hispanic/Latino identity 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.

6. **Do I count my ARRA patients on this table?**
   To the extent that they qualify as patients, they are counted. This means that they must have been seen in 2009.

Reporting Period: January 1, 2009 through December 31, 2009

TABLE 3A – PATIENTS BY AGE AND GENDER

	AGE GROUPS	MALE PATIENTS (a)	FEMALE PATIENTS (b)
NUMBER OF PATIENTS			
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 IDENTITY / RACE / LANGUAGE

		PATIENTS BY HISPANIC OR LATINO IDENTITY			
PATIENTS BY RACE		HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED / REFUSED TO REPORT (c)	TOTAL (d)
NUMBER OF PATIENTS					
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)
NUMBER OF PATIENTS		
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 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. Note 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.**

NOTE: The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Lines 8 column D (total patients by race and Hispanic/Latino identity); 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).

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. Patients for whom the information was not collected within the last year ***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. (Available at http://aspe.hhs.gov/poverty/09poverty.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 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 is likely to change throughout 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+. Primary patient medical insurance is divided into seven types as follows:

- Uninsured (Line 7) – Patients who do not have *medical insurance* at the time of the last visit are counted on line 7. This includes 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 as uninsured a patient whose medical insurance did not cover 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.

- CHIP (Line 8b or 10b) – The Children's Health Insurance Program (also known as CHIP) provides primary health care coverage for children and, on a state by state basis, others – especially parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans. In some states that make use of Medicaid, it is 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). Where it is not obvious, CHIP may often 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.* 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.

- 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 above. 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, 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 should be reported as "Medicaid", not as privately insured.

- 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 this line. 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) – CHIP programs which are run through the private sector, often through HMOs. The coverage may appear to be a private insurance plan (such as Blue Cross / Blue Shield) but is funded through CHIP.

- 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.

PATIENTS BY SOURCE OF INSURANCE

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 editor can make sure that the classification of the program as other public is appropriate.); and Line 10 is the sum of 10a + 10b.

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 (usually less than $10 per member per month) to "manage" patient care. Do not include managed care enrollee 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 can often be obtained from monthly enrollment lists generally supplied by managed care companies to their providers.

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 and Medicare it is usual for there to be a second "wrap-around" payment for managed care visits to adjust total payment to FQHC 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: Do not include 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

CHARACTERISTICS OF TARGETED SPECIAL POPULATIONS, LINES 14 - 26

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. Section 330(g) grantees (only) 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 the past 24 months 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 the past 24 months and their dependent family members who have also used the center.

For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation, and *on-site* processing for market or storage. 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

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.

- 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.
- "Street" includes 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.
- 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, code as "street".
- Section 330(h) Homeless Program grantees should report previously homeless patients now housed *but still eligible for the program* on Line 21, "other".
- Patients residing in SRO (single room occupancy hotels) or motels or other day-to-day paid for housing should be classified as "other", line 21.

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.

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, 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 a Health Care for the Homeless, or Migrant grant, 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. It 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 2009 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, the number of visits they render and the number of patients served by service category. Unlike Tables 3A, 3B, and 4, where an unduplicated count of patients is reported, Column C of Table 5 is designed to report the number of unduplicated patients within each of six major service categories: medical, dental, mental health, substance abuse, other professional, and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes. (NOTE: Staffing data are not reported on 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 grants 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

This table 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 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 annual Full-Time Equivalents (FTEs)**. A person who works 20 hours per week (i.e., 50 percent 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 10 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 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, 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 list appears in Appendix A.

- **MEDICAL CARE SERVICES (Lines 1 – 15)**
  - **Physicians** - M.D.s and D.O.s, except psychiatrists, pathologists and radiologists. Naturopaths and Chiropractors are *not* counted here.
  - **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. Medical records and patient support staff are *not* reported 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.

- **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 20 and 21 as appropriate.)

- **Psychiatrists (Line 20a)**
- **Licensed Clinical Psychologists (Line 20a-1)**
- **Licensed Clinical Social Workers (Line 20a-2)**
- **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 providing counseling, treatment or support services related to mental health professionals.

- **SUBSTANCE ABUSE SERVICES (Line 21)** - 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. (Note: Behavioral health services are include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between lines 20 and 21 as appropriate.)

- **ALL OTHER PROFESSIONAL HEALTH SERVICES (Line 22)** - Occupational and physical therapists, nutritionists, podiatrists, optometrists, naturopaths, chiropractors, acupuncturists and other staff professionals providing health services. 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.) There is a "specify" box that must be completed. Explain the specific other professional health services included.

- **PHARMACY SERVICES (Line 23) -** Pharmacists (including clinical pharmacists), 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.

- **ENABLING SERVICES (Lines 24 - 29)**
  - **Case Managers (Line 24)** - staff who provide services to aid 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 may include nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, but not when it is an integral part of their other function. Care / Referral Coordinators are considered Case Managers.
  - **Patient and Community Education Specialists (Line 25)** - health educators, 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.
  - **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 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, and related assistance programs.

Personnel Performing Other Enabling Service Activities (Line 28) - all other staff performing services as enabling services, not described above. There is a "specify" field that must be used to describe what these staff are doing.

- **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.

- **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, 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 30 - 33)**
  - **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*.
  - **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 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.

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 editing 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.

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical (physicians, mid-level providers, nurses)	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 – 20: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g. nutritionists, podiatrists, etc.)	9: Other Professional
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 independent professional judgment in the provision of services to the individual. (See "Definitions of Visits, Providers, Patients, and FTE" section, page 6, for further details on the definition of visits). Grantees are to report visits during the reporting period which were rendered by staff identified in column A, regardless of whether the staff are salaried or contracted 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 had 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, or referrals where only nominal amounts are paid,*** or referrals for services that would otherwise not be counted as visits.

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 9 for further details) Report the number of patients for **each** of the six 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 (as a medical patient) regardless of the number of medical visits. 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 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)

If you show visits in Column B for any of these six categories, you are required to show the unduplicated number of persons 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 service are not counted as medical patients, etc.

