Bureau of Primary Health Care

UNIFORM DATA SYSTEM (UDS)
Calendar Year 2012

UDS Reporting Instructions for Health Centers

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

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

BUREAU OF PRIMARY HEALTH CARE

BPHC UNIFORM DATA SYSTEM MANUAL
For use to submit Calendar Year 2012 UDS Data

Health Resources and Services Administration
BUREAU OF PRIMARY HEALTH CARE
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2012 UNIFORM DATA SYSTEM MANUAL

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

INTRODUCTION

This is the 17th edition of the Bureau of Primary Health Care's User's Manual: Uniform Data System. It is designed for use in submitting Calendar Year 2012 UDS Data, and updates all instructions and modifications issued since the first UDS reporting year (1996). **This Manual supersedes all previous manuals, including instructions provided on the BPHC Web site prior to December 13, 2012.**

The Manual includes a brief introduction to the Uniform Data System, definitions of terms as they are used in the UDS, instructions for completing each of the tables, and information on the submission of the UDS to the Bureau of Primary Health Care (BPHC) through HRSA's Electronic Handbook (EHB) system. Detailed table-specific instructions follow and include a set of "Questions and Answers," addressing issues that are frequently raised when completing the tables. The table-specific instructions highlight any changes to the table that may have been implemented for the current year. Five appendices are included which:

(A) list personnel by category and designation of personnel as providers who can produce countable "visits" for the purpose of the UDS;
(B) describe how to report issues which have impact on multiple tables;
(C) provide sampling methodologies for selecting charts for clinical reviews;
(D) explain the reporting of Electronic Health Record (EHR) system capabilities and Quality Recognition; and
(E) explain reporting differences for look-alikes

The Uniform Data System (UDS) contains the annual reporting requirements for recipients of the cluster of primary care grants funded by the Health Resources and Services Administration (HRSA). (The authorizing statute is section 330 of the Public Health Service Act, as amended.) The UDS includes reporting requirements for grantees of the following primary care programs:

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

Look-alikes do not receive grant funds, but report certain UDS data to record program changes, and track program performance. Affordable Care Act (ACA) funded activities are also reported in the UDS, since activities (patients, visits, income, and expenses) which have been and/or are being supported by the ACA are integrated with other section 330 funded activities.

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

The UDS includes two components:

- The **Universal Report**, completed by all grantees. The Universal Report consists of one copy of each of the UDS reporting tables. This report provides data on patients, services, staffing, and financing **across all programs**. The Universal Report is the

source of unduplicated data on BPHC programs.

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

In addition, there is a separate "look-alike version" of the UDS filed by organizations which are so designated. The look-alike UDS differs from the grantee UDS in that it deletes some data fields. These differences are highlighted in Appendix E and mentioned with each table where there is a difference. A small number of health centers have both grantee *and* look-alike sites, each with separate scopes of project. These "dual status" health centers will complete both grantee and look-alike versions of the UDS, reporting data that represents the scope of project supported by Health Center Program grant funds and the scope of project represented by the look-alike designation. Reporting instructions referring to "grantee" and "Health Center" apply to look-alikes, except where noted.

The UDS is comprised of 12 tables designed to yield consistent clinical, operational, and financial data that can be compared with other National and State data and trended over time. These tables are:

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

BPHC will collect information on Quality Recognition and the status of EHR adoption. This form will be included in the EHB along with the regular tables and must be completed as part of your UDS report submission.

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

GENERAL INSTRUCTIONS

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

WHO SUBMITS REPORTS AND REPORTING PERIOD

UDS Reports should be submitted directly by the BPHC grantee. A **grantee** is the direct recipient of one or more BPHC grants. All grantees that were funded before October 1, 2012 are required to report. Grantees must report activity for the entire calendar year, even if they were funded, in whole or in part, for less than the full year, and even if they did not draw down any grant funds in the year. Grantees who are funded for the first time after October 1, 2012 and who received no other funds from BPHC during the year are not required to submit a 2012 UDS report. Under extreme circumstances, most commonly involving the physical destruction of the health center, exemptions may be granted. Grantees must request such exemptions directly from the BPHC Office of Quality and Data.

DUE DATES AND REVISIONS TO REPORTS

UDS Reports may be submitted after January 1, 2013 and are initially ***due no later than February 15, 2013***. Between February 15th and March 31st grantees work with their UDS reviewer to identify and correct possible errors. Final corrected submissions are due by March 31st and changes after this date are not accepted. To request assistance at any time, please contact the UDS helpline at 1-866-UDS-HELP.

HOW AND WHERE TO SUBMIT DATA

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

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

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

[1] While most popular browsers should work with the EHB, it is certified to work with Internet Explorer Version 7 or higher. Grantees having a problem with other browsers should consider using IE-8 or 9 for this task.

DEFINITIONS OF VISITS, PROVIDERS, PATIENTS, AND FTES

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

VISITS

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

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

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

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

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

result in visits regardless of the level of documentation.

3. When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of service is noted in **each** person's health record. Such visits are limited to behavioral health services. Examples of such non-medical "group visits" include: family therapy or counseling sessions, and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. In addition, when a behavioral health provider conducts services via telemedicine/telehealth (traditional treatment sessions usually 40 minutes to an hour in length), the provider can be credited with a visit only if the service is noted in the person's record. *Medical* visits must be provided on an individual basis in order to be counted in the UDS. Other categories of telemedicine, patient education or health education *classes* (e.g., smoking cessation) are not credited as visits.

