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Introduction to UDS for LAL

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Please stand by for real-time transcript.

Thank you for standing by. Please continue to hold. The conference will begin in two minutes. You will hear music until we start.

Welcome and thank you for standing by. To ask a question during the question-and-answer session please press star 1 on your touch-tone phone. Today's conference is being recorded. If you have any objections, you may disconnect. I would like to turn it over to miss Jennifer Joseph. You may begin.

Thank you. Good afternoon, and everyone, and good morning to those on the West Coast and beyond. I'm pleased to welcome you to today's Webinar on 2012 UDS reporting for look-alikes. You experience any technical difficults, you can emay Joey Conroy at JCONROY at HRSA.gov. I'm trying to advance in the slide, and I am unsuccessful at doing so. Our web far will take place in two parts. First, a very brief program overview of look-alike reporting requirements, as a complement to HRSA's assistance letter 2012 data system reporting changes for look-alikes. This is located on the health center policies web page

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The slide for today's presentation are located at B Ph.D..HRSA touch-tone "Gov"/health center data statics/reporting/at that same location will be a recording of today's call. In the second half of our presentation of after this very brief overview, we will have a detailed overview from art. I also wanted to address for the newly designated look-alikes who might be interested to know to what extent these reporting requirements apply to you. The 2012 data reporting requirements apply to all look-alikes prior to August 1st, 2012, and for the full calendar year beginning January 1, 2012, and that's why we spend a lot of time in our application reviews, making sure that program data reporting systems for place, and that your organization is operational at the time you apply to the look-alike program. I just wanted to provide some brief back ground before we continue on. As many of you know, this is the second year that look-alikes have been required to report data electronically through HRSA's electronic hand book and uniform data system. Prior to one to level reporting, look-alikes reported comparable data through paper application. For 2011 reporting, several accommodations were made to reduce the burden on look-alikes, including not all tables being required, and once submitted in most cases, the data was considered complete. And 42011 reporting, we did get a 100% response rate with these accommodations, and thank all of you for the work in doing that for us. Our goal for 2012 reporting is to improve data quality to pretty better allow for program changes, track program performance and program needs. Of course we also would like a 100% on-time response rate, as well. With improved did data quality we anticipate making 2012 look alike summary data available to the public. Now I'll hand things over to Esther Paul, and Art, who will each share more details recording the UDS reporting requirements.

This is Esther. I'm a public health analyst with the strategic relations Branch, and we is are spoken to many of you because I was responsible for getting the UDS mission is completed last year, so I want to begin by thanking you for your cooperation, and last year's submission was a resounded success, and you helped make it that, and I also want to let you know that I look forward to working with you for the upcoming mission is. We learned many lessons both in process and in reference to the data mission is, and all year long, a team here at HRSA has been working to make the upcoming mission is more efficient and more smooth sailing for you, but also to get a more robust data set, and for that we need your cooperation. This is important because the data you provide us is is in reality a snapshot of where you are in your progress toward your goals, and using this information, we look forward to working with you to improve the quality of care for the health center. While the data tables and processes for the upcoming data mission is for 2012 will be similar to the one to 11 data reporting, there will be some changes, both to the process for submission, and the data collected. The most significant change will be that each health center will have the benefit of an assigned UDS review. What does that mean? This means that once you have completed your data submission and will start working with you if they see any inconsistencies in your data. Ask you to lend them your cooperation so they can work with you to get a complete data set. These changes include reporting on three new clinical measures which will agree that are critical to providing quality care. A new table that collects data on staff tenure will also be reviewed, and as you know, staff tenure is an important part of the information, so this table will not only collect this useful information, but this year's information can be used by the healthcare -- health center center. Now let's talk about the data submission timeline. The UDS emergency -- module will be open for from January 1st, 2013 through February 15, 2013. The submission must be complete nod later than February 15th. Starting February 16th, the UDS reviewers will begin their work with you, so please make sure that your submissions are completed by February 15th, and March 31st is not the date for completion of submission. Next I want to talk briefly about the resources that HRSA is making available to you, which are pretty diverse. That is, they range from the availability of a UDS manual on the HRSA website, on the UDS website that HRSA has through training about which Art will also be telling you more about, and the availability of a couple of helplines. With all of these resources available to you, I think that if you continue -- if you start your process ahead of time, you should be able to fulfill your data requirements and submissions without much difficulty. I urge that -- you to take advantage of these opportunities, and if you need additional help, please feel free to contact me. Wee are here to assist you in whatever way we can to make your journey smoother, so please make note of the resources available, and use them to the best of your ability. And we are here, call us when you need us. In addition to all of this, we will also be post be PDF versions of the tables on the look-alike website, and to plan your submission, please take a look at these, because they will help you to put your data together. In addition to all the other training, I wanted to let you know that has a new user interface which has been designed to make it easier for you and more user-friendly. You will hear about it later in another call just to introduce you to this new interface, so please mark your calendars and look out for the information providing more information on this technical assistance call or Webinar, whatever they decide to have. With that, I'm going to hand it over to Art, who works with a UDS contractor. Art has been involved with the UDS for a long, long time, so you can get a lot of information from him, so be ready with your questions at the end of his presentation. Thank you, and look forward to working with you.

