Please stand by for realtime captions. >> Thank you for standing by, today's call will begin shortly.

[ Music ]

[ Captioner Standing By ] >>
Welcome and thank you for standing by. At this time all participants are in a listen only mode and today's call will feature a Q&A time at the end and at that time if you would like to answer -- ask a question you may do so by pressing start and then one on your phone your phone.

Good afternoon everyone and good morning to you on the West Coast. I am the chief of the data branch here in the office of quality and data at the euro a primary healthcare at HRSA and today's webinars for individuals cementing the uniform data system or the UDS for the first time and this will be about the purpose, importance, and review assess including information on deadlines and definitions were successful submission.

If there is any technical problems and if you are having any IT or connection issues, although we are not taking any chat questions, or questions over the phone until the very end, if you need to contact us please contact us at
jconroy@hrsa.gov this time I would like to introduce you to [ Indiscernible ] Frederick who will go over UDF -- UDS for new submitters.

I am Sue Friedrich and I want to support you in preparing an accurate report and the purpose of the webinar is provide for those of you who are new to this recording with a brief overview and this does not substitute for the daylong trading, but is designed to complement it. You'll need to attend a daylong training to get step-by-step instructions on how to complete all the tables correctly.

During this webinar you will be introducing you to the UDS , why it is important, expectations were submit your report, available assistance you can access, and a brief overview of all the reporting tables. As we go through the UDS report it is important to understand interrelatedness of all of the tables. At the end of the webinar I was sure some strategies for successfully completing your report.

So what is the UDS? It is a standardized data set reported by the federally funded programs including this section 330 grantees, health centers, health care for the homeless programs, migrant health care and public housing primary care program and it is also supported by FQHC look-alikes and the urban Indian health programs. This report your scope of project for the 12 month period from January 1 until December 31.

For many of your scope of service is entire program but sometimes the scope project may not include all of your activity and if you don't already know you can look to grant application or your notice of Grant award to see was included in your scope. If you are part of a larger organization, for example, a health department or medical center, it is likely your scope of services not defined by the organization.

Alternatively, you may have more than one service that that is not approved in your scope. If you're one of those organizations who only report on that part of your program that is approved in your scope. It is critical that you consistently report your activity across all tables, when you are reporting only a portion of your program.

The UDS report is made up of 12 tables that provide a snapshot of your performance for your approved scope of work. This snapshot provides on holistic picture of your activity including the patients they serve, services you provide, the staff it takes to deliver those services, the quality of the care that you deliver, the costs to operate your program, and your various sources of revenue.

The BPHC have a long tradition of collecting data from these kinds of programs and this information is invaluable and documenting this to funders and this data is purported anyway to the Congress to demonstrate how federal dollars are used in the programmatic mandates. In addition, it is used by the purists sure that your programs are meeting their legislative and regulatory requirements and identify areas for technical assurance, excuse me, technical assistance to ensure program effectiveness.

Most important, you should be using your data to evaluate your performance and identify opportunities for improving a program. Your UDS data is used to set a finding goals and your health care plan and your business plan, and to track your performance over time.

Your UDS report is due February 15, 2013 for this reporting year and you will be able to start entry your data into the electronic and look starting January 1. If you're new to the EHB you should refer to the online training available at the technical assistance website which will learn about our next slide. There is also a help function which you can access an application for assistance. You are expected to submit a complete and accurate report February 15.

Please do not submit a partially bedded report author for you 15th just to meet a deadline. You'll need to plan ahead and start your data entry early so you have time to review your submission and address problems before the deadline . To assist you with make sure that your report is complete and accurate there are over 1000 edits built into the EHB and these edits are designed to fly when there appears to be problems or questions with your report. It is important to review these edits and address them by either correcting your air or commenting on why the data is correct is reported great

Failure to provide thoughtful expeditions of your data and correcting erroneous data on your initial summation will result in more work for you later your it after you have submitted your report, it will be assigned to a reviewer who will work with you one-on-one to ensure that your report is accurate, and your reviewer for work with you to finalize your sufficient up until March 31 your it

To that, your data cannot be changed. -- After March 31 your data cannot be changed . As I mentioned you will be working with a reviewer to make sure that your report is complete and accurate and we assign a reviewer to each state who becomes expert and the unique reporting differences for your state. After you submit your report your reviewer will analyze your data and perform the most -- numerous data trends and your reviewer is looking for inconsistencies in the report that may suggest air is in reporting.

Again, your thoughtful comments will save your reviewer from time looking at sloppy reviewers and issues for which you have a reasonable explanation your after reviewing your tables the reviewer will prepare a summary of possible

problems with your report and e-mail them to you within a few weeks of use at many the report. You should review and address all the issues that they identify and all the issues that your reviewer identifies are necessarily errors with your data sometimes you just need to confirm with your reviewer that your data is correct or at other times when he to go back and review your data source and correct the data you have submitted.

Is a very important that your initial summation is complete and as accurate as possible so you do not waste your time and your reviewers I'm having to realize all of your data. Your review will -- reviewer will work with you by phone and e-mail and report data must be finalized by March 31. If you submit late, and that is after February 15, that means less time for your reviewer to work with you to correct your data, your reviewer's last task will be to rate your data and have not corrected or provided excavations were issues raised by your reviewer, it make a be -- they may conclude your data is not complete and they rate your data questionable. Russia will data is that reviewers are not confident that the data accurately perfect -- reflector performance.