4. A visit may take place in the health center or at any other approved site or location in which project-supported activities are carried out. Examples of other sites and locations which may be approved include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. (If visits at these sites occur on a regularly scheduled basis the site ***must*** be an approved site within the scope of the agency's grant.) Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the grantee for these services and the patient is billed either for the specific service or through a global fee. A reporting entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so. When a patient is first encountered in a hospital or nursing home or a similar facility, *which is not specifically approved as a service delivery site by BPHC,* none of the services for that patient are reported on the UDS.

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

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

   If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and in Internist treats hypertension) ***only one of these visits may***

be counted on the UDS. While some third party payors may recognize these as billable, only one of them is ***countable.*** *The decision as to which provider gets credit for the visit on the UDS is up to the grantee. Internally, the grantee may follow any protocol it wishes in terms of crediting providers with visits.*

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

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

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

Further definitions of visits for different provider types follow.

PHYSICIAN VISIT – A visit between a physician (including a licensed resident) and a patient.

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

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

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

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

which case no visits would be counted for them. Note also that under no circumstances are services provided by Medical Assistants or other non-nursing personnel counted as nursing visits.)

DENTAL SERVICES VISIT – A visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide independent services or the volume of service (number of procedures) provided. The application of dental varnishes, and dental screenings, especially in a group setting, or absent other comprehensive dental services, does not qualify as a visit. Under no circumstances may the services of students or anyone else other than a licensed dental provider be credited with dental visits.

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

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

VISION SERVICES VISIT – A visit between a vision service provider and a patient during which eye exams are performed by an Ophthalmologist or an Optometrist for the purpose of early detection, care, treatment, and prevention for those with eye disease or chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis. These exams also provide opportunities to promote behavioral changes linked to eye health (e.g., smoking, excessive use of alcohol.) Under no circumstances may the services of students or anyone else other than a licensed vision services provider be credited with vision services visits. Retinography, whether performed by a licensed vision services provider or anyone else is not considered a vision visit absent a more comprehensive vision exam by a vision service provider.

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

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

housing or Medicaid eligibility) only one visit is generated, generally for an adult member of the family, regardless of charting in other charts.

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

PROVIDER

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

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

PATIENT

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

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

same cell on the Universal Report. For this reason, the number in any cell of a Grant Report will never be greater than the number in the comparable Universal Report

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

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

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

FULL-TIME EQUIVALENT EMPLOYEE

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

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

Staff may provide services on behalf of the grantee under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health

Service Corps assignment, under contract, or donated time. Interns, residents, and volunteers are counted consistent with their time with the grantee and their licensing. (See Appendix B for further discussion.) Individuals who are paid by the grantee on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours (however their visits are still counted.)

INSTRUCTIONS BY TABLE

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

OVERVIEW OF UDS REPORT

The UDS includes two components:

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

- **Grant Reports** are completed by a sub-set of grantees **who receive BPHC grants under multiple program authorizations**. These reports repeat all or part of the elements of five of the Universal Report tables. Grant reports provide comparable data for that portion of their program that falls within the scope of a project **funded through a specific funding authority**. Separate Grant Reports are required for Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *except for* grantees funded under one and only one of these programs which receive no other BPHC funding. No Grant Report is submitted for the portion of a grantee's activities supported by the Community Health Center grant. (The EHB is programmed to display only those tables that are required of a grantee. If grant tables are not required, they will not appear in the EHB.)

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

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

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

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

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

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

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

Look-Alike Tables

Look-alikes are health centers which meet all Health Center Program requirements but do not receive a Health Center Program grant. Look-alikes submit a slightly reduced data set (see Appendix E for details), but, for those tables and cells that are submitted, the program is to follow all the same rules that are spelled out in this manual. The look-alike UDS module in the EHB will have the reduced data set clearly identified, and cells or tables which are not reported will be closed off or grayed out in that system.

There are a very small number of health centers which are Health Center Program grantees which have one or more sites designated as a look-alike. These health centers will need to complete *both* grantee and look-alike UDS reports, limiting reporting to the approved scope of project for each respective program. Care must be taken to not include the same provider time, visits or associated costs in both reports. It is *possible* that the same patient will be reported on both reports if that patient is seen at both the grantee and look-alike sites.

INSTRUCTIONS FOR ZIP CODE DATA

PATIENT BY ZIP CODE

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

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

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

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

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

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

QUESTIONS AND ANSWERS FOR ZIP CODE REPORTING

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

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

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

PATIENTS BY ZIP CODE

Zip Code	Patients
Other ZIP Codes	
Unknown Residence	
TOTAL	

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

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

Tables 3A and 3B provide demographic data on patients in the program and are included in **both** the Universal Report and the Grant Reports.

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

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

A visit is a face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient, and the services rendered must be documented to be counted as a visit. See the "Definitions of Visits, Providers, Patients, and FTE" section (above page 7) for complete definitions.

TABLE 3A: PATIENTS BY AGE AND GENDER

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

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

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

HISPANIC/LATINO ETHNICITY:

- Table 3B collects information on whether or not patients consider themselves to be of Hispanic/Latino ethnicity *regardless of their race*.
    - Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do *not* count persons from Brazil or Haiti whose ethnicity is not tied to the Spanish language.
    - Column B (Not Hispanic/Latino): Report the number of all other patients *except* those for whom there is neither racial *nor* Hispanic/Latino ethnicity data.