Thank you, else the, and good morning to those on the West Coast. Good afternoon to those in other places. We will be concentrating on the difference between the look alikes and the rest of the health centers that report on the UDS. So first, what is this thing? Hopefully some of you have had some experience with the UDS and it's first initial utilization in 2011. The UDS is a standardized set of data which is reported by all federally funded programs who are in the 330 is system, the CHC, community health centers, the healthcare for the homeless, and the my grant health centers, and the primary care programs. Was provided by yet another system that was operational for 20 years, so there really is a 35-year data tracking of health centers and their activities in the community and how they have served their communities. As we said, last year the look-alikes became full-fledged members of this system, and were added to the process to begin entering their data so that BPHC can getter describe the entire effort. Now, what are you reporting on? For the community health centers that are funded by the bureau, this tends to generally a clear-cut issue. They report on everything they are. But for many look-alikes, the scope of projects, the scope of their look-alike designation is not for their entire corporate entity. In completing the UDS, a look alike agency will report specifically and exclusively on those portions of their agency which are part of the designation. That means anything from the sites that are included, but not the sites that weren't in that designation. It may mean the services that weren't included, but not the services that were excluded. So a health center that offers podiatry, but didn't have that in their scope of projects will not be reporting on podiatry. The health center that operates one more site in the next town over, but didn't include in the scope of their project and is not part of their designation will not report on that. Everything that is reported is for the calendar year. So regardless of your fiscal year, regardless of your designation period, regardless of anything else, the reporting period is January 1 to December 31st. And that means that if you changed your scope mid-year, or if you were just designated mid-year, we still want everything reported back to January 1, and for some of you, they may be a problem, and, if so, it's the sort of problem you will talk with your reviewer, so far as resolving how to describe who you are, what you are, with the best data available. Note that there are some look-alikes who are, if you'll parent the expression, dually designated. They were both health centers, and FHQC look alikes. Such organizations, and don't have a good handle on it because you are regularly becoming designated. You are becoming grantees, and so it keeps changing, but such organizations will in fact have to file two UDS reports. One for their 330 activity to the grant program. One for their look-alike activities, and the same site will never be in both, nor will any individual be 100% in both. So you'll need to parse out those people who are are serving both organizations, or both operations, and obviously 0 a visit will be either to a look-alike site, or a grant you site, though it is possible the patients may overlap. So sites. Patients, not necessarily so. Staff, allocated. UDS provides us with a snapshot of performance on 12 tables. Those tables will look at the patients. Who are you serving? What are their socio demographic characteristics. What is their language, et cetera. We'll then look at the types and qualities of services that are provided, and we will ask who are the staff providing those services. How many staff do you have? What is their tenure with the organization? The bureau has made a strong commitment to quality of care, and you will see an ever-increasing number of data sets that look at quality of care specifically for your look-alike patients. And then financial tables. Those that look at the cost and efficiency of your services, as well as those that look at where your money comes from. Why are you doing this? Well, for one thing, to report your program achievements S in a standardized fashion, and as transparency invades government further and further and further, you will find that, in fact, data from community health centers that are grantee, and in the coming years, health centers that are look alikes, partial data are being placed in a public environment, where