To help you in completing your report there are a number of resources available to you. In addition to this webinar there are regional trainings held in 45 states in partnership with state primary care associations. You should refer to the BPHC training website for a complete list of training and location and we offer a series of online training modules you can download on demand and a UDS manual and a fact sheet that provides step-by-step instructions for completing the tables and there is a help line available year-round, 9 PM to 5 PM at 866- UDSHELP. -- If you're having trouble accessing the EHB or you have problems with the application of the EHB you should contact the call center number on your screen.

The next section of this webinar is a brief overview of the 12 UDS tables that make up the report. As mentioned, it is reported by federally funded health centers and look-alike designees and reporting requirements differ slightly for these three types of organizations. This table shows which tables are submitted by which types of organizations. All 330 funded programs completely universal report which is made up of the 12 tables as you can see in the first column.

For those 330 funded programs which received more than one funding stream, a migrant health Brand, public housing, or community health Center grant for example, you'll need to complete duplicate copies of some of the tables. This duplicate copy of the table is called the grant report and that is the second column of the table. Programs that receive multiple funding streams are going to complete table 3A, 3B, 4, and parts of five. The bureau is able to aggregate or poor -- activity for the homeless, migrant, public housing program to funders.

Look-alike programs report only 11 of the 12 tables and you are exempted from reporting table 6A this year in a number of other tables a selected field shaded out to simplify reporting and please note that the look-alikes will likely submit a complete report and 2014. You should pay attention to the full instructions and preparation for next year. A separate webinar is scheduled for September 24 two review differences in reporting for look-alike programs, and I encourage you to attend it for more details.

As I said, the UDS is comprised of 12 tables that can be grouped into four categories. The first four tables make up the patient profile and these tables describe the patient that you serve. To tables make up the utilization and

staffing profile and describe your staffing model and the quantity of services you provide your patients. Three tables make up the clinical profile and describe the services you provide and the quality of the care that you deliver. And the last of three tables make up our financial profile and these tables describe cost to operate your program and your revenue sources.

It is important to see that together these 12 tables provide a holistic richer of your organization and the tables are all interrelated. The numbers and types of patients that you serve impact the staff that you need to deliver the services and the types of services you provide. Your staffing levels are related to your costs and the volume of services you provide are related to your revenue. Since all of the tables are interrelated you cannot complete patient, political, and financial tables in isolation . You cannot have your CFO provide your financial tables and your IT staff completed demographic tables in the clinical staff completed clinical tables independently and hope to have a complete and consistent report . How you report it on one table and backs up data is reported on other tables so for this reason it is important that you work as a team to prepare your report. The next set of slides are an introduction to each of the tables and again for each -- for details on how to correctly complete each table you should attend a daylong training or revert to a manual. >> The patient profile is made up of four tables and these four tables describe the total number of patients who serve. For example, if user 1000 patient the first table describes his patients where they live. For each zip code you will report the number of patients receiving service from that ZIP code. Table 3A reports the same patients, 1000 is our example, but by age and gender. The third patient table describes your patience by race and density. The fourth, table number four report total number of patients by income, and medical insurance. Since it is the same patients for all of these tables the total number you report must be the same across all four.

The last part of table number four ask how me of your patients are agricultural workers, homeless, and/or the terms. For those of you who receive more than one section 330 funding streams and that is you have a health Center grant or a homeless grant, migrant grant, and/or a public housing grant, you'll need to complete an additional copy of 3A, 3B, and 4 for each additional grant for which he received funding. Report the total rapacious on the universal report, 1000, and then the subset of your patients were homeless on the grant report. For example it had 200 homeless patients you will complete his second set of tables in the grant report for your 200 homeless patients. Know that your homeless patients are included in your total count and are reported again on the grant table. In this way the bureau is able to add up all of the patients on the universal report to get a complete count of the patient served by this 330 funded program.

Since the grant table is a subset of the universal table, it is not possible for any field on the grant table to exceed the number reported on the universal table. In other words you could not have more homeless Medicaid children then you have total Medicaid children. So if you see those kinds of lies you probably have an error in data reporting or there is a problem with your data source.

In summary, four tables including the patient by ZIP code, tables 3A, 3B, and 4 describe the patients who serve and the state is helpful for comparing your patient population with census data in your service data to see if you are serving long herbal populations that are a priority to the bureau and your patience by ZIP code data are used to map your service area and the data used to populate the UDF -- UDS mapper and it calculates indicators such as cost

per patient. If you're underestimating or over Mr. that -- overestimating your patient out these indicators will not be correct and you will not be able to rely on the state of her decision-making.

Before you submit your report you should make sure that your data is complete, with some simple checks with patient tables is making sure the have accounted for the same total number of patients on all for patient tables. And at the same number of special populations are reported on the grant tables.

The next group of tables describes your staff and utilization. Table 5 reports are staffed full-time equivalents, patient visits and patient by service. This report is also completed for each additional funding stream if you have multiple funding streams. However, only visits and patients are recorded and not staff for each grant program.

The second staffing table is new this year and it describes the number of consecutive months selected staff have worked at your health organization. Staff tenure is reported for most clinical staff and health Center leadership including the CEO, CFO, CMO, and CIO.