QUESTIONS AND ANSWERS FOR TABLE 5

1. **Are there changes to this table?**
   No, but in 2008 several changes were made:
   a. Line 1 now reads "Family Physicians" instead of "Family Practitioners". This is a title change only and does not denote a new group of providers.
   b. Line 20a1 and 20a2 have been added for Licensed Clinical Psychologists and Licensed Clinical Social Workers. These individuals were previously counted on line 20b, Other Licensed Mental Health Providers.
   c. Line 20c, "Other Mental Health Staff" no longer includes Licensed Clinical Psychologists and Licensed Clinical Social Workers.
   d. Line 30, Administration has now been divided into lines 30a (Management and Support Staff), 30b (Fiscal and Billing staff) and 30c (IT staff.) All staff time formerly counted on line 30 which does not explicitly fit into lines 30b or 30c should be included in line 30a.

2. **How do I count participants in a group session?**
   If you have group treatment sessions (e.g., for substance abuse, mental health, 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. *No group medical 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 time?**
   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 providers doing administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc. is not to be adjusted. 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 including chairing or attending meetings, supervising staff, and writing clinical protocols. 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. **Is it appropriate for the total number of patients reported on Table 3A to be equal to the sum of the several types of service patients on Table 5?**
   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 six different types of patients identified on Table 5, a patient who is counted only once on Table 3A may be counted up to six different places on Table 5.

   Grantees which provide only medical services *will* report the same number of total patients on Table 3A as they do medical patients on Table 5 (Line 15). But where an agency has more than one type of patient (e.g., medical and dental or medical and enabling) the sum of the numbers in column c of Table 5 will *never* be the same as those on Table 3A.

5. **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.

6. **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.

7. **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 line 20. 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.

8. **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.

9. **Do I count the time of residents?**
   Yes. 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 and often have more vacation time or other time off than other practitioners. This would make them less than full time. See also the discussion in Appendix B.

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

10. **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 "Mid-Levels" (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	**Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
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			
30	**Total Administrative Staff (Lines 30a-30c)**			
31	Facility Staff			
32	Patient Support Staff			
33	**Total Admin & Facility (Lines 30 – 32)**			
34	**Total (Lines 15+19+20+21+22+23+29+29a+33)**			

INSTRUCTIONS FOR TABLE 6A - SELECTED DIAGNOSES AND SERVICES RENDERED

This table reports data on selected *primary* diagnoses and services rendered. It is designed to provide information on primary diagnoses and services 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 selected conditions and services provided 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. 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 only those visits provided and those individuals served within the scope of the program being reported on.

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.

Selected Tests/Screenings/Preventive Services – Lines 21 through 26c present the name and applicable ICD-9CM diagnostic and visit codes and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served. On several lines both CPT codes and IC9 codes are provided. Grantees should use *either* the CPT codes *or* the ICD9 codes for any given line, *not both.* Note that for these lines, the concept of a "primary" code is neither relevant nor used. *All* services are reported. A reported *service* may be in addition to a reported primary *diagnosis* or may stem from a visit where there was no UDS-reportable diagnosis code.

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 – 18.* Wherever appropriate, services have been grouped into code ranges. Some codes are included on more than one line. In these cases the service would be counted on *each* line. 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.

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. Note: 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 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 an 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 lines 9 and 11, regardless of how many times they were seen.

LINES 21 – 26c: Services Data.

Patients by Selected Diagnostic Tests/Screenings/Preventive Services (Lines 21-26c). 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 21-26c 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 during the reporting period for each of the selected dental services listed on Lines 27-34. 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. Note that some ADA codes are listed twice. For example, the code for "fluoride treatment and prophylaxis" is listed once under fluoride treatments and once under prophylaxis. In these cases the service would be counted on *each* line.

QUESTIONS AND ANSWERS FOR TABLE 6A

1. **Are there changes to this table?**
   Yes. Several new lines have been added this year including two new diagnoses and three new services. Specifically:
   - 14a. Overweight or obesity
   - 19a. Tobacco use disorder
   - 26a. Childhood lead testing (9 to 72 months)
   - 26b. Screening, Brief Intervention, and Referral to Treatment
   - 26c. Smoking and tobacco use cessation counseling treatment

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.

3. **The instructions call for diagnoses or services as 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 and the level of documentation that is done. If a service is provided *as a result of a prescription or plan from an earlier visit* **it *is* counted.** For example, if a provider asked a woman to come back in four months for a Pap test, 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 and 2	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 pay and 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 will understate services in the circumstances described. 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 have a zero charge attached to it.

Line #	Problem	Potential Solution
21	HIV Tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Use other data sources such as logs of HIV tests conducted or reports to Ryan White programs and use this number of tests.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Use the bills from the independent contractor to identify the total number of mammograms conducted during the course of the year and report this number.
23	Pap tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Use other data sources such as logs of Pap tests conducted and use this number of tests.
24	Flu shots are not counted because they are obtained at no cost by the center.	Use the Medicare cost report data on influenza vaccination reimbursements as an estimate for the number of actual visits where flu shots were administered.
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.	Use records developed for the Title X or state family planning program to count the number of family planning visits. Take care not to count the same visit twice.

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.	Symptomatic HIV	042 , 079.53		
2.	Asymptomatic HIV	V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
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		
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; 90669; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24a	Seasonal Flu vaccine	**CPT-4:** 90655 - 90662		
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;		

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
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		

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, 2009. American Medical Association.

Current Procedural Terminology, (CPT) 2009. American Medical Association.

Current Dental Terminology, (CDT) 2009 / 2010. 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 are commonly seen in the health care community as indicators of overall community health. These 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 routine and preventive care, we can expect improved health status of the patient population in the future. For example,

- 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

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 and that individual health centers may be using others in addition to these.

The table is included only in the Universal Report, and includes patients and services supported by the ARRA program.

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS, SECTIONS A AND B

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 include 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.

[2] Note that this is a minor change from prior years. In prior years patients who delivered in early days of the new year but had their last prenatal care visit in the prior year were not counted. This new table counts those women as well. Thus, a woman whose last prenatal care visit was December, 2008 who delivered on January, 2009 will be reported on the 2009 table.

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*[2] during the reporting period, are reported on lines 7– 9. The trimester (line) 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 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 midlevel provider who initiates prenatal care with a complete physical exam. 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.