people in your community can look at it. These data also assist both the bureau and grantees in making decisions about where they're going to provide services, and what kind of services to provide there, and there's now a tool, the UDS mapper that lets us see better and better where grantees are, where their patients are, what areas are unserved or underserved. You, the look alike programs, the grantees, can also take that UDS days and use it as a source of information about you to compare yourself with your state and with the nation and with others, to help you improve your performance both year over year, but also compared to your peers in the community. The UDS will be available January 1st, 2013. Don't bother looking for them today. It's not there. It will thereby on January 1, 2013, in the electronic handbook, and you can see the web address where you will go to log in. There is a help but innocence that application. There are on-line training modules available if that application, and then once you begin entering data, you will begin to see the editing functions of the program, alerting you to at least mathematical problems that require correction. Those of you who have worked with the full grantee interface know that there are a large number of consistency and logic checks that are built into that component, and not all of those are included in the look-alike module at this point. We need a period of time of data in there before we can begin comparing you and contrasting you to yourself and to your peers to use it to identify issues. So you'll see more than last year, but less than the full module, which over time we hope to incorporate for you. On or before February 15th, we ask that you push that button that says submit. Now, don't push it if it's not done. The idea is not to see how well you can push the button. The idea is to see your completed data. And so if your data are not complete at that point, then your report is going to be late, you will push the button when the data are are complete. But don't send your reviewer down a wild goose chase trying to make sense of data that don't make sense yet. Your reviewer will get back to you within the next three to four weeks, and you should understand that reviewers have substantial caseloads of 50 to 75 or more health centers, so they will not review every one of them on the first date and get back to you by that afternoon, but they will get back to you, and then we will work with you back and forth through the end of the month of April, and then sometime during in the summer we will begin to make available to the look-alikes some of 0 the same reports that the grantees currently have, showing things like your trends over time. So all of that will be coming to you. Your reviewers, and they're not assigned yet, but for the most part, your reviewers will be individuals who are familiar with the data from your state, because they have also done editing of community health centers in your state. So they should know what the EPSDT program is called in your state, what the breast ander is cervical cancer care program is, and they'll have an idea of how things operate there. They will get back with you with an e-mail which will generally is a list of issues, also all of which will end with please explain or correct at that point, we will be asking for responses for you, and be working interactively with you to make the changes where appropriate, or to document the reasons why, in fact, your data are different than what we expected. When that process is complete, we will notify you, at which point you will not be able to go back and make changes. So the changes are made when both you and your reviewer agree that the best data are now incorporated in the report. So we're now going to go through those tables highlight this differences between the look alike health centers and the 330 grant-funded health centers. in a nut shell, the tables tend to be similar. On table 4, you will find a couple of changes. Table 8A is not being collected at this point. You may remember if you were around last year that we told you that it's going to be collected next year. Well, here it is next year, and, yes, we're telling you it will be collected next year. So at such time as it is appropriate, the table will be added in, but we are not doing it this year. On table 7, there will be some differences, in that we will not ask for data on race andeth thisty. On table 9D, we will not be asking about details of managed care and retroactive