- Column C (Unreported/Refused to Report): Only one cell is available in this column. Report on Line 7, Column C only those patients who left the entire race and Hispanic/Latino Ethnicity part of the intake form totally blank.

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

RACE:

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

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

LANGUAGE:

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

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

QUESTIONS AND ANSWERS FOR TABLES 3A AND 3B

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

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

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

4. **How are individuals who receive different types of services or use more than one of the grantee's service delivery sites reported? For example, a person who receives both medical and dental services or a woman who receives primary care from one clinic site, but gets prenatal care at another.**
   UDS Tables 3A and 3B provide unduplicated counts of patients. Grantees are required to report each patient once and only once on Table 3A and on Table 3B, regardless of the type or number of services they receive or where they receive them. Each person who has at least one visit reported on Table 5 is to be counted once and only once on Table 3A and on Table 3B. Visits are defined in detail in the "Definitions of Visits, Providers, Patients, and FTE" section (page 7). Note the following:
   - Persons who receive WIC services and no other services at the agency are not to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).
   - Persons who only receive lab services or whose only service was an immunization or screening test are also not to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).

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

patients age 0-19 years). The sum of Table 3A, Lines 21-38, Column A + B (total patients age 20 and above) must equal Table 4, Line 12, Column B (total patients age 20 and older).

6. Does race *and* Hispanic/Latino ethnicity of all our patients need to be collected and reported?

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

7. I have a separate data system for my Mental Health patients. How do I include their data on these tables?

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

TABLE 3A – PATIENTS BY AGE AND GENDER

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

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

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

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

INSTRUCTIONS FOR TABLE 4 – SELECTED PATIENT CHARACTERISTICS

Table 4 provides descriptive data on selected characteristics of health center patients. The table is included in **both** the Universal Report and the Grant Reports. Look-alikes do not complete lines 13a, b, or c: Managed Care Utilization or lines 17 -22: Details about homeless patients.

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

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

INCOME AS PERCENT OF POVERTY LEVEL, LINES 1 - 6

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

Income is defined in ranges relative to the Federal poverty guidelines (e.g., < 100 percent of the Federal poverty level). In determining a patient's income relative to the poverty level, grantees should use official poverty guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register during the first quarter of each year. The guidelines for CY 2012 are available at http://aspe.hhs.gov/poverty/12poverty.shtml.

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

PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE, LINES 7 - 12

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

- Uninsured (Line 7) – Patients who did not have *medical insurance* at the time of the last visit are counted on Line 7. This may include patients whose visit was paid for by a third party source that was *not* an insurance, such as EPSDT, BCCCP, Title X, or some State or local safety net program. Do *not* count patients as uninsured just because their medical insurance did not *pay for* their visit. For example:
    - A patient with Medicare who was seen for an dental visit which was not paid for by Medicare is still classified as having Medicare for this table.
    - A patient with Private insurance that has a $200 deductible who had not yet reached that deductible is still considered a Private insurance patient.
    - A Medicaid patient who is assigned to another provider such that the health center cannot bill Medicaid for the visit is still classified as having Medicaid.
    - Grantees in states piloting the impact of the Affordable Care Act implementation with those currently uninsured are to still report patients as uninsured on this table. If the program services are reimbursed by Medicaid, table 9D will report the revenue under line 1, Medicaid.

- Medicaid (Line 8a, 8b, and 8) – State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act. Medicaid includes programs called by State-specific names (e.g., California's "Medi-Cal" program). In some States, the Children's Health Insurance Program (CHIP) is also included in the Medicaid program – see below. While Medicaid coverage is generally funded by Federal and State funds, some States also have "State-only" programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients) and these individuals are also included on Lines 8a or 8b and 8. (As the nation transitions toward the enhanced coverage of the Affordable Care Act it is anticipated that there will be more and more of these state-only programs.) NOTE: Individuals who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the State Medicaid agency *are still* reported as "Medicaid" not as privately insured.

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

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

Medicaid, classify all covered patients as "regular" Medicaid (Line 8a).

- Medicare (Line 9) – Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act). Patients who have Medicare + Medicaid or Medicare + a private ("MediGap") insurance are reported on line 9.

- Other Public Insurance (Line 10a) – State and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, providing a broad set of benefits for eligible individuals. Include public paid or subsidized private insurance not listed elsewhere. Do not include any CHIP, Medicaid, or Medicare patients on Line 10a. Do not include uninsured individuals whose visit may be covered by a public source with limited benefits such as the Early Prevention, Screening, Detection and Treatment (EPSDT) program or the Breast and Cervical Cancer Control Program, (BCCCP), etc. ALSO DO NOT INCLUDE persons covered by workers' compensation, as this is not health insurance for the patient, it is liability insurance for the employer.

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

- Private Insurance (Line 11) – Health insurance provided by commercial and not for profit companies. Individuals may obtain insurance through employers or on their own. Private insurance includes insurance purchased for public employees or retirees such as Tricare, Trigon, Veterans Administration, the Federal Employees Benefits Program, etc.

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

SOURCE OF INSURANCE: Definitions.