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[2]. If the woman began prenatal care during the first trimester at the grantee's service delivery location, she is reported on Line 7 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 Column B, regardless of when she begins care with grantee.

SECOND TRIMESTER (Line 8) Includes women who received prenatal care during the reporting period and 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 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, 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 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 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, 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.) The sum of the six cells will equal the number on line 6 – patients by age.

CHILDHOOD IMMUNIZATIONS AND PAP TESTS, SECTIONS C AND D

[2] 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.

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):

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 to be reported. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 2007 and December 31, 2007.

SECTION D: PAP TESTS (Line 11)

Women aged 24 through 64 with at least one medical visit during the reporting period, who were first seen by the clinic at some point prior to their 65th birthday are to be reported. For the purposes of this year's reporting this includes women whose date of birth is between January 1, 1945 and December 31, 1985.

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 sampling profile.

For each of the two 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 are quite likely to portray a much 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 criteria as 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 (and gender) comparisons to the numbers on Table 3A will be made. But because the definitions are different, 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.

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 (the universe) or a scientifically drawn sample of 70 patients from all patients who fit the criteria, *whichever is less*. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire user population identified for 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 result in over-sampling 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 single clinic patient who meets the criteria described below for inclusion in the universe.
- Every item in the 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 1 year full operation for the EHR before it can be used in lieu of chart audits.

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.

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." 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. 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) and 4 Pneumoccocal conjugate 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. For measurement year 2009, this includes all children with date of birth between January 1, 2007 and December 31, 2007. Children who were never seen by the clinic prior to their second birthday are excluded, but anyone seen on or before their 2nd birthday is included in the universe. There will no doubt be a number of children for whom no vaccination information was available and 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, 2007 and December 31, 2007, *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 2007 or 2008.)

Include all children meeting this criterion regardless of whether they came to the clinic specifically for vaccinations or well child care, or they came for an injury or illness.

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 allowable vaccination-exclusions:

- **Any particular vaccine:** Contraindication: Allergic reaction to the vaccine or its components: ICD-9: 999.4.
- **DTaP:** Contraindication: Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine).
- **VZV and MMR:** Contraindications:
  - 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.
  - 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:** Contraindication: Allergic reaction to streptomycin, polymyxin B or neomycin.
- **Hib:** Contraindication: None.
- **Hepatitis B:** Contraindication: Allergic reaction to common baker's yeast.
- **Pneumococcal conjugate:** Contraindication: None.

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

Enter number of charts sampled in column b, or, if an EHR is used, copy the number from column a. The number of charts to be sampled equals all patients who fit the criteria (the universe reported in column a) or a scientifically drawn sample of 70 patients from all patients who fit the criteria, whichever is less. See discussion of sample size above on page 48.

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) and 4 Pneumoccocal conjugate 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) vaccination, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be

counted. Note: because use of Comvax (a product which immunizes against both Hep B and Hib) requires only three doses, the measure requires meeting the minimum possible standard of three doses, rather than the recommended four doses, though the intent is to ensure complete HiB vaccination.

- **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.

- **Combination 2 (DtaP, IPV, MMR, HiB, hepatitis B, VZV):** Children who received four DTaP/DT vaccinations; three IPV vaccinations; one MMR vaccination; three HiB vaccinations; three hepatitis B; and one VZV vaccination.

- **Combination 3 (DtaP, IPV, MMR, Hib, hepatitis B, VZV, pneumococcal conjugate):** Children who received all of the antigens listed in combination 2 and four pneumococcal conjugate vaccination.

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

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)

* 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 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 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. This applies only to 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. Percentage of women 24 - 64 years of age who received one or more Pap tests during the measurement year or during the two calendar years prior to the measurement year.

- **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. For measurement year 2009, this includes patients with a date of birth between January 1, 1945 and December 31, 1985.

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

Enter the number of all female patients who:

- Were born between January 1, 1945 and December 31, 1985 *and*
- Were first seen by grantee prior to their 65th birthday *and*
- Had at least one medical visit in a clinical setting during 2009.

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.

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 or a scientifically drawn sample of 70 patients from all patients who fit the criteria, *whichever is less*. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire user 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.

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 2007 through 2009. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. A female patient is counted as having had a Pap test if a submitted claim/visit contains any one of the following codes or if a copy of a lab test performed by another provider is in the chart or if a note documents the name, date, and results from a test performed by another provider: 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 documentation.

QUESTIONS AND ANSWERS FOR TABLE 6B

1. **Are there any changes to the table this year?**
   All elements in this table were present in 2008, however the specific CPT codes for vaccines have been changed. Further, the women included in the Pap test universe have been changed to 24 to 64 years olds from 21 to 64.

2. **Can we continue to use 21 – 64 year olds in our Pap test sample?**
   No. In order to align the data from the UDS with data nationally,HRSA has updated the ages tested. Using the incorrect age range 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 age range (such as 21 and older or one which begins at onset of sexual activity) *for their own internal quality assurance process,* but this may not be substituted for the requirements set for UDS reporting of women 24 to 64 years old.

3. **A child came in only once in 2009 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 considered to be responsible to provide all needed preventive health care and/or document that they have received it.

4. **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 part of our sample for Pap tests? 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 2009. If there is no copy of the results of her Pap test included in her chart, she would be considered out of compliance.

5. **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 will now be valid for successive years depending on when the test was performed.)

6. **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**.**

7. **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 this is not required. 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 through other appropriate means. Health Center patients should not be requested to return to the center to provide immunization documentation.

8. **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.

9. **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 or the grantee is to report on the total universe, whichever is smaller. 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.

10. **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.

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	Number of children who have received required vaccines who had their 2nd birthday during measurement year (on or prior to December 31)			

SECTION D – PAP TESTS				
	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	Number of female patients aged 24-64 who had at least one Pap test performed during the measurement year or during one of the two previous calendar years			

INSTRUCTIONS FOR TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

This table reports data on selected health outcome indicators by race and Hispanic/Latino identity. 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. For example:

- 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 and that individual health centers may be using others in addition to these.