payments, and, of course, on table 9E, we do not ask look-alikes to tell us how much their grant was, that being an oxy more on. We want to know about the patients you serve. Where do they come from? And we ask that in terms of zip codes. What's their age and gender, and we have that in one year segments, and then five-year segments. So what is their gender, we go on to ask about their race, their Latino ethnicity, and in what language they are best served, and then go on to ask others, such as demographic questions. Income, health insurance. Are they members of special populations that the bureau is charged with serving? All of these are asking you to report about your patients, and a patient is defined very narrowly and explicitly. Who has had one or more visits during the calendar year which you reported on table 5. Yes, we'll get to table 5 in a few minutes. So a patient had a visit, and, yes, there are people who are health education patients. Everybody who is served by a community health center is called a patient. We want to know their demographics and the zip code table, and a patient is counted once and only once. We're all standing here saying wasn't that line on the slide last time we looked at it? It's counted once and only once in each of the number of places where it may make sense. So a patient will be counted once when we look at their zip code of residence. Once with their age, once when we ask about their insurance, and so on. Table four looking at those special characteristics, and asks first about income. Were the patient below poverty? Between 100% and 150% of poverty, between 150% and 200% of poverty, overpoverty, or unknown. If you don't have their income, near unknown. And we ask about what kind of insurance do they have? And that must be known. It is a bureau expectation that you will ask every patient what their primary medical health insurance is. That could be none, but it will be asked of every patient. Homeless patients, we will not ask for details, but -- oh, sorry -- we will ask about the number of homeless patients you serve, in the number of agricultural workers you serve, the number of veterans you serve, and the number of patients that you serve through a school-based health center. So when we talk about who is doing the service, who is providing the service, we want to know first, on table 5, about the staffing. We then want to know about the visits. How many visits were delivered by this staff. , and what services did they receive. Table 5A asks more about the staff, specifically about their tenure. Table 5, tell us about the people who are working in your lookalike program. And remember, if you have people who are allocated, you'll have to allocate them partly into the program, partly out of the program. We're asking about an FTE. Full time equivalent of an annual year. So it's one person working full time for one year. A half an FTE could be one person who started July 1st, or someone who was working only 20 hours in an environment where 40 hours is full time. So we want to know about the FTEs. Based on hours paid, not hours worked, or hours seeing patients, or anything else. So note that CMS and Medicare cost reports in some states reports count FTEs differently. So the UDS, how many hours were they paid for, including their vacation time, including their sick leave, including holidays, including continuing education. All of that is included. And full-time, of course, is based on your standards. These days most everybody has a 40-hour workweek, but in fact there are some organizations who have some other work week, or there are some professions who have a different work week, and, if that is the case, you use that definition of a work week. So this is looking at the full year, and it's not a snapshot on the last day. Table 5A is a snapshot on the last day. It looks only at selected clinicians and nonclinical support is staff, so it's going to be your clinical workers, and key management staff, and it's reported in terms of consecutive months in their current position. So an individual is counted who is there on the last day is counted as one person, whether they were hired 20 years ago, or hired 0 minutes ago. They are counted as one person. Then we report how many months they've been working in that position continuously, and that could be working there 20 years, 20 times 12, 240, and if they have been working there for just one month, one month. Some