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

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

Patients served in correctional facilities, may be classified as uninsured.

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

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

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

MANAGED CARE UTILIZATION, LINES 13a – 13c

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

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

> **MEMBER MONTHS FOR MANAGED CARE (CAPITATED)** (Line 13a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month. A patient is in a capitated plan if the contract between the grantee and the Health Maintenance Organization (HMO) stipulates that for a flat payment per month, the grantee will perform all of the services on a negotiated list. This usually includes, at a minimum, all office visits. Payments are received (and reported on table 9D) regardless of whether any service is rendered to the patient in that particular month. In the case of Medicaid, Medicare, and CHIP-RA, it is common for there to be a second "wrap-around" payment for managed care visits to adjust total payment to FQHC/PPS rates.
>
> **MEMBER MONTHS FOR MANAGED CARE (FEE-FOR-SERVICE)** (Line 13b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery location for one month during which time the patient may use only that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: It is common for patients to have

their primary care covered by capitation, but other services, such as behavioral health or pharmacy, paid separately on a fee-for-service basis as a "carve out" in addition to the capitation. Do not include member months for individuals who receive "carved-out" services under a fee-for-service arrangement on line 13b if those individuals have already been counted for the same month as a capitated member on line 13a.

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

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

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

CHARACTERISTICS OF TARGETED SPECIAL POPULATIONS, LINES 14 - 25

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

MIGRATORY OR SEASONAL AGRICULTURAL WORKERS AND THEIR DEPENDENTS, LINE 16

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

DEFINITIONS OF MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

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

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

usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within 24 months of their last visit and their dependent family members who have also used the center.

For both categories of workers, the term agriculture means farming in all its branches as defined by the OMB-developed NAICS, and includes seasonal workers included in the following codes and all sub-codes within: 111, 112, 1151, and 1152.

HOMELESS PATIENTS, LINES 17 – 23

All grantees are to report the total number of patients, known to have been homeless at the time of any service provided during the reporting period, on Line 23.

HOMELESS PATIENTS – Are defined as patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing.

Section 330(h) Homeless Program grantees will provide separate totals for homeless program patients by the type of shelter arrangement the patient had when they were first encountered during the reporting year. For section 330 (h) grantees Line 23 will equal the sum of Lines 17 through 22. In categorizing patients for Lines 17 through 22:

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

SCHOOL BASED HEALTH CENTER PATIENTS, LINE 24

All grantees that identified a school based health center as a service delivery site in their grant application and scope of project description are to report the total number of patients who received primary health care services at the school service delivery sites(s) listed. A school based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services. Services are targeted to the students at the school, but may also be provided to their children, siblings or parents, and may occasionally include persons residing in the immediate vicinity of the school.

VETERANS, LINE 25

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

QUESTIONS AND ANSWERS FOR TABLE 4

1. **Are there any changes to this table?**
   Minor changes have been made to the definition of agriculture, however the definition includes no new individuals not previously defined as migrant or seasonal agricultural workers.

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

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

4. **We have never collected information on whether or not a patient is homeless, an agricultural worker or a veteran. Do we have to do this now for reporting?**
   Yes. All grantees are required to ask every patient who comes into their health center whether or not they are included in one of these special populations and to add this as an item on their profile so it can be reported.

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

6. **How are state programs piloting impact of ACA transition to be reported?**
   The patients under these pilot programs typically do not qualify for Medicaid under the current rules and are uninsured. Report these patients on Line 7, Uninsured. Note that the typical arrangement under these programs is for Medicaid to reimburse for these services. If this is the case, the revenue are to be reported on Table 9D, Line 1, Medicaid.

TABLE 4 – SELECTED PATIENT CHARACTERISTICS

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

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

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

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

INSTRUCTIONS FOR TABLE 5 – STAFFING AND UTILIZATION

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

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

STAFF FULL TIME EQUIVALENTS (FTEs), COLUMN A

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

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

All staff time is to be allocated *by function* among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week, and provided medical care services for the other 30 hours per week, time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out the components of an interaction. The nurse who handles a referral after a visit as a part of that visit would *not* be allocated out of nursing.

The nurse who vitals a patient who they then place in the exam room, and later provide instructions on wound care, for example, would not have a portion of the time counted as "health education" – it is all a part of nursing.

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. (Similarly, providers who routinely are required to work more than 40 hours per week are not counted as more than 1.0 FTE.) The time spent by providers performing tasks in what could be considered "non-clinical" activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in QI activities, supervising nurses, etc., is counted as part of their overall medical care services time and not in the Non-Clinical Support category. The one exception to this rule is when a Medical Director is engaged in non-clinical activities at the *corporate* level (e.g., attending board of directors and senior management meetings, advocating for the health center before city council or congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies, etc), in which case time can be allocated to the "non-clinical support services" category. This does not, however, include non-clinical activities in the medical area such as supervising the clinical staff, chairing or attending clinical meetings, writing clinical protocols, etc.

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

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

records and patient support staff here – they are reported on Line 32, Patient Support Staff.

NOTE: Quality Assurance Personnel – Individuals in any or all of the above positions may be involved in Quality Assurance and EHR activities. They will be classified on the line that describes their main responsibility, not on the "IT" line. Individuals fulfilling help-desk, training, and technical assistance functions who do not have a position that places them on one of the other Medical lines are included as "other medical personnel".