Tables 5 and 5A describes a staff it takes to serve your patients, the volume of services provided and tenure of your staff and data reported on table 5 is used cockily many important efficiency indicators such as staffing levels, visits per provider, patients per provider and cost per visit. Again, if you're underestimating or overestimating your patience and visits Related indicators will not be correct and you will not be able to rely on the data for decision making.

The tenure table is used to evaluate continuity of staffing which is important for patient satisfaction and practice stability and before you submit your report you should make sure that your data is complete and there are some simple checks you can do for table 5. First, you want to look at your tables 3A, 3B and 4 total number of patients served and it should be relation to that and the number of patients that you're serving on table 5. Similarly, staffed full-time equivalents on table 5 needs relate to the cost your report on the cost table which we will get to send. And the visits you report on table 5 will be related to the revenues that you report on the revenue tables.

Finally, that the grant table is a subset of the universal table again, no field on the grant report can be bigger than the number you have reported on the universal report. The next three tables describe your clinical services and quality of care. Table 6 Table 6A reports visit the patients were selected dynasties of services and these are not all the diagnosis of services you may provide, it is a subset of them. For those of you with multiple funding streams you will complete a copy of six-day for each special population that you serve. As I mentioned, do not report table 6A this year. Table 6 be and 7 describes quality of care for the patients by using proxies for good health all comes.

The real test of your success in improving the health of your patients is a long and healthy life and realistically we cannot wait that long to evaluate the quality of the care that we provide. As a result we use proxies as predictors of good health outcomes. Table 6B looks at 11 process measures as indicators of good quality care and these routine and preventive uncle measures are call process measures because they reflect services you provide your patient.

Process measures and proxy for quality of care, we know the patients who receive timely, routine, and preventive services are likely to have her outcomes as a result of early prevention or treatment. For example, if a child receives all childhood immunizations in a timely manner the child is less likely to develop vaccine or vegetable disease. Similarly the woman receives a regular pats test -- Pap test and cancers Takashima treated early and is less likely to serve at first outcomes from HPV and cervical cancer .

Table 7 reports of outcomes by race and ethnicity in these clinical measures are called intermediate outcome measures because they are not the ultimate outcome. Again, a long healthy life . But they are a quantifiable outcome which is predictive of a good long-term out -- prognosis. It reports on three intermediate outcome measures, normal birthrate, control hypertension, and controlled diabetes . By achieving a good intermediate outcome, normal birth weight, were controlled hypertension or diabetes, the risk of a negative help -- of outcome is reduced.

For example, a patient with control hypertension weblog to have cardiovascular damage, heart attack, stroke and organ damage and later in life. The format for submitting is the same in all measures and as you can see on the table on the screen, and column A you have to identify the universe of the patients meeting the reporting criteria and you will need to attend a daylong training or refer to the manual on permission for reporting criteria for each of the measures is one not be covering them in detail in this overview.

The second column, column B for all of the measures except prenatal measures you have the option of reporting on the universe, or sample of 70 patients that were meet the reporting criteria. It is important to understand that this is a random sample of 70 patients for each measure that you are unable to report the universe or choose to report example. It is not 70 patients preclinical location or per provider but a total of 70 patients for each measure you are reporting a sample.

And column C you will review the universe or sample of 70 chart to determine how many patients were in compliance for the measure, and report the number that were in compliance. You will need to refer to the manual to know how to categorize compliance for each of the individual measures.

For each measure the are doing, compliance rate is calculated as the number of records in compliance or the number that you reported in column C divided by the total number of records reviewed, the number that you reported in column B. If you used a random sample of 70 chart and determined that 50 were in compliance, the compliance rate is 50 divided by 70 or 71% of the patients are compliant on that particular measure.

When you complete your report you will be asked a series of questions about whether you have an electronic health record and if you do, about your system capabilities. It is a simple seven questions that you answer online. In summary, for the three clinical tables, they describe the services you provide, and provide a proxy for the quality of care that you provide . Before you submit your report you should make sure that the data is complete and again, there are some simple checks you can do to make sure the data make sense. For example you can check the universe to see if it is reasonable, compared with the patient population by age, gender, or race to if you are reporting on women with a Pap test we cannot report more women on table 6 B with a Pap test than the total number of women who served in the health center. Similarly you can't not report more occasions than a racial or ethnic

group. Make sure that your data is at least reasonable. >> The last category of tables is the financial profile which is comprised of three tables, and describes the cost operator program and your revenue sources. Table 8A reports that crude cost by cost center and if you look at table 8A and table 5 you want at the same cost centers are reported on both tables. If in completing table 5 and 8A you will need to be consistent and where you report FTEs, you need to report those costs in the same cost center on table 8A so if Sam Smith is an outreach worker on table 5 you should report a salary and benefits for Sam Smith and the outreach cost center on table 8A.

Table 9D reports all patient related revenues on a cash basis. For each payer class including Medicaid, Medicare, other, public am a private, or commercial insurance, you will report the total gross charges, cash collect 10 -- collection, reconciliation payments and allowances. For self-pay patients you will report gross charges, cash collections, discount, and self-pay bad debt.

The last table, table 9E reports non-patient related revenues including grants and contracts and other revenues. Since total revenue is calculated by adding revenues as reported on table 9D and 9E you should not report revenue of both tables or you will be duplicating. As the cash report you should report them out you received were true down and grants and contracts and not the grant award on table 9 E .