Table 7 reports health outcomes by race and Hispanic/Latino identity to provide information on the extent to which health centers help reduce health disparities. Race and Hispanic/Latino identity is self-reported by patients and should be collected as part of a standard registration process. Health centers who report on a sample 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 health outcome indicators which can be used to evaluate disparities for BPHC-funded programs, overall.

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 in column (i) *regardless of whether or not they provide prenatal care services*.

DELIVERIES AND LOW BIRTH WEIGHT BY RACE AND HISPANIC/LATINO IDENTITY, SECTION A (LINES 1-5)

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 HC prenatal care patients who delivered during the reporting period[3], and all children born to them, are reported on lines 1 – 5. This table is similar to a table previously collected in the UDS, but has a different population reported.

PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Line 1)

Report the total number of women who were known to have delivered during the year, even if the delivery was done by another provider. Grantees are required to follow up on women who

[3] Note that this is a change from prior years. In prior years only those patients who also had a prenatal care visit in the reporting period were counted, and some patients who delivered in the first few days of the new year were left out. This new table counts those women as well.

are referred out, 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.)

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 / Hispanic/Latino identity 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, regardless of the method of compensation. Do *not* include deliveries where a clinic doctor bills separately, receives, and retains payment for the delivery.

BIRTHWEIGHT OF INFANTS BORN TO PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Lines 3 — 5)
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. **NOTE:** Grantees must report deliveries and the birthweight of live children delivered for **all** women who were in their prenatal care program and who delivered during the reporting period, *regardless of whether the grantee did the delivery themselves, referred the delivery to another provider or was for a woman who transferred to another provider on her own.* The number of deliveries reported on line 1 will normally not be the same as the total number of infants reported on lines 3 - 5 because of multiple births and still births.

HYPERTENSION AND DIABETES BY RACE AND HISPANIC/LATINO IDENTITY, SECTION B

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 at least two medical visits during the reporting period):

SECTION B: HYPERTENSION (Lines 6-8)
The proportion of hypertensive patients whose most recent blood pressure showed a systolic pressure under 140 and a diastolic pressure under 90 is calculated.

SECTION C: DIABETES (Lines 9-13)
The proportion of diabetic patients whose most recent HbA1c is in a given range: HbA1c levels less than 7%, 7% to 9%, greater than 9% is calculated.

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.

For each of the two populations being surveyed, 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.

HYPERTENSION (Lines 6-8):

This section of Table 7 reports on all HC adult patients, 18 to 85 years of age, who have been diagnosed as hypertensive before June 30 of the measurement year and 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: Proportion of patients born between January 1, 1924 and December 31,1991 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. This may well be appropriate, but for the purposes of UDS reporting, the 140/90 measure must be used.)

- **Numerator:** Number of patients with last systolic blood pressure measurement <140 mm Hg and diastolic blood pressure < 90 mm Hg during the measurement year among those patients included in the denominator.

- **Denominator:** All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension (HTN), who have been seen for medical services at least twice during the reporting year, and who had a diagnosis of hypertension before June 30 of the measurement year whose chart was reviewed.

TOTAL PATIENTS AGED 18 to 85 WITH HYPERTENSION, ROW 6

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

- Were born between January 1, 1924 and December 31, 1991 and,
- Have been seen at least twice during the reporting year for medical services 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 or is currently being treated. The notation of hypertension may appear during or prior to the year 2009. Hypertension may also be identified by finding any of the following:

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 hypertension" are not sufficient to confirm the diagnosis of hypertension if such statements are the *only notations* hypertension in the medical record.

Blood pressures 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 changes based on those readings, the health center can use the measurement.

CHARTS SAMPLED OR EHR TOTAL, ROW 7

Enter the total number of hypertensive health center patients by race and Hispanic/Latino identity for whom data have been reviewed. In most cases this will be all patients who fit the criteria or a scientifically drawn sample of 70 patients, *whichever is less*. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire universe identified on row 6. 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 over-sampling 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.

If the EHR is to be used, the number on line 7 will be equal to the number on line 6. NOTE: Your PC-DEMS or PECS system may be used to report the universe ONLY IF it includes all required data elements, e.g., it includes data for the required time frame for all hypertensive (or diabetic) patients from all service sites.

PATIENTS WITH CONTROLLED BLOOD PRESSURE, ROW 8

Hypertensive patients born between January 1, 1924 and December 31, 1991 whose charts have been reviewed (those identified on line 7) 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 2009 are to be reported on line 8 by race and Hispanic/Latino identity. (Patients who have not had their blood pressure tested during the reporting year will not be counted as meeting the performance measure.)

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO IDENTITY NUMBERS:

1. Comparisons are made between the universe reported on Table 7, line 6 and the data reported on Table 3B. Under no circumstances may a grantee report more hypertensive Hispanic/Latinos or individuals from any given race on line 6 than reported on Table 3B.

2. Under most circumstances Column h will be zero. Use Column h only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the 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 (Lines 9-13):

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

PERFORMANCE MEASURE: Proportion of adult patients born between January 1, 1934 and December 31, 1991, with a diagnosis of Type I or Type II diabetes, whose most recent hemoglobin A1c (HbA1c) was less than or equal to 9% will be calculated. Grantees are to report results in three categories: less than 7% (good control); greater than or equal to 7% and less than or equal to 9%; and greater than 9% (poor control).

- **Numerator:** Number of adult patients whose most recent hemoglobin A1c level during the measurement year is ≤ 9% among those patients included in the denominator.

- **Denominator:** Number of adult patients 18 – 75 as of December 31 of the measurement year with a diagnosis of Type I or II diabetes 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.

TOTAL PATIENTS AGED 18 - 75 WITH TYPE I OR II DIABETES, ROW 9

Enter the number of adult patients by race and Hispanic/Latino identity who meet the following criteria:

- Were born between January 1, 1934 and December 31,1991 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 2009. To confirm the diagnosis of diabetes, one of the following codes must be found in the medical record:
  - ICD-9-CM Codes 250.xx, 648.0, or
  - diabetic patients may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics / antihyperglycemics.