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

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

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

- **OTHER PROFESSIONAL HEALTH SERVICES (Line 22)** – Other Professional Health Services includes a broad array of providers of care. Some common professions include occupational and physical therapists, dieticians, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and community health aides and practitioners. Optometrists, previously included on this line, are now reported on Line 22b. NOTE: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff. (A more complete list is included in Appendix A.) Services other than those listed above must be described in a clear detailed

statement. Grantees are encouraged to check the reporting of such services with the UDS help line or their reviewer. There is a "specify" box for this line that must be completed for all services. Explain the specific other professional health services included.

- **VISION SERVICES (Lines 22a – 22d) –** Persons working in the area of eye care, specifically
    - **Ophthalmologist (Line 22a)** – Medical doctors specializing in medical and surgical eye problems.
    - **Optometrist (Line 22b)** – Optometrists (O.D.) – not physicians.
    - **Other Vision Care Staff (Line 22c)** – ophthalmologist/optometric assistants, aides and technicians.

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

  Some States license "Clinical Pharmacists" whose scope of practice includes reviewing and altering medications. In some States they are permitted to order tests. Despite this expanded scope of practice, *no pharmacy visits are recorded on Table 5.* Clinical pharmacists must be reported on Line 23 and may not be allocated to other clinical or non-clinical lines, nor may their interaction with patients be counted elsewhere.

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

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

    - **Patient and Community Education Specialists (Line 25)** – health educators, with or without specific degrees in this area. Family planning specialists, HIV

specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach may also be included here. Services may be one-to-one with the patient or in a group, however *group visits are not reported in Column B.*

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

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

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

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

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

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

- **NON-CLINICAL SUPPORT SERVICES (Lines 30a - 32)**
  - **Management and Support Staff (Line 30a)** – Management team including Chief Executive Officer, *Chief Financial Officer*, Chief Information Officer and Chief Medical Officer, other non-clinical staff and office support (secretaries, administrative assistants, file clerks, etc.) for health center operations within the scope of the grant. In the case of the Medical Director or other individuals whose time is split between clinical and non-clinical activities, report only that portion of their full-time equivalent corresponding to the management function.

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

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

- **Facility (Line 31)** – Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff. If facility functions are contracted (e.g., janitorial services) do not attempt to create an FTE, but the costs will be shown on the facility line on table 8A.

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

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

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

FTEs reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical providers and clinical support staff	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16 – 18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a – 20c: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists, etc.)	9: Other Professional
22a-22c: Vision (Ophthalmologist, Optometrist, Optometric Assistant, Other Vision Care)	9a: Vision
23: Pharmacy	8a: Pharmacy

FTEs reported on Table 5, Line:	Have costs reported on Table 8A, Line:
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs/services (non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Non-clinical Support Services including Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Non-Clinical Support Services
31: Facility (e.g., janitorial staff, etc.)	14: Facility

CLINIC VISITS, COLUMN B

VISITS (Column B) – A visit is a documented, face-to-face contact between a patient and a provider who exercises their independent professional judgment in the provision of services to the patient. (See "Definitions of Visits, Providers, Patients, and FTE" section, page 7, for further details on the definition of visits). Grantees report visits which occurred during the reporting year which were rendered by the staff identified in Column A, regardless of whether the staff are salaried, contracted or donated. ***No*** visits are reported for personnel who are not "providers who exercise independent professional judgment" within the meaning of the definition above. In addition, the BPHC has chosen not to require reporting grantees to report on visits for certain other classes of staff, even if they *do* exercise professional judgment. The cells applicable to these staff (e.g., laboratory, transportation, outreach, pharmacy etc.) are blocked out in Column B.

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

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

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

PATIENTS, COLUMN C

PATIENTS (Column C) – A patient is an individual who has at least one visit during the reporting year. (See "Definitions of Visits, Providers, Patients, and FTE" section, page 8 for further details.) Report the number of patients for **each** of the seven separate services listed below. ***Within*** **each category, an individual can only be counted once as a patient. A person who receives multiple types of services should be counted once (and *only once)* *for each service*.**

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

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

If you show visits in Column B for any of these seven categories, you are required to show the unduplicated number of patients who received these visits in Column C. Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Also, individuals who only receive services for which no visits are generated (e.g., laboratory, transportation, outreach) are not included in the patient count reported in Column C. For example, individuals who receive outreach or transportation services are not included in the total number of patients receiving enabling services in Column C on line 29; individuals who received flu shots but no other medical service are not counted as medical patients on line 15, etc.

QUESTIONS AND ANSWERS FOR TABLE 5

1. **Are there changes to this table?**
   Only a technical change has occurred. The term "non-clinical" is being used in places where "administrative" was used in the past, however the definitions and numbers being reported are exactly the same as they would have been with the previous language.

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

3. **How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call the remaining 25 percent of his/her salary?**
   An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or hours spent on clinical committees, or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by a physician (for example) while not in face to face contact with the patient, such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc., is not to be "adjusted off" – it is to be considered part of their time as a physician. The one exception to this rule is when a Medical Director is engaged in non-clinical activities at the *corporate* level, in which case time can be allocated to the "non-clinical" category. This does not, however, include non-clinical activities in the medical area such as chairing or attending meetings, supervising staff, writing clinical protocols, designing formularies, approving specialty referrals, etc. Note that the FQHC Medicare intermediary has different definitions for full time providers. These definitions are ***not*** to be used in reporting on the UDS.
4. **Our physicians work 35 hour weeks. Are they reported as 87.5% (35/40) FTEs?**
   No – they are each counted as 1.0 FTE. Grantees are not required by BPHC to have a 40 hour work week, but whatever workweek they have must be considered full time.