individuals will have two position and be reported on two lines. So if you somewhere somebody who is a pediatrician and has been for a long time, and has been promoted to be the medical director this year, then you'll report them once on the pediatrician line, once on the medical director line, but on the pediatrician line, they might have been there 120 months, and on the medical director's line, they may only have been there for 12 months. So is these are our employees, then. We're learning how many of them there are, and how long they've been there, and that tenure table is going to tell us something that we don't currently know. What is the tenure of our health center staff. We have believe that our doctors have been there a long time providing continuity of care for our patients, that our nonclinical support staff have been leading their organizations for extended periods of time, and that as a program, woe show great stability. The data from table 5 will allow us to document that, and table 5A. And then we'll ask about your visits. A visit is interaction between a patient and a provider. These are face to face, one-on-one visits with the very slim exception for behavioral health where some group or telemedicine visits are allowed. Group activities are not reported. Labs are not reported. X-rays are not reported. Prescriptions and immunizations are not recorded. Just this very narrow face to face activity between a patient and a provider where the provider is qualified to deliver care, either because they're licensed, which is the case for medical, dental, and vision, or because they're credentialed by the health center, which all is the rest of your staff. The staff are using professional judgment you back in to their training and education to deliver the service. So it's not just a blood draw. That's not a medical visit. A medical visit is where the provider is doing something unique to their training. services must be charted. And a patient gets only one visit of each time in a day. Only one medical visit, regardless of how many different providers you may have chosen to send that to. And we're muttering, that's the other one that was supposed to have been fixed. Sorry about that. So we have medical, centle, mental health, substance abuse. Others professional, vision and enabling services. 7 distinct type offers services you are reporting on. A patient may be count as a patient once and only once in each of these categories, if in fact a patient was seen in each of these categories. So that tells us about who is providing services, who is getting the services, how many of those services are there, and how many patients receive each type of service. Now we'll start looking at clinical activities. We'll start with a broad clinical profile. As I said at the beginning, table 6A, Alpha, will not be collected this year from look alike agencies. Table 6-A asks about a large number of diagnosis and asks centers to indicate how many patients fall into the category of having received those services. We're keeping those at abeyance in the look alikes if for to other reason than they're dropped on ICD9 codes, and ICD10 is coming. That's not a thread threat. It's a promise. So rather than have everybody set up systems for ICD9 and convert them, we will most likely wait until the ICD numbers are in there, and bring the look alikes on board. Table 6D and table 7 deal with quality care and outcome gindy indicators. There are a long series of these. We're not going to go over them in detail here. We will be doing a separate Webinar, on November 14th, from 1:30 to 4:00 p.m. There's the URL. I will not read a URL that includes OE121DK6, but there's the URL. You'll be able to call in on that, and we will, in fact, go over the details of these. In general, what each one of these does is say, tell us how many of the people that you serve are in a universe of, say, two-year-olds, or 50 to 75-year-olds, or 24 to 64-year-olds, a universe defined by an age, or who I hypertensive, or diabetic, or have hyper LIPODEMIA, who fall into a category based on a diagnosis, tell us about the universe, and then tell us about your review of that universe, and then we will have a separate seminar on sampling on December 17th, from 1:30 to 3:00, through a sampling process, or if you can use your EHR to get the entire universe, tell us that you looked at all of these people the measures will be from the measures that UDS has put out there that most of you are involved in now in your adoption of