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. Also exclude any patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year. [4]

CHARTS SAMPLED OR EHR TOTAL, ROW 10

Enter the total number of diabetic health center patients by race and Hispanic/Latino identity for whom data have been reviewed. In most cases this will be all patients who fit the criteria or a scientifically drawn sample of 70 patients, *whichever is less* using the methodology described in Appendix C. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire user population defined as the universe on line 9. 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

[4] 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.

stratification mechanisms that result in over-sampling 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.

If the EHR is to be used in lieu of the chart audit, the number on line 10 will be equal to the number on line 9.

REPORTED HEMOGLOBIN A1c LEVELS, ROW 11-13

For this report, the most recent hemoglobin A1c (HbA1c) level as documented through laboratory data or medical record review is reported. If there is no HbA1c level during the measurement year, the chart will be reported on line 13: "greater than 9.0%". Thus a patient with no test during the current year is counted with those who have poor HbA1c control.

- **Patients with HBA1c < 7% (Line 11):** Number of patients included in the sample (i.e., in both lines 9 and 10) whose most recent HbA1c was less than 7%.
- **Patients with 7% ≤ HBA1c ≤ 9% (Line 12):** Number of patients included in the sample (i.e., in both lines 9 and 10) whose most recent HbA1c was greater than or equal to 7%, but less than or equal to 9%.
- **Patients with HBA1c > 9% (Line 13):** Number of patients included in the sample (i.e., in both lines 9 and 10) whose most recent HbA1c was greater than 9% ***or*** patients who did not receive a HbA1c test during the reporting year or whose test result is missing.

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO IDENTITY NUMBERS:

1. Comparisons are made between the universe reported on Table 7, line 9 and the data reported on Table 3B. Under no circumstances may a grantee report more diabetic Hispanic/Latinos or individuals from any given race on line 9 than reported on Table 3B.

2. Under most circumstances Column h will be zero. Use Column h only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the 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?**
   Beginning 2009, grantees report on Table 7 using a matrix in order to report both race and Hispanic/Latino identity. One section provides, for Hispanic/Latinos, a set of columns for each reportable race as well as "unreported/refused to report race". A second section does the same for Non-Hispanic/Latinos. Individuals who do not classify themselves as Hispanic/Latino are to be reported as non-Hispanic/Latino. Those patients who refuse to report both race information and Hispanic/Latino identity are to be reported as "Unreported/Refused to Report" discussed in question 2 below.

2. **When would we use Column h?**
   Column h will normally not be used. It is to be used only in those instances where a patient states that they refuse to provide their race and say whether or not they are Hispanic/Latino. Patients who do not answer affirmatively to a question about Hispanic/Latino identity are to be classified as Non-Hispanic/Latino in the second set of columns.

3. **Data are requested by race and Hispanic/Latino identity. How are these to be coded?**
   Race and Hispanic/Latino identity 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 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*** or the total universe, whichever is smaller. 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

		Hispanic/Latino (1)								Non - Hispanic/Latino (2)								Unreported / Refused to Report Race and Identity (h)	Total (i)
		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to Report (g)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to report (g)		
HIV Positive Pregnant Women		<<report total only>> ---------->																	
(NO PRENATAL CARE PROVIDED? CHECK HERE: □)																			
SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO IDENTITY																			
1	Prenatal care patients who delivered during the year																		
2	Deliveries performed by Grantee Provider	<<report total only>> ---------->																	
3	Live Births < 1500 grams																		
4	Live Births 1500 – 2499 grams																		
5	Live Births ≥ 2500 grams																		

		Hispanic/Latino (1)								Non - Hispanic/Latino (2)								Unreported / Refused to Report Race and Identity (h)	Total (i)
		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to Report (g)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to report (g)		
SECTION B: HYPERTENSION BY RACE AND HISPANIC/LATINO IDENTITY																			
Patients 18 to 85 diagnosed with hypertension whose last blood pressure was less than 140 / 90																			
6	Total hyper-tensive patients																		
7	Charts sampled or EHR total																		
8	Patients with HTN controlled																		
SECTION C: DIABETES BY RACE AND HISPANIC/LATINO IDENTITY																			
Patients 18 to 75 diagnosed with Type I or Type II diabetes: Most recent test results																			
9	Total patients with diabetes																		
10	Charts sampled or EHR total																		
11	Patients with HBA1c < 7%																		
12	Patients with 7% ≤ HBA1c ≤ 9%																		
13	Patients with HBA1c > 9% **OR** No test during year																		

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 grants covered by the UDS including costs covered by an ARRA IDS or NAP grant. All costs are to be reported on an accrual basis. These are the costs attributable to the period, including depreciation, regardless of when actual payments were made. Do not report on the UDS the repayment of the principle of a loan.

DIRECT 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 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 Medical, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, 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. 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 Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenue (Line 10).
>
> **ADMINISTRATIVE COSTS** should be allocated after facility costs have been allocated, and should include the facility costs allocated to it. Administrative cost is allocated based on a straight line allocation method. The proportion of total cost (excluding administrative 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. If you have an alternative method that provides more accurate allocations, it may be used, but save your 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 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 reporting software. Column C also shows the value of any donated facilities, services and supplies on Line 18. These non-cash donations should be reflected 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 costs without 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, or professional dues and subscriptions). It does not include costs associated with pharmacy, dental care, substance abuse specialists, or mental health (psychiatrists, clinical psychologists, clinical social workers, etc.) services.

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 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 allocated in Column B. Include the cost for vouchered or contracted medical services on line 1.

LAB AND X-RAY COSTS (Line 2) – Include all costs for 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 COSTS (Line 3) – Include all other direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, CME, laundering of uniforms, recruitment, membership in professional societies, books and journal subscriptions, 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, and services rendered by other professional personnel (e.g., optometrists, occupational and physical 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 and facility costs should be included on Line 15 Column A and allocated 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 and facility costs should be included on Line 15 Column A and allocated in Column B. (See also Q & A discussion for table 5 on page 36.)

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 and facility costs should be included on Line 15 Column A and allocated in Column B. (See also Q & A discussion for table 5 on page 36.)

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. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in 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.)