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

6. **If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?**
   Yes. There should be a logical consistency between Table 5 and 8A. If a grantee reports that costs for case management services one would expect to see case managers reported

on Table 5. Similarly, if there are staff on Table 5 we would expect costs on Table 8A unless all of the staff are volunteers.

7. How are contracted providers and their activities reported on Table 5?

If the contracted provider is paid on the basis of time worked (for example – one day a week,) the FTE is reported on Table 5 Column A as well as the visits and patients receiving services from this provider. If the contracted provider is paid on a fee-for-service basis, no FTE is reported on Table 5 Column A but visits and patients are reported.

8. Where does "Behavioral Health" get reported?

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

9. If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during a visit, how should this be counted?

Because "substance abuse" is also seen as a mental health diagnosis, it is permissible to count the visit as mental health. Under no circumstances would it be counted as "one of each." The provider will also need to be classified as mental health for this visit as must be the cost of the provider on Table 8A.

10. Do I count the time of volunteers, interns or residents?

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

Reporting Period: January 1, 2012 through December 31, 2012

TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	Total Physicians (Lines 1 - 7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	Total NP, PA, and CNMs (Lines 9a - 10)			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	Total Medical (Lines 8 + 10a through 14)			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	Total Dental Services (Lines 16 - 18)			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	Total Mental Health (Lines 20a-c)			
21	Substance Abuse Services			
22	Other Professional Services (specify___)			
22a	Ophthalmologist			
22b	Optometrist			
22c	Other Vision Care Staff			
22d	Total Vision Services (Lines 22a-c)			
23	Pharmacy Personnel			
24	Case Managers			
25	Patient/Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify___)			
29	Total Enabling Services (Lines 24 - 28)			
29a	Other Programs/Services (specify___)			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
33	Total Facility and Non-Clinical Support Staff (Lines 30a - 32)			
34	Grand Total Lines 15+19+20+21+22+22d+23+29+29a+33			

INSTRUCTIONS FOR TABLE 5A – TENURE FOR HEALTH CENTER STAFF

Table 5A is reported on the **Universal Report** only. This table provides further information on the tenure of health center staff and of your providers. Providers are defined as falling into one of two categories – (1) Full and Part Time staff and (2) Locums, On-call and Others – as defined further below. The staffing information in categories on Table 5a uses the same definitions as Table 5, and individuals on the selected lines on Table 5a are the same as for individuals that are reported on Table 5. Line numbers on Table 5A correspond to those on Table 5. Not all Table 5 lines are reported. Specifically, lines for non-providers, other than health center management staff, are excluded, as are providers of "Other Professional" and Enabling services.

Definitions

Full and Part Time Staff: Columns A Full and part time staff are individuals who are considered regular employees of the health center. They may be paid in a number of different ways and may work different amounts of time. Future employment may be limited by the expiration of a contract or may be "open-ended" with no specific end date. The following are considered full and part time staff and are reported in columns a and b.

- **Full Time Staff** Are "employed" by the health center, receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to IRS on a form W2. Staff may or may not have a contract. Staff are considered to be full time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if a full time employee gets eight hours off for a holiday, these staff also receive eight hours off.) They may have assigned work hours which are less than 40 per week, and may actually end up working more than those assigned hours.

- **Part Time Staff** Are "employed" by the health center, receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to IRS on a form W2. Staff may or may not have a contract. Staff are considered to be part time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if a full time employee receives eight hours off for a holiday, a 75% part time staff person would receive six hours off.) Part time staff may actually end up working more than their assigned hours.

- **Part Year Staff** Persons employed full or part time for a specific period because of a recurring special need. This is especially common in centers that serve fishing fleets, agricultural workers, cannery workers or recreation areas. To be included they must either be working at the time of the census or be under agreement to return to the clinic in the following year.

- **Contract Staff** Are "contracted" by and work at the health center. They work regular assigned hours every day or week or month. They may or may not receive benefits appropriate to their FTE. They do not have withholding taxes deducted from their paychecks and have their income reported to IRS on a form 1099. Do not include contract physicians who are paid by the visit to deliver services in their own offices.

- **NHSC Assignees** Are members of the National Health Service Corps who are assigned by the Corps to the health center. This includes members of the "ready reserve." These individuals are employees of the U.S. Government. The health center

may or may not have a contract with the NHSC to pay a specific amount to cover the cost of their assignment.

Locums, on-call, etc. (Other Service Provider/Person Arrangements): Columns C
Health centers often make use of individuals other than their regular staff to provide services to patients. They have many different names though the difference between categories may be subtle or non-existent and different centers may use the names differently. For the purpose of this table, the following are considered locums, on call staff, etc. and are reported in columns c and d:

- **Locum tenens** Locums work at a health center on an "as needed" basis. They are most commonly used to fill in for a part time absence of another provider (i.e., on a day off or to cover for a vacation, sick leave, FMLA, etc.) but may also be used when the center is unable to hire a full- or part-time staff person for a position. Locums are uniquely identifiable because they work for an agency and the center pays the agency rather than the individual. They do not receive benefits from the health center (though they may from the agency they work for) and generally are not covered by the health center's professional liability insurance. Generally locums cannot be hired by the center as a full- or part-time employee without paying a fee to the agency.