Financial tables provide a picture of the financial viability of the program in terms of diversification and funding in your cash flow. Again, before you said that your report you could make quick checks to make sure the data is reasonable in some simple checks include checking total cost on table 8A as opposed to the sum of cash revenues as reported on 9D or 9E at if you are reporting $5 million in cost and only $2 million in revenue, unless you have serious cash flow problems, you probably want to look and see if you're missing some information that you have reported on the tables.

Similarly, charges reported on table 9D should report your payer mix as you reported on table for an billable visits which are some of the visit that you report on table 5. It is important that everyone uses the same definitions and reporting data so you can compare performance with your peers and so the data can be aggregated across all programs at the national level. There are a few definitions I'm going to review with you, although there are more the daylong training, but these are the most critical for overlong understand -- overall understanding of the report.

The first definition is what do we mean by a patient? Tables 3A, 3B, and 4 addition by ZIP code, you report whole number of individuals and we need to know what we mean by patients as far as this report is concerned your not every patient who has contact with a health center during the reporting year is considered a patient of the UDS and to count as a patient on this report individual must have received one or more visits they count on tables 5 and the reporting year. A patient count as a headcount and that means that each patient count once and only once regardless of how many visits they may have.

You just heard that the an individual account as a patient, they have to have at least one visit on table 5. As you can see, looking at table 5, on column be -- B for clinic visit not all fields are open for reporting visits, only selected positions can report visit. So again, just as not every person who has contact with a health center counts as a patient, not every contact a person has with the health center counts of the visit. To count as a visit

the visit must meet some criteria. First, only types as -- or has a staff -- you can see those areas were have -- where has unshaded fields. Physicians, network questioners, physician assistants, nurses, behavioral staff, nutritionists, podiatrists, case managers, health educators. Static and never during visits include ancillary satellite lab and x-ray, medical assistance, transportation, eligibility assistance, and nonclinical support staff such as childcare, housing, wit -- WIC programs, non-health-related stuff and nonclinical supportive staff. If a person only receives one of these services that does not generate a visit for the UDS, then that person should not be counted as a patient with health center is that your. Not only must the visit the Performa eligible staff but there is an additional requirement you need to meet in order to report a visit on the UDS a divisive has to be face-to-face between a provider and the patient. In general, telemedicine and group visits do not count and that the only exception to that rule is for behavioral health, as mental health and substance abuse services, which to count group visits and telemedicine visits but all of the visits must be one-on-one, face-to-face between the patient and provider .

Providers must be appropriately licensed or credentialed to generate visits and select the categories for physicians, nurses, and other physicians have a good digital in or licensing requirement. To count the visit of must be documented in the patient's chart and the provider must be operating independently and using professional judgment. The list goes on, there are a few more rules. You can count only one visit per patient per provider type her day. One visit, per patient per provider type per day .

That made the patient thing a nurse and a nurse practitioner and physician all in one visit towns as one medical visit. It does not count as of three separate medical visits. It is considered a comprehensive visit there are multiple providers participating in that visit her at similarly, a patient seeing a hygienist and a dentist in one visit counts only as one dental visit. This is designed to make sure the visits are not inflated and the exception to this rule is if the patient is seen by two different providers and two different locations on the same day. For example, the patient goes to a remote site and sees a triage nurse and goes to the main site to see a physician, in that case you can count to patients, to visit for the patient for that day. Note the rules of the one visit per patient per provider type or day.

The same patient can see as many different provider types in one day as you have. So the same patient to get a medical, dental, mental health, substance abuse, nutrition visit all on the same day in each one would count separately but there cannot be more than one of the same type of visit. The next rule says you can only count one visit per provider per patient per day. That is one visit per provider, per patient per day. Again this rule of them is the potential for inflating visits but this rule says that a physician who does the medical exam or by the recent mental health intervention and oral screening is providing a comprehensive medical visit. You cannot count that as a medical, dental or mental health visit.

Other visits include all the paid referral visits that are Performa staffer Carlos of whether they are salaried and visits provided by salary regardless of whether they are salaried, contracted or volunteer. Remember there are certain types of visits than ever count. Immunization only and lab only visits should not be counted as medical visits. Dental varnishes do not count as dental visits, math screenings, health fairs, outreach pharmacy visits do

not count. Some of those are group visits and others is to not get counted on the report because that field is shaded.

The third and last definition I want to go over with you is what we mean by a full-time equivalent. Table 5 asks you to report your full-time equivalent so who and how do you account for FTEs ? The full-time equivalent is a person who works full-time for the entire year at your health center and this includes all staff contribute to the operation of your organization regardless of whether you pay them. You should include employees as well as contracted staff, residents, and volunteers a staff of table 5. You do not count persons who are not staffed such as paper for a -- referral provider Susie Patience at their place of business. A full-time equivalent is a person who works full-time for the entire year so any staff who worked less than full-time, or only part of the year, you need to prorate your time for them to The late FTEs and you cannot use the staffing list as of December 31 to complete table back -- table 5. -- You need to look at payroll records for the entire year to identify all the staff who work in the health center and how many hours they worked. For volunteer staff you need to refer to volunteer logs to identify the number of hours they worked.

Reporting tenure on the staff table 5 A is not the same thing is reporting staff on table 5. To complete table 5A you do look a staffing as of December 31 so the method of filling up the two reports is quite different. 10 your reports, consecutive months work for selected staff and it is not prorated for FTEs. The every person that you report on table 5 for tenure is considered one person regardless of their FTE.