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

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

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, 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 and

facility costs should be included on Line 15 Column A and allocated 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 (11 b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (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, 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 included on Line 15 Column A and allocated in Column B. 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, interest payments, utilities, security, grounds keeping, facility maintenance, 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 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:

FTE’s reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical (physicians, mid-level providers, nurses)	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 – 20: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g. nutritionists, podiatrists, etc.)	9: Other Professional
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.,	15: Administration

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
corporate, intake, medical records, billing, fiscal and IT staff)	
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, 2009, allocates 25 percent of costs in each cost category to the 2009 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, 2009 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 are no changes to this table in 2009.

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?**
   The UDS report does not follow all FASBI and GAAP accounting rules and this is one of those rules. 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 an individual comes to your health center and provides 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 the Vaccines For Children (VFC) program. 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 2009 depreciation on those capital projects which have been placed in use, consistent with the health center's usual depreciation rules.

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 _____)			
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9)			
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, retroactive settlements, allowances, self-pay sliding discounts, and self-pay bad debt write-off. It is not acceptable under the statute to not have a fee schedule or to not charge patients and their third party payors. This does not preclude the center from discounting these fees (see discussion regarding Sliding Discounts below, page 77) 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 is 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, 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.

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, 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.

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, BCCCP (Breast and Cervical Cancer Control Programs with various state names,) and other dedicated state or local programs as well as state insurance 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 other public programs are reported as "uninsured" on Table 4.

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 of this table);
- Report all amounts not collected from the patients as sliding discounts or bad debt write-

off, as appropriate, on line 13 of this table; and
- Report collections from the associated state and local indigent care programs on Table 9E. 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 or private insurance companies. 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, the Federal Employees Insurance Program, Workers Compensation, etc. 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. **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, the patient, or written off to sliding fee discounts. Full gross charges should always be reported and 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 some instances, a charge will initially be made to one carrier, only to be denied or paid only in part. It will then be moved to the secondary payor.

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 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 the dispensing of these pharmaceuticals, however, may 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 the proper category is an incorrect procedure since it will result in overstatement by including both charges and the adjustments.

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 amount of net 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 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 and due from patients are recorded as "self pay" on Line 13.

RETROACTIVE SETTLEMENTS, RECEIPTS, OR PAYBACKS (Column c) — *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 Medicare and Medicaid that cover services provided during the current reporting period.

COLLECTION OF RECONCILIATION/WRAP AROUND, PREVIOUS YEARS (Column c2) Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during previous reporting periods.

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/INCENTIVE/WITHHOLD (Column c3) Enter other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans

PENALTY/PAYBACK (Column c4) – Enter payments made to FQHC payors because of overpayments collected earlier. Also enter payments made to managed care plans (e.g., for over-utilization of the inpatient or specialty pool funds).

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.*

ALLOWANCES (Column d) – Allowances are granted as part of an agreement with a third-party payor. Medicare and Medicaid, for example, may have a maximum amount they pay, and the center agrees to write off the difference between what they charge and what they receive. *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 Medicaid, Medicare, other third-party, and other public payors reimburse less than the grantee's full charge, and the grantee cannot bill the patient for the remainder, enter the remainder or reduction on

the appropriate payor line 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 are recorded as sliding fee 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 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 of the net collectable amount for the Self-Pay category should be made on Line 13 column f. Bad debt write off 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.

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?**
   Beginning in 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) added requirements for managed care programs to reconcile payments to cost similar to FQHC for Medicaid. As a result, columns c1 and c2 have been opened up on lines 7 – 9. These cells are to be used for CHIPRA adjustments only.

2. **Are there any important issues to keep in mind for this table?**
   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 and collections from patients as "self-pay" (Line 13);
   - Report all amounts not collected from the patient as sliding discounts or bad debt, as appropriate, on Line 13 of this table;
   - 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 a `cash' table in as much as all entries represent charges, collections, and adjustments recognized in the current year. All entries represent actual charges and adjustments for the 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 check 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 deductible 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 deductible 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 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 cash receipts for the reporting period that supported activities described in the scope of project(s) covered by any of the four BPHC grant programs. Income received during the reporting period means cash receipts received during the calendar year for 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 Agricultural, but are always passed through the State, and are reported on Line 6.

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. (Do not include ARRA funds on these lines.) 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.

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

INTEGRATED SERVICES DEVELOPMENT INITIATIVE GRANTS — This line has now been deleted. Most of these grants are completed, but if you drew down funds from an ISDI grant in 2009, report them on line 3, Other Federal, and explain.

SHARED INTEGRATED MANAGEMENT INFORMATION SYSTEMS GRANTS — This line has now been deleted. Most of these grants are completed, but if you drew down funds from a Shared Integrated Management Information Systems grant in 2009, report them on line 3, Other Federal, and explain.

CAPITAL IMPROVEMENT PROGRAM GRANTS (Line 1j) — Enter the amount of Capital Improvement Program grant dollars drawn down. ***DO NOT INCLUDE ARRA CAPITAL IMPROVEMENT GRANTS ON THIS LINE. They are to be reported on line 4a.***

TOTAL BPHC GRANTS (Line 1) – Enter the total of Lines 1g (Total Health Center Cluster), and 1j (*non-ARRA* Capital Improvement Program 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 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 in 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 Title II Ryan White funds. These are included below on Lines 6 through 8. Grantees are asked to describe the programs so the UDS editor can make sure that the classification of the program as a federal grant is appropriate.

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 (line 4) and/or ARRA Capital Improvement and/or Facility Investment grant funds (line 4a) which were drawn down in 2009. 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.

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

NON-FEDERAL GRANTS OR CONTRACTS

STATE GOVERNMENT GRANTS AND CONTRACTS (Line 6) — Enter the amount of funds received under State government grants or contracts. "Grants and Contracts" are defined as amounts received on a line item or other basis which are not tied to the delivery of services. They do NOT include funds from state/local indigent care programs. When a state or 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 editor 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 editor can make sure that the classification of the program as a state/local indigent care program is appropriate.

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** their 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). Grantees are asked to describe the programs so the UDS editor 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 editor 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. Two lines were removed (1h and 1i) and two were added (Line 4 – ARRA-NAP/IDS and line 4a – ARRA-CIP and ARRA-FIP).