- **On-call providers** On call providers also work at a health center on an "as needed" basis, and are also most commonly used to fill in for a part time absence of another provider (i.e., on a day off or to cover for a provider who is on vacation, sick leave, FMLA, etc.) but may also be used for an extended period when the center is unable to hire a full- or part-time staff person for a position. Unlike locums, on-call providers are paid by the health center. They may or may not receive benefits, and may or may not have payroll and income taxes withheld. On-call providers are generally not covered by FTCA though they may be covered by the center's gap insurance.

- **Volunteers** Health center volunteers may have a regular schedule which may include a large number of hours or just a few hours a month. They are generally scheduled by the session. Volunteer providers are not paid by the health center and do not receive benefits. They are not covered by FTCA though they may be covered by the center's gap insurance.

- **Residents / trainees** Many health centers are involved in training programs which involve the trainee providing services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) are licensed in their own right:
    - In the case of medical residents, they are included on the line for which they are in training, so a family practice resident will be counted on the family practice line, even though they have not yet passed the boards for that additional certification.
    - In the case of mental health interns or residents, those who are licensed at a level other than that for which they are training are eligible to be reported. A Psychology resident may be a Licensed Clinical Social Worker, in which case they would be considered on the LCSW line. But an LCSW trainee who holds no independent license would not be reported on this table at all.
    - An individual who is not licensed is not to be counted.

- **Off-site Contract Providers** In some instances health centers contract for the services of providers who work at a location that is not an in-scope site as defined in

their application. This may be because the center does not have the critical mass to be able to establish a service (e.g., a dental contract) or because they are serving a wider area than their existing sites can reach (especially in migrant voucher or homeless programs.)

- If the provider is contracted for a specific time (e.g., Monday and Wednesday afternoons or two days per week) they are to be considered for this table.
- If the provider is paid by the visit they are *not* to be considered for this table.

- **Non-Clinical Consultants** Some organizations – especially smaller and more remote organizations – use consultants to fill administrative non-clinical management positions because they are unable to recruit health center management staff or are unable to support a full time person in such a role that role. These individuals may be considered for inclusion on lines 30a1, 30a2, 30a3, and 30a4.

Persons (Columns A and C) Include all individuals who are working on the last day of the year or who are current employees / contractors / etc. who have that day off, but are scheduled to return on a specific day. (In other words, include someone who has the day off or who is on vacation or sick leave, but do not include individuals who may be used again in the future, but are not regular staff.) *Unlike Table 5,* Table 5A is a census of staff as of the last work day of the year (e.g., December 31st.)

Also *unlike Table 5* count each individual that serves in one of the roles identified on Table 5A as 1 person. *FTEs are not to be considered,* and Columns a and c only permit the entry of whole numbers. In order to be included in the count of health center staff and clinicians, an individual must meet *one or more* of the following criteria:

- Be employed full time
- Be employed part time on a regular basis with a regular schedule that includes no less than two days per month
- Be an NHSC clinician who is assigned to the health center
- Be contracted on a regular basis with a regular schedule that includes no less than two days per month
- Be an on-call, locum, resident, or volunteer provider who has worked a regular schedule of no less than two days per month for at least six months

> DO NOT count individuals who may work many days, but do not work a regular schedule, such as a locum or on-call provider who is called in any time one of the many physicians on staff are sick.

Total Months (Columns B and D) The number of months reported for each person being included on Table 5A, is equal to the number of continuous months (rounded up to the next whole number) that that person has been in their current position. For example:

- Persons who have been continuously employed (contracted for) in their current position, regardless of whether or not the census day is a regular work day: Report the number of months since they were hired.
- Persons who have been employed more than once and whose employment was terminated between the two (or more) periods: Report the number of months since they were *most recently* hired.
- Persons who have served multiple positions in a health center (e.g., a long term physician who was recently promoted to medical director): Report the number of months since they began the position they are being counted for.

- Persons who are counted on Table 5A in two or more positions (e.g., a pediatrician/medical director or CEO/CFO): Report the number of continuous months they have been holding each position. (So it might be 50 months as pediatrician and 9 months as medical director.)

INSTRUCTIONS FOR COLUMNS:
FULL AND PART TIME STAFF: COLUMN A.
Table 5a column a provides information on *the number* of full and part time staff as defined above who work in selected positions within the scope of the project for all of the programs covered by the UDS. **All staff reported on a given line on table 5A will have been reported on the same line on table 5.** Count each staff person working in a given position who qualifies under the definitions above as 1 staff person. For example:

- A full time physician who was employed on the census date is counted as 1 person.
- Two half time physicians who were employed on the census date (regardless of whether or not they actually worked that day) are counted as 2 persons.
- A part time physician who works two months every summer during the migrant season, but was not present on the census date is counted as 1 person.
- A full time physician who worked for the center for ages, but resigned prior to the census date is not counted at all.
- A physician on pregnancy leave who has been out for 8 weeks but intends to return after the leave is over is counted as 1 person even though she was not present on the census day.