You will not be able to reconcile tables 5 and 5A is the waitstaff is calculated it for different on both. -- As the way the staff is calculated is different for both. As webinar was intended to give you a high-level overview of key issues related to your UDS reporting and we cannot cover all of the content of the daylong training in a two-hour webinar. It is important that you attend the daylong training for set by step instructions for reporting your UDS . This is designed to introduce you to the tables but not provided a complete details of how to report, just to give you some insight. Hopefully in reviewing this information it has become clear to you how interrelated to you all the tables are and for most organizations in multiple staff involved with completing these tables, including your IT, finance, and clinical staff, in order to successfully complete your report you need to work together as a team to agree upon how you're going to report what staff, what tables, and what additional information needed to report. You cannot hope to have a consistent and accurate report technical, administrative, and financial tables are completed and isolation. As I mentioned we provide resources to help you produce your report which includes online training, face-to-face training , detailed manual which uses step-by-step suggestions for each of the tables, fact sheets and technical assistance. You will receive another on February and March and the goal is to make sure the goal -- report is as an -- the report is as complete and accurate as possible so you can use the information for your own program improvement in decision-making.

Finally, take the time to review your report before you submit it. Be sure to address all the edits that have flagged in the EHB with fossil excavations. Comments like your date is correct is assistance that was is not very helpful. Our vision in, garbage out . Make sure the information you are reporting makes sense and the true test of your understanding of your data is whether the data is consistent, and it is consistent with your expectations and when you speak with the reviewer you can explain what it means.

I would just like to thank you for your time and wish you luck with reporting your UDS, again we are here to help you. At this time we are going to open up for questions the first of a few comments before we do that.

Thank you so much, it was excellent hesitation and you covered a lot of ground in the short time. We wanted to let you all know that there will be a series of webinars in the next two months. The next webinar is called introduction to the UDS four look-alikes and that will take place on October 24. The webinar after that is entitled Introduction to UDS Clinical Measures and that will occur on November 14. Another method -- one on sampling methods occluding using the randomizer is on December 19. And then there is another webinar in December about this and maybe important to all of you, the new electronic handbook or EHB user interface training and that will look for in December as well.

For a complete list of the webinars as well as for the archive of this today's webinar can be found at
bphc.hrsa.gov/healthcenterdatastatistics . Thank you for attending the webinar and this time was open up for questions.

Thank you. At this time, pressed Starr and then one on your telephone if you like to ask a question. One moment please while our questions queue up.

Our first question today comes from Ellen. That line is now open. Do I have a question regarding -- regarding the period four UDS reporting and we are to be reporting from the date of our own work that is which is 16 June and I want to know that is what you are expecting question as opposed to reporting from January 1.

If you receive funding at anytime during the year you do report for the full year, January through December, even though you're granted not cover the timeframe before the grant award. We do ask you to capture the full year of activity on your report even though you received your grant later on in the your.

Do you know why my product officer would say otherwise?

They might just be mistaken.

Our next question today comes from David. That line is now open.

Hello, just a question about reporting the FTEs and things of that nature. If we are in a situation where we are losing all of our HR and some other services like that from another company, do I just try to figure out how may FTEs they have used to provide me that care or that serve as?

Know, if you are contracting for any kind of accounting, financial, billing support, any of those functions, you do not count those people as your FTEs. So you may have very few staff on table 5. You will come the cost is nonclinical staff cost on table 8A just will not have bodies associated with them.

Banks.

-- Thanks. That you're welcome.

Hello, I may have missed this in the conversation but when will the 2012 manual be available online?

It should be online before the end of the year. If you attended the daylong training will get access to the draft and they are in the pot -- the process of finalizing it and it will be posted as an official document before the end of the year.

Terrific.

Our next question today comes from Sarah.

Hello, I am sorry to be redundant on at length -- on Ellen's question but we are a newly designated look-alike designated in late August and it was my assumption we need to report on the full calendar year of 2012. But then I was told we would only need to report from the date of our designation. I know that you confirmed that for her but I want to make sure that that is also accurate for look-alikes amah that we do need to report on the entire calendar year.

You do. The reason for doing that is that it would be extremely hard to look at a few months of your activity across all of the tables and have a consistent report. It is easier to get a full year picture for consistency purposes. Whether you are a look-alike or 330 program we ask that you report on the full year.

You should probably know that a couple of people did give that information to see my want to let people know that is not the case.

That is very helpful, we will try to get that word out.

Thank you.

Hopefully anyone who attend the daylong training more member to tell them then to.

Our next question comes from Philip.

I just want to know if you could repeat that last website over to the schedule of the webinars and copy of the PowerPoint that was used to be.

Sure. I will do it again more slowly. It is
bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html.

Thank you.

Is also available on slide eight in this series of slides. We'll go back to slide number eight as well so you can see it on the screen.

Thank you.

Our next question today comes from Bob.

Just a quick Russian and I believe it was mentioned at the end of the presentation that there was a manual that covers each one of the forms in detail. Is that manual the one that is currently being developed and will be available in December, or is it currently available online?

Yes, that is a manual it will officially be available in December. As I mentioned, if you attended the daylong training, rafts are available at the training for you as well.

You can also access the previous year's manual which might be helpful to have you get an idea of what our reporting looks like and you can also ask us to set up the URL we mentioned. We update our manual every year and even though we do not have the most recent one on the web yet, you can definitely use this, it is an older version and it does give you pretty good detail. There is some changes but not very many major changes.