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, 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)	
1.	**TOTAL BPHC GRANTS** (SUM LINES 1G + 1J)	
	OTHER FEDERAL GRANTS	
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify:_____)	
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:_____)	
90.	**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)

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	
• Ophthalmologists	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 Or 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 staff		
LABORATORY PERSONNEL (Line 13)		
• Pathologists		X
• Medical Technologists		X
• Laboratory Technicians		X
• Laboratory Assistants		X
• Phlebotomists		X
X-RAY PERSONNEL (Line 14)		

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Radiologists		X
• X-Ray Technologists		X
• X-Ray Technician		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	
• Nurses - Psychiatric And Mental Health (Line 20b)	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	
• Optometrists	X	
• Podiatrists	X	
• Physical Therapists	X	
• Respiratory Therapists	X	
• Speech Therapists / Pathologists	X	
• Traditional Healers	X	
• Nutritionists/Dietitians	X	

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
PHARMACY PERSONNEL (Line 23)		
• Pharmacist, Clinical Pharmacist		X
• Pharmacist Assistant		X
• Pharmacy Clerk		X
ENABLING SERVICES		
CASE MANAGERS (Line 24)		
• Case Managers	X	
• Care / Referral Coordinators	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	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
• Patient Transportation Coordinator		X
• Driver		X
E LIGIBLITY ASSISTANCE WORKERS (Line 27a)		
• Benefits Assistance Workers		X
• Eligibility Workers		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

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Head Start Workers		X
• Housing Assistance Workers		X
• Child Care Workers		X
• Food Bank / Meal Delivery Workers		X
• Employment / Educational Counselors		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
• 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

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• 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
• 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. Beginning with this tenth edition of the UDS manual, we will be presenting some of these special situations along with instructions on how to deal with them. In this edition, we deal with 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; as 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)** is amount written off if the patient is uninsured (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 on a regularly scheduled basis 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 grantees clinic. Hours volunteered are used to calculate FTE as with any other part time provider, however because volunteers are not paid the denominator in the equation to calculate FTEs 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 the site in the contractors scope of service and under the grantee's control.
	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

ISSUE	TABLES AFFECTED	TREATMENT
		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: 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 of 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 <u>pays</u> 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 17. Be sure to describe the nature of the donation on the table at this line.
WIC	Cover Sheets	Do not list WIC-only sites on the cover pages.
	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 <u>*are not counted as patients on any of these tables.*</u> Do not count as patients because of 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.
	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.

ISSUE	TABLES AFFECTED	TREATMENT
	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 [see below for other situations]. *(including only that part of pharmacy that is paid for by the grantee and dispensed by in-house staff.)*	5	**Column A: Staff.** Pharmacy staff are normally reported on line 23. To the extent that the pharmacy staff have an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs, 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 (generally calculated at 340(b) rates) is 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 11, column A: Enabling Direct Costs.** Show the staff and other costs of staff (full- time, part-time or allocated time) spent assisting patients to become eligible for PAPs. **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 here *only.*
	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 if the patient is uninsured (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)
In-house pharmacy for	description	Many CHCs which own licensed pharmacies which also provide services to members of the community

ISSUE	TABLES AFFECTED	TREATMENT
community (i.e., for non-patients)		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 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."
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 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 if the patient is uninsured (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.

ISSUE	TABLES AFFECTED	TREATMENT
	9E	No income would be reported on Table 9E.
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* no accounting for the value of the drugs is made in the UDS, even if the CHC receives and holds the drugs for the patient.
	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 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.
	6	Because these are not visits, they are not counted on Table 6.
	8A	Costs are reported on line 8b – pharmaceuticals. In the case of vaccines obtained at no cost through the Vaccines For Children program, the value may 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 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.

ISSUE	TABLES AFFECTED	TREATMENT
	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.
	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 between its FQHC rate and what Medicare paid.
	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 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 large 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 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.

ISSUE	TABLES AFFECTED	TREATMENT
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.
	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 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 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,***	description	Some CHCs have included in their scope of service 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.

ISSUE	TABLES AFFECTED	TREATMENT
jails, etc.)	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. Do not consider the agency with whom the clinic is contracted to be an insurer. (Schools and jails are not "other public" insurance.)
	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	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.* *For information about the type of CHIP Program in your state: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Program+Type*
	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 which the HMO will pay for on a fee-for-service basis whenever it is appropriate. Most common carve-outs involve lab, radiology and pharmacy, but specific

ISSUE	TABLES AFFECTED	TREATMENT
		specialty care or diagnoses (e.g., perinatal care) may also be carved out.
	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.
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 verified or reported as unknown. Individuals receiving health services under this contract is 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.
	9D	The patient's services are reimbursed by the jail/prison. For purposes of reporting, there *is* an "other public" payor for the service. The clinic's usual and customary charge for the service 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.
(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 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.

ISSUE	TABLES AFFECTED	TREATMENT
		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.
	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, health centers have the option of reporting on their entire patient population as a universe. 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 easier (i.e., queries are automated). Although optimal, there is no requirement that health centers report the universe. Indeed, BPHC has no preference for reporting the universe or a sample.

If the health center cannot report on the universe (or chooses not to), a random sample will 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.

The following measures can be reported using a sample:

- Table 6B Childhood Immunization Rate – percent of patients 2 years of age with up-to-date immunizations.
- Table 6B PAP Test Rate – percent of female patients aged 24 – 64 who have had a PAP test during the measurement year or during the previous two calendar years.
- Table 7 Controlled Diabetes – Percent of 18-75 years of age diabetic patients with HbA1c levels ≤ 9%.
- Table 7 Controlled Hypertension – percent of patients 18-85 years of age with hypertension whose latest blood pressure was less than 140/90.

Table 6B and 7 prenatal indicators cannot be reported using a sample.

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

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 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.

STEP 2: Determine the sample size for manual chart review:

The number of charts selected for manual chart review will be the lesser of 70 charts or all patients who meet the criteria.

STEP 3: Select the random sample

Using one of the two recommended sampling methodologies, identify the sample of 70 charts (assuming the universe is greater than 70, otherwise report on all patients).