electronic health records. Again, for look alikes, on table 7, table 7 asks about continues, and then asks for details by race, and by Latino ethnicity. The look-alikes will not report by race and ethnicity. So you will see on the little sample table there, lines 1A, 1, B, 1C, bottom line, line I says total, and while in a community health center, item I will be qualitied automatically when the grantee puts in the details for a look-alike health center you will enter the numbers on the total line, and not have to put in all the detail. Again, sooner or later, you will be privileged to answer all the detail, as well. Then we'll move on to a financial profile. So, tell us about where your money comes from, tell us about where your money goes to. And that financial profile consists of table 8A, which looks at your costs of delivers services. Table 9D, which talks about income from patient services, which you got paid to deliver a service, and table 9E, all the rest of your revenues that come from other than the patient service payment area. To start with table 8A, we're going to look at expenses for the beer BPHC-defined cost centers. So again, if you are a health center that is a look-alike and nothing else, and all of your health center is part of the look-alike, then you will simply report on your corporate identity. If you are part of a larger entity, which may in fact be a grantee, or may be a hospital, or a county health department, or a university, or whatever, then you will report only on those expenses that relate to the services that you just reported on tables 1 through -- or zip code through 7. This does mean that if you have any share of costs for top level nonclinical support staff, they are to be included here. If in describing your organization you say your CEO is a 10% part of this look-alike activity, then we expect to see 10% of your CEO showing on table 5 and 5A, and then expense, the costs of that CEO on table 8A. And if you have health centers, some of which are in scope, and some of which are out of scope, some of which are part of the designation, and some of which are not part of the designation, and your doctors go back and forth between them, you need to come up with a wholey consistent logical method of allocates those individuals, so that their FTE is shows correctly on table 5, and their cost shows correctly on table 8A. And when that doesn't happen, some of it may be picked up by Ed its within the system, and kindly advise you, you said you had a dentist, but you don't have any dental costs, what's going on? Or, alternately, you say you have some dental costs, but no dental visits, tell us what's going on. And then in some instances, that won't be automated but your reviewer will be picking up on those things and talking to you. Note that unlike your audit, donated services, supplies, facility, staff, visits, what have you, are not broken out as cost items. Instead, there is a single line on table 8A that says donated facilities services or supplies, and the entire cost is shown on that one line. That means that if you have a volunteer physician who comes in two days a week, their two days a week will show on table 5, but their cost will not be on the medical cost line, it will be on the donated services line. When we get to income, that is, as we said, broken into two parts. It is partly the income you are paid for delivering services to your patients, the charges that you have, and partly all other income. Your full undiscounted, unadjusted charge for the services based on your fee schedule. as a look-alike health center, you must have a fee schedule. You must have a set of fees which are designed, as a whole, to cover your cost of operations, and those may or may not be collected for various good or bad reasons, but those are the charges we ask you to report. If you're charged for a 99213 vanilla return visit for a medical patient is $125 in the charge column, you'll be recording 125. In the collections column, we get all cash income received during the year. For the accountants, yes, this is a cash table. Table 8A is an a cruel table, table 9D is a cash table, table 9E is a cash table. This sometimes leads weak-spirited accountants to tear their hair out. This is not an accounting exercise here, this is a data reporting exercise, and we are asking you to deal with that cash versus accrual. Here, what were you paid in 2012 regardless of when the services that generated that payment occurred? This is going to include cash payments by your patients, either of the full fee, or

of a discounted fee, or of a nominal fee. It's going to be payments by third parties, like insurance companies, Medicare, Medicaid, or by grant and contract programs, like the breast and cervical cancer program, or the title 10 family planning program. So all of those are being shown is as checks. They may also include contract programs for when you say contract with the head start program to do physicals for the kids as they enter the program that year. So all of these are reported as collections. That contract may call for you to write off some of your fee. Yes, your fee is $125 for a routine visit, but your contract says that you'll accept $85 in payments, and that means you have a $30 allowance. And allowances that are made in 2012 are reported on this table. If they said, yeah, see you tomorrow, and that's the last you saw of them, then sooner or later, and it probably should be sooner, you'll have a bad debt to write off, and that bad debt will be reported as the $125 that was not collected. Now, the full table 9D asks you to go into details about wrap-around payments and settlements, and prior year settlements and wrap-arounds, and the look-alikes do not do that. All the payments are shown in column B, but column C1, C2, C3, and C4, which are details of some of what's in column B, are great outs. So when you get on-line with the electronic hand book, and start looking at how much you get to report, you won't be able to enter numbers in those cells. And similarly, table 9D tries to differentiate between payments that come to you from third parties as part of a managed care program versus part of a fee for service program. And for the look-alikes, you will not make that breakout. So you'll tell us your total charges to Medicaid, your total collections from Medicaid, your total Medicaid allowances, but you won't be breaking that out between fee for service, or managed care cap dated, or managed care fee service. It will just be one line. And then table 9E is going to ask about all the rest of your income. Income from all other sources, grants, contracts, contributions, et cetera. If you have other federal grants. If you're for example a Ryan White part C organizations, and you're drawing down funds for that grant, and it's part of your project description, part of your designated look-alike, then they'll show drawn down. If you are getting contracts from the city that just give you money to help you run your health center, that will be reported. If you get money from donors that gets reported. All of it is detailed, and, of course, because it's so incredibly varied, we're going to ask you for each of those to specify where did this money come from, and, quite frankly, we do that for two reasons. One, so we have a better understanding of you and where your income comes from, and, two, to work with you if in fact it looks like the money you put on one line should, in fact, go on another line. Again, there's some slight differences on table 9E, because the top third of the table asks you to report about your section 330 health center grant, and one may say, ofty mystically, as of yet, you do not have a 330 grant. So that will be blank. That also means that if you are working with a 330 grantee who passes through money to you, you do not report it in that grayed out area. If you are getting 330 funds secondhand from another grantee, that's going to get reported on line 8, as coming from other sources. So lines 1A through 1K, and line 1 will be grade out, and then line 4A for our grant will similarly be be grade out. Now we have a picture of who you serve, who in your organization serves them, what it costs you, and where your money comes from and this is what is grist for the analytic mill both at your health center, and at the bureau, and, we should mention, any number of outside academics who pull these data as the data which best represents how the underinsured and uninsured in America get served to do their academic pieces. Now, as you go through this process, there is assistance available to you. First, strategies for success. You have to work together on this thing. As I've indicated, the takes interact with one another. The worst thing that we see, the most common thing that we see, is a dedicated HR department tells us exactly how many people are on this grant, or on this program, and they dedicated finance department telling us all the money spent by cost categories. But somebody put the nurse that runs the health education program in health