The new content for addition for reporting on the inner August incentives or a slight changes to the table.

One follow-up, I'm currently on the web, what should I be looking for in terms of last year's manual?

There should be a column on the right that says manuals. There are some links to the 2011 manual, 2010 manual, 20 to the 2011 manual, 2010 manual, 2009 manual, just on the right side of the page.

I have got it. Thank you.

Sure. As for our next question comes from Daniel. That line is now open.

My question was already answered, thank you.

Moving on. Our next question comes with Kathy.

Hello. I wanted some clarification on nurse visits that would count as encounters. I understand labs and vaccinations would not but what your cleanings -- ear cleanings, medicine instructions, what does count as encounters?

Typically enters within a patient before the patient is seen by the providers at anytime a nurse visit precedes, or follows a position or nurse practitioner or PA visit, that is it would obviously not count because you want to credit the visit to the physician or mid-level so all a those visits would not count your it as I mentioned, vaccine only visits do not count. Visit that absolutely to count our work there or triaged visits and the nurse did the triage, they provided the service but did not refer the patient immediately to see another provider, either they scheduled for another day or the processed the patients need themselves are also, nursing home visiting visits always count because they are providing a primary care. If there are other types of visits were they are providing the primary care for that particular patient for that day, then those would count. There is a relatively small number that ends up killing -- because of the definition of what gets counted.

Thank you. Is that so a pharmacy or prescription visit would not count as it is not appropriate anyway. I am not sure if it was another one that you mentioned that you need to respond to.

Will something like getting their it years -- ears cleanout once a month.

As a procedure?

Yes.

That would probably count.

Thanks.

To remind our participants it is starring in one to ask a question and please report your name. Our next caller did not record their name. The line is open for your questions.

[ Silence ] Moving on . Our next question comes from Johnny.

Hello. I have a question on table 6A. The basic report on line 1 up to 20 B, is it group -- reported only based on primary diagnostics. Spent know, this table is the revised so that you report for each of the diagnoses and a visit that reports that diagnoses, either as primary, secondary, or tertiary, it doesn't matter. Unlike other years where it was visit by primary diagnosis of it is no longer the case, as primary visit with any diagnosis. It gives us a better picture of the prevalence of the various diagnoses in the population so a visit with any diagnosis that you will capture on table 6A for that line.

Thank you.

Our next question today comes from a belief the name was Fatima.

Good afternoon everyone. I was just wondering if there will be another all-day training . The one that you have scheduled coming up is on the 15th and as many of you are going to the operational management training, it is happening that same week as I was hoping they would be another training scheduled.

I'm not sure that -- what you are referring to but there are 45 instructor led training is around the country in 45 different states. What state are you in?

I am in Ohio. I should know the date of that often cover my head but I do not. There is a list of trainings and there will be one in Ohio.

[ Indiscernible-multiple speakers ] So I have to look in another state?

Yes, you may attend any other state, you just have to contact that PCA and register for the training and that state if your state happens to be a conflict date.

We do not do multiples in the same state.

Thank you.

Sure.

The next question today comes from Cara.

Hello. My question was, hello?

Hello, go ahead.

Oh, I am sorry. We are a newly designated look-alike and to my knowledge we have not been assigned a program officer so there is a lot of references to checking with your program officer. Does that apply to look-alikes and what

that person come from a CMS or HRSA ? We're getting our encounter rate for Medicare and Medicaid established at this time so I was wondering where that would come from, or if I had -- or if I should have already see it -- receive notification of you that person was.

You should have a program officer assigned to you yes. If I can get your name, we will make sure that you have a program officer.

Okay. We did have a reviewer but that is not the same person as it? That reviewed the application?

No, you should have a program officer assigned to you. If you could e-mail us?

Sure,
you can -- I can't. -- Sure I can.

--

Thank you very much.

Our next question today comes from David Wagner.

Hello, I was going back to the question about whether visits are allowed will to be counted. Can you tell me were I can go look for a reference on that because I have some additional questions on types of visits? Or should I just send those to you guys?

You can certainly check them out -- the manual and I would suggest that you do call that helpline and they can go through them with you if you have specific questions. If you missed this -- if you have a particular question right now I should be able to answer for you.

Well, to her question about procedure, a lot of times our doctors have our patients come back in for committed -- for Coumadin monitoring and a nurse that looks through its right there, or he can ferment, talk to the patient and then go see the doctor and discuss the case with them quickly or it -- and either adjust or maintain the same medications. Would that be something that would qualify?

You would probably count the physician visit for that date.

The physician does not see the patient face-to-face, but the RN does.

If the physician did not see the patient face-to-face you would count as a nurse visit.

That is what I was wondering, right. --

I'm not sure that the code numbers would always dictate but that kind of visits obligate would definitely count. But feel free to call the helpline of Yemeni particular questions and we can go through them specifically and make sure that we give you consistent advice.

That sounds great. Thanks.

Our next question comes from Ty. >> Did you say from Ty or Ky?

Your line is now open.

Okay, a question on table 5, the new one on 5B, number of months per year working...?

The number of months cumulative . It should come from the personnel records but again it is the physician so there is a physician that worked with you for 10 years and became medical director two years ago, it is consecutive month in that particular position you are reporting on table 5A.

Thank you very much.

You're welcome.

Once again, it is started in one if you have a questions. The next question comes from Barbara.