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 include all patients from all service sites and programs. Examples of data sources include:

- Electronic health record
- PECs database
- State immunization registries for vaccine histories
- Logs
- Practice management system

For each patient in the sample, determine whether sufficient information is available in available data source(s) to assess compliance. If information is not available, pull the paper record to retrieve required information.

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

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. Exclusions are as follows:

- Childhood immunizations – none
- Pap tests – women who have had a hysterectomy
- Controlled hypertension – none
- 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.

Using this method, the final sample size to be reported on the UDS will be the lesser of 70 charts or all patients who meet the criteria for each measure but never more than 70.

METHODOLOGY FOR OBTAINING A RANDOM SAMPLE

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

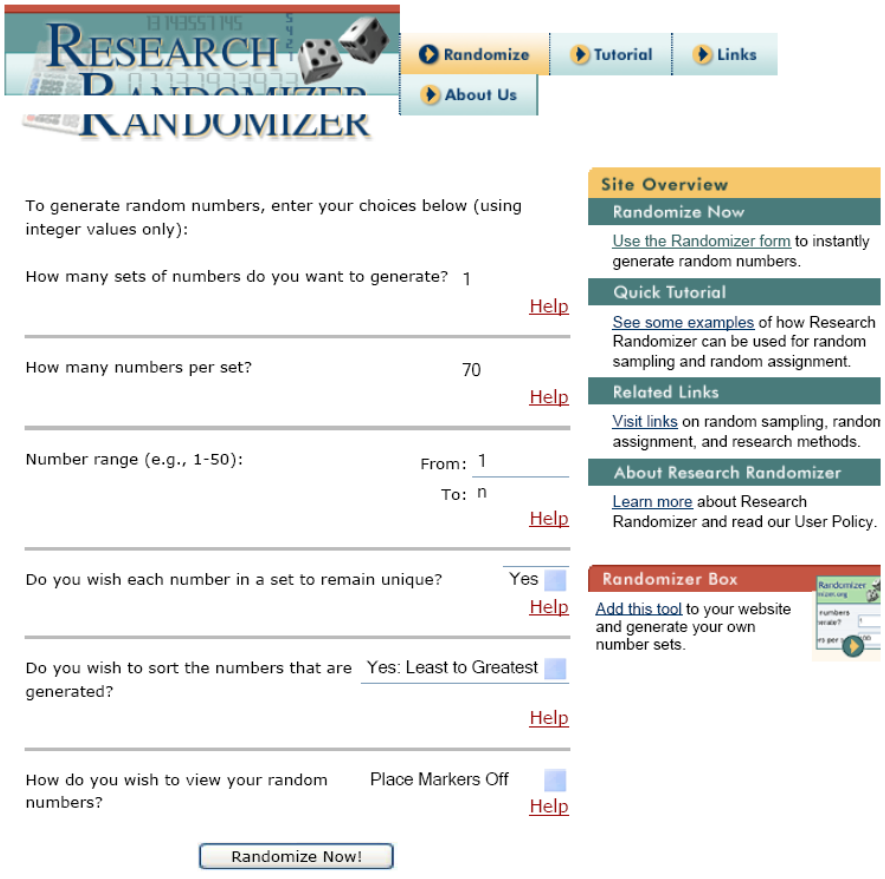
- Work with a list of random numbers generated for your total patient population.
- Select a random starting point and use a calculated interval to find each next member of the sample.

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

Option #1: Random Number List

A 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. Complete the "Number Range" by entering the maximum number of patients in the universe for the particular measure under consideration as "n". For example, if there are 700 children who turn two in the reporting year in the universe, enter 700 as the maximum range.



Then press 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 small sample of 5 charts. If a patient should be excluded from the original random sample of 70, replace that patient with one of the patients from the replacement sample. 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.

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 by dividing number of patients in the universe by 70:

   Sample Interval Size (S1) = Population size (number in universe)/ Sample size (70)

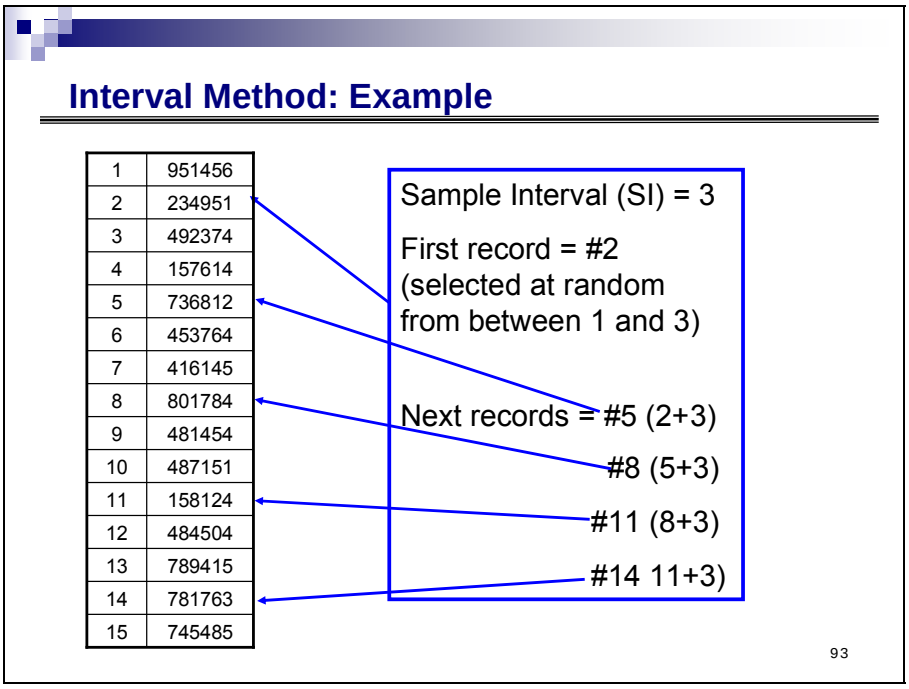
2. Randomly pick a patient from the first sampling interval. For example, if the sampling interval is 10, the first sampling interval includes patients no.1 through no.10. Randomly select one patient from this interval.

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 excluded patient by the next patient on the list. 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.