education, and somebody else put them in nursing. You've got to make sure that you are talking to each other, that somebody is responsible for looking at this whole thing. The EHR -- sorry, the EHB is tricky. It allows two or three or four of you to sign on and work independently there, and to put in your own data without checking with each other, in which case you may find yourself producing errors. Yes, you can enter the data separately, but work together. As was mentioned, there is a UDS manual, the manual for 2012 will be posted soon. It is going through final review as we speak. It has detailed information, painfully detailed information. Printed out, scribble in the margins, but also recognize that that electronic keep that you download is fully searchable, and that the good old control F let's you type in a word and go zooming through that UDS manual to find what it is you're looking for. Pay attention to all those Ed its that pop up when you are entering data. There is a point in the process where you will have to push a button run an audit report. Run that audit report and see what it says. We can't catch the cross table problems when you enter them, because one person may not have entered the other data. So until you run the audit report, it's not complete. Run that audit report, see what the errors are, and then correct them or explain them. To the extent that you correct them and explain them, you may have a very boring interaction with your reviewer, which I assure you your reviewer will enjoy, and so will you. The fewer questions we have to ask you, the faster this process goes. So correct those errors that pop up, explain valid data that look inconsistent. If I'm reviewing your UDS, and I see that you have a .5 dentist, and zero dollars for dentistry, I'm going to say that's an error,out may say that's the volunteer dentist who brings in his own equipment and works with our patients, and there is no cost. We're going to flag it as an error unless and until you let us know that it's not. There are resources available to you. The bureau is sponsoring 42 Webinars located in 42 of the 50 states and territories. Okay, 43, 44. And those are posted now on the bureau's website. You can go in, they're posted in order by region. You can go down and see them. You will see is that the first was yesterday, so if you're in New Hampshire, you're going to have to go to Rhode Island. All the rest are yet to come. and of course on where near being held, who the contact person is for them, because the state and regional primary care associations are our valuable allies in setting up and running these training sessions. There are on-line training modules available to you. Again, you have the link there. And fact sheets that you can give to somebody if you are not cruel enough to give them the entire UDS manual, and wanted to just give them something that oils what it is we're looking for on the table that they're responsible for. There are data and reports available right now on-line. Want to see what your state looked like last year? That data, on-line. Those data are on-line, our statistics teacher would hit me. And you can go on right now and see what your state looks like as a profile. There's a telephone and e-mail hotline, henline. 866-UDS-help will get you one of four people, three of whom have editing experiences themselves, and the fourth of whom has been pushed into this, and is, at this point, greatly experienced. They will answer your questions, or they'll get back to you with an answer. If you want it in writing, if it's complicated, if it's detailed, send us an e-mail. You want to have it in writing so that your CEO believes the answer that you've been given. Send it to us in writing, we will respond to you in writing. Again, hopefully within a day or two, I think almost never as much as 3 days away. And if it's really arcane, it will get kicked up the line to one of us who have been around since dirt and can answer the question that may not be as logical and as obvious to those reading the manual. Once you have submitted your UDS report, it will be assigned through a reviewer, and that person will be available to work with you during the course of the review. And then for support with the electronic handbook, and again remember there will be a new user interphase training, which will take place sometime in December, stay tuned to the station for more information, and if you need support with the electronic handbook, you can call into either the