Hello. I have a question regarding a residency clinic. Patients are seen by the residents faculty. [ Indiscernible-muffled speaker ] Do we include that on the FTE?

Yes. You will be looking at the hours the residents were and clinic providing services to patients and calculating the FTE of the time they are in the clinic. Again, you are wanting to count those visits. You're going to have staff that delivered the visit so for consistency, we want to give credit for those bodies. You do not necessarily have full cost for that staff on 8A and depend upon the range that you have you may have no-cost or low-cost for those residents but you would definitely count the FTE for the hours they are in residence which may be a fairly small FTE based on the time of services.

Also, this did not materialize until July. So six months of the year we really do not have data because they were not part of our clinic. So how do we do that?

Were residents providing services in your clinic for the first six months, or only in the last six months or whatever time for?

Only in the last six months.

So again, look at the number of hours those residents were providing services, say it was 100 hours over six months, you divide the 100 hours they worked over the full-time equivalent hours left leave, holiday, and sick. Because you're not paying that to them correct?

Correct. This is a contractor though, they are not actually employed by us, we contract out with a physician group.

That is okay. Again, we are trying to do is capture on table 5 all of the personnel it takes to deliver the services to your patient population, whether you are paying for them or not. He could have a volunteer that comes in one day a week am a you still want to A person because you are going to want to capture the visit that they are a visit generating person, or you want to recognize the support they provide if it is a nonclinical function . Similarly for a contract personnel you want to count those visits as they are clinician and you want to recognize the FTE that corresponds with the production.

Thank you so much.

Sure.

Our next question today comes from David.

Is, I would like to know how you define an FTE. For example, we consider a doctrine or clinic full-time if he works 40s a week. -- Four days a week.

Right, the way that the FTE is calculated on the UDS is based on higher health Center to find the FTE. Some say 40 hour workweek is the equivalent and other clinics have 37.5 hours so whatever you consider to be the full-time equivalent will be the denominator you use to do your copulations . For physicians it is based on contracts with your contracted full-time what would you have coverage for three days a week, every night, or 60 hours a week, it doesn't matter, it is based on your contract.

Thank you very much.

Our next question today comes from I believe the name was [ Indiscernible ], that line is open.

Yes I have a question about the new schedule, table 5A. It is it for specially contracted employees or W-2 employees?

If you actually look at table 5 there is a number of different columns. There is a full-time and part-time column and then there is an on time -- there is an on call column and contracts are included in the table and you should refer to the assertions of a daylong training because there's a lot of new stuff in terms of how to report a tease, not FTE's, excuse me, body's on the tenure report. It is not all staff, and there are some rules about how long, or how often per -- for part-time people you capture them on the stable.

So I look at my staff on December 31, why for December, and if I have one family physician who had four months and one who had 34 months, lets say that would be two persons at 38 months?

Correct, although there may be other subtleties involved that we have not totally pick up . Again, it is important to read the destructions in more detail or go to the training but yes, fundamentally that is correct.

Okay.

Once again if you'd like to ask a question it is star and then one on your phone. One moment please to see if we have any additional questions.

[ Silence ] >> One moment we do have a question queuing up now. Our next question is from Kathy.

Thank you. How do you find out about those daylong training is? I have been poking around the website that you gave us and I cannot find the information.

There is a link right now to the daylong trainings right on the URL that we stated earlier. It was previously on the screen, we will bring it back up again but it is the bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html . It is listed

there and it is one of the first links in the yellow box. There is a link there to go to a PDF file are all the trainings across the nation.

Thank you.

If anyone has any difficulty finding what you need feel free to call the helpline as well
at
866-UDS-HELP.

At this time I do not show any other additional questions in the queue. One moment, I do have one more question coming up. Our next question is from Kathleen.

Hello, my question is on table 6A that is no longer primary diagnosis I believe you said for this year.

Correct.

Am I correct in assuming, will diagnosis is be the same but the numbers will be higher probably?

Correct.

So we'll probably see it pretty big increase with hepatitis C or something because it could be anywhere, any diagnosis correct?

Right, the average number of visits per patient for a particular diagnosis is likely to go up.

Thank you.

You're welcome. That one moment while our next question choose up. Our next caller did not record their name so if you could queue up to ask a question your line is open.

Thank you. This is on table for. -- This is on table 5. Where am I supposed to report the visits and FTEs for nutritionists and pediatrics.

Nutritionists and pediatrics are considered other professional staff. Which is line.....
29 A, no, excuse me, line 22 is other professional.

Okay, I have got it. Thank you.

There will be a Appendix A with a long list of we consider under other professional on also have any other staff position that you are not sure what category they may logically fallen, please check Appendix A in the manual and where we recommend putting the staff.

[ Silence ]

Our next question comes from Betty.

Hello. I wanted to ask about visits in which you ask a patient about behavioral health issues that may be experiencing. And if they experience behavioral health issues during that visit, you actually bring in Pedro

health therapists into the room to have a visit at the same time. Can we count that is to visit?

Absolutely, it is two different services provided by two different providers, one a mental health provider and one of medical provider. So as a convenience to the patient being able to do it in concert assign . So yes, one medical, and one either mental health or substance abuse depending upon what kind of behavioral health you are referring to.

Okay. And we also have a reverse scenario under which our therapists sometimes will just consult with a medical provider about medications or possible medication choices, and the provider doesn't actually see the patient. It is my understanding we would not count that but sometimes the provider will actually step into the room and have a visit with the patient, even though it is a brief visit, related to the medications that have side effects and some different options. We be able to count those as two visits as well?

If the provider comes into the room and has a face-to-face encounter with the patient and documented in the chart, then yes. If it is just a consult with a provider, with a mental health practitioner, no.

Thank you very much.

You're welcome.

At this time I have no additional questions in the queue.

[ Silence ] >> One moment, I do now have another question queuing up. To remind participants it is star and then one if you have a question. Our next question comes with Johnny.

Thank you. If the patient is being seen on the same day by the nutritious -- nutritionist and a podiatrist, as it reported us to visit or want?

It actually is reported us to visit although that seems counterintuitive to what I just said he and other categories each additional visit counts as a separate category.

Thank you.

You're welcome.

One moment please for our next question. Our next question comes from John.

This has to do with adult weight screening and follow-up is a clinical measurement. I'm curious because I measurement to me seems [ Indiscernible ] because it contains two variables. For example, a low percentage of patients are outside of the BMI limit or it might be undesirable many a low percentage of patients needing follow-up which never actually got the follow-up. How do we interpret the percentage, or how do we as a community or HRSA interpret that percentage?

Adult weight or childhood weight?

I am not sure about childhood.

Is relatively the same for both. It is true that the weight measures have to component, BMI and a follow-up, it is slightly different for the childhood and the adults in terms of what exactly is required. And the poor performance on the measure overall could be a failure to capture the BMI come a or it could be a failure to follow up with the counseling , so you are correct, looking at the number on its own makes it difficult to know what you need to work on for improvement. They obviously have to delve a little bit into the data . If you're doing a sample I do strongly recommend that in the process of sampling the 70 chart you document where the failure is. Is it because the documentation is missing? Is it because no BMI was recorded in the charge, no-fault the plan -- and no follow-up plan developed ? That way you can evaluate possible causes of low performance and work on improving them but the number by itself, you cannot really tell what the underlying and contributing factors are without further investigation.

However, there is a denominator an excellent some sense, if the person is not eligible because their weight is completely normal, that is also captured in the denominator. The person would not be included in the denominator if he or she is at complete and normal weight.

I do not think that is correct I think the denominator is any patient who has been seeing.

It is included in the numerator. If it is a -- it is an adult with a normal weight you'll included in the numerator said have a lot of normal patients it will look good on this measure although you will not be successfully counselor those patients who have a weight issue. So the denominator does include all adults in the category and the numerator would include all normal, plus any patients who are in compliance, measure.

I am not sure about that because I think the numerator is only patients who are outside the limit and who have not had a follow-up.

That is not true. I mean , it is definitely the case that you want to include in the numerator all of your normals or you will have a compliance rate was much lower than in fact is the case.

Oh okay, that helps. Thanks.

Sure, you're welcome. And I do want to reiterate that there is a clinical webinar which may be very helpful. Obviously the daylong training goes over the specifics, numerator, denominator, and compliance. But the clinical webinar will provide additional framework for clinicians terms of how to evaluate the data, what is reasonable and what some of those national benchmarks are that are helpful to know and evaluating the performance of the program. And that training is on November 14 for any what -- for anyone who is interested.

Our next question today comes from Joanne.

Thank you very much. Again, on this visit question I am understanding that a visit to a dentist and a dental hygienist on the same day with be just one visit, correct?

Correct.

Also, if I could ask, if there is a psychiatrist who sees a patient has a patient come in with a follow-up with a social worker, and that social worker sees a patient and then these physician that as well, is that still just want?

It depends, the psychiatrist that social worker saw the patient on the same day or two different days?

The same day would count only as one mental health visit preferably with a psychiatrist because that is the more expensive person come up with a medical visit housed separately as the mental health visit to the one medical and one mental health visit. Assuming the patients all the medical provider, as documented in the chart and the medical provider provided some service.

If the patient comes back to see just the social service, behavioral individual, is that a visit as well though? On a different day just to see that person?

Absolutely. Provided that provider with all the criteria with a face-to-face with the patient .

Are podiatrists considered other professionals or specialty?

Not other specialty. That would be like cardiologists, and technologists, etc. and technologists, etc. The other professional category, why 22 on table 5, is where you would put nutritionist, podiatrist, occupational therapist, physical therapist, etc. physical therapist, etc.

Thank you very much.

You're welcome.

Our next question today computer Johnny, -- our next question today comes from Johnny, that line is now open.

Thank you. My question is on table 6A I see that we can pull the visits and the patients based on the diagnosis, ICD-9 codes or CPT is. Let's say I decided to use ICD-9 code, I have my list report, but, to doublecheck I use the CPT codes and icy a significant amount [ Indiscernible ] on the list and I take it knowing that and put it together?

Typically we say that usually use ICD-9 or the CPT or your double counting. So I am not quite sure you -- how you might end up with exclusive counts using both. So I cannot speak to that. Our recommendation is to choose only one, ICD-9 or CPT, or your double counting patient.

Somehow or other government blue different patients in both groups then yes, you would count them but I'm not sure how that would happen.

Okay, thank you.

You're welcome.

[ Silence ] At this time I have no additional questions in the queue .

[ Silence ] >> Thank you very much for attending today's webinar and thank you for all of your questions. We look forward to seeing you in the in person training.

That concludes today's conference,  thank you for  your participation.

[ Event Concluded  ]