HRSA call center, or the BPHC help desk, if you're locked out and don't know what to do, if the UDS does not display in your wonderful effective 1993 version of net scape, call in, and we will provide you with as much assistance as possible to make sure that you're able to do everything you need to to submit your report in a reasonable fashion. So with this, we would like to again thank you for participating in this Webinar, for preparing yourself for this task. We would caution you that it is not a simple task, that it does take 40, 50, 60 person hours to get this report in, so plan for it, and we thank you for the hard work that we know is required to produce this, and your questions early and often, send your questions or call them in. Remember, February 14th is not a good day to start working on your UDS, or calling in your questions. But now is. So perhaps we can open up the lines right now, we can go ahead and take questions from whoever has them.

Thank you. At this time, if you would like to ask a question, please press star 1 on your touch-tone phone. Please insure your phone is unmuted. Once again, that is star 1. It will take a few moments for them to come through. Please stand by. I'm showing no questions at this time.

Okay. Well, we will give those of you -- surely if you have no questions it means that you didn't understand how confused we made you, but if you have any questions, please holler.

One moment, please. We did get a question that came through. The question comes from Betty. Go ahead, your line is open.

Thank you for taking my question. We actually have two systems, two EMR systems, one for dental, one for oral health, and one for medical, and I'm wondering how it is we would go about, or any recommendations you might have on how to combine unduplicated patient counts between the two systems.

Well, you're asking a question that occurs not only in this environment, but, also, for all of those out there who are adopting new EHRs, where some of your information is in the EHR, and some is in what we call the legacy system, that old PMS that is sitting in the corner, and you're absolutely right in sensing how excruciatingly painful this is going to be. For some things, like how many visits you had, there will be no problem. You can add all the visits in the dental EHR to the visits, and in the medical EHR, and of course there will be no problem, or from the legacy. And the new system, and there will be no problem, but so far as the patients, who definitely will overlap, unfortunately the only thing available to you is to work either with your own IT staff, or some consultants, or someone from one of the two organizations, to actually download the patient information complete with all the identifiers. That is, their age, their gender, their zip code, their insurance status, their income, to download it from both systems, and then remove the duplicates. It will be, at best, a haphazard system. If they have the same medical record number in each system, it will work smoothly. If you're going to try to match by name and date of birth, you know, one was registered as John Joseph, and the other one was registered as Jack Joseph, and it's the same person, and then some people try to unduplicate using additional information like date of birth, but that doesn't always work. So we want your best efforts. We know that it will probably result in an overstatement, but hopefully not a great overstatement. We really want to avoid that overstatement that would come from adding the two together, because if that occurs, then in 2013, if everything stays the same, it will look like you lost patients, and we definitely don't want to see that.

Thank you.

Thank you. And I show no further questions at this time.

All right. Well, thank you everyone. This concludes today's call. We appreciate your attention, and encourage you one more time to take advantage of the technical assistance resources available to you, and including future trainings, both regional and our nationally focused training, and look guard to working with you during the reporting process. Thanks so much.

Thank you. That does conclude today's conference. Thank you for participating. You may disconnect at this time. [event concluded]