LOCUMS, ON-CALL, ETC.: COLUMN C:
Table 5a column c provides information on the number of persons defined above who work in selected positions within the scope of any of the programs covered by the UDS. **All staff reported on a given line on table 5A will have been reported on the same line on table 5.** Count each staff person working in a given position who qualifies under the definitions above as 1 staff person.

MONTHS: COLUMNS B AND D:
Report the total number of continuous months with the health center for those persons identified in column a or c for example:.

- A full time physician who has worked since 1/1/2010 is credited with 36 months. (3 full years times 12 months)
- Two half time physicians who began working on 7/1/1999 are credited with a total of 324 months. (13.5 years X two staff X 12 months)
- A part time physician who has worked every summer migrant season since July 1, 2002, is credited with 126 months. (10.5 years X 12 months)
- A cardiologist who has worked the first and third Wednesday of every month since 1/18/2010 is credited with 36 months.
- A full time physician who worked for the center for many years, but resigned prior to the census date is not reported on this table.
- A physician who has been (and remains) a pediatrician since 1/1/2010 and medical director since 7/1/2012 is credited with 36 months as a pediatrician and six months as a medical director.

TABLE 5A – TENURE FOR HEALTH CENTER STAFF

Health Center Staff		Full and part time		Locum, On-call, etc	
		Persons (a)	Total months (b)	Persons (c)	Total months (d)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
11	Nurses				
16	Dentists				
17	Dental Hygienists				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer				
30a2	Chief Medical Officer				
30a3	Chief Financial Officer				
30a4	Chief Information Officer				

INSTRUCTIONS FOR TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

Table 6A has been significantly revised for data submitted for CY 2012 and years thereafter. In the past lines 1 through 20d of the table focused exclusively on ***primary*** diagnoses. Beginning with this reporting year, these lines will report on ***all*** visits with the designated diagnoses and *all* patients who received this diagnoses, regardless of whether it was a primary diagnosis, a secondary diagnosis, a tertiary diagnosis, or any other level. (Lines 21 through 34 – which deal with services provided – remain unchanged. They have always reported on all services, regardless of the order in which they might have been listed.)

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

The table is included in **both** the Universal Report and Grant Reports. Look-alikes *do not* complete this table.

- The **Universal Report:** Column a provides data on *all* visits where each of the specified diagnostic or service codes was reported. Column B reports all individuals who had at least one visit where the specified diagnostic or service category was reported. The report includes all applicable diagnoses coded and services provided within the scope of any and all BPHC-supported projects included in the UDS.
- The **Grant Report:** The Grant Report provides the same data for those visits provided to individuals served within the scope of the specific grant program.

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

Selected Diagnoses – Lines 1 through 20d present the name and applicable ICD-9CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range of ICD-9CM codes is shown, grantees should report on all visits where the *diagnostic code* is included in the range/group. In prior years, data were provided for only the primary diagnosis. Beginning with the report on 2012 activities, grantees will provide data on *all* diagnoses regardless of their order in the list of diagnoses reported for a specific visit.

(NOTE: Many health centers are beginning to make the transition to ICD-10 codes. These codes are sufficiently different from the ICD-9 codes that they may not be used. They will need to be translated to ICD-9 codes for purposes of this report. Additional information is available on the conversion process at https://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp.)

Selected Tests/Screenings/Preventive Services – Lines 21 through 26d present the name and applicable ICD-9CM diagnostic and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served or of particular interest to HRSA. On several lines both CPT codes and ICD-9 codes are provided. Grantees may use *either* the CPT codes *or* the ICD-9 codes for any specific visit, *not both. As in the past, all* visits meeting the selection criteria and definitions are reported. A reported *service* may be in addition to another service, and may be in addition to a reported *diagnosis* or may stem from a visit where there was no UDS-reportable diagnosis code.

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

Grantees must actually perform the test in their labs or collect the sample and transfer it to a reference lab for the test to be counted. (Lab tests ordered by a grantee, but paid for by a third party payor including Medicare and Medicaid *are* included, as are mammograms performed by a grantee, but read by an outside radiologist who then bills a third party.) Do not report referral for tests or procedures which are not performed by or paid for by the grantee.

Selected Dental Services – Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services may be performed *only by a dental provider who is reported on Lines 16 – 17 on Table 5.* Wherever appropriate, services have been grouped into code ranges. For these lines, the concept of a "primary" code is neither relevant nor used. *All* services are reported. Note that sealants or varnishes which are applied outside of a comprehensive treatment plan, especially when provided as part of a community service at schools, are *not* to be counted nor does this activity generate a visit reported on Table 5. Dental services reported on table 6A must be provided directly by a licensed dental provider.

PLEASE NOTE: Only services which are provided at a "countable" visit are reported on table 6A. Included in these would be services "attendant to" a countable visit. Thus, if a provider asks that a patient come back in 30 days for a flu shot, when that patient presents, the shot is counted because it is considered legally to be a part of the initial visit. Another person, who is not a clinic patient and who comes in just for the same flu shot and without a specific referral from a prior visit would not have the interaction reported on Table 6A.

NUMBER OF VISITS, COLUMN A

LINES 1 – 20d: Diagnostic Data

Visits by Selected Diagnoses (Lines 1-20d). Report the total number of visits during the reporting period where the indicated diagnosis is listed on the visit/billing record. If a visit has a diagnosis which is among the many diagnoses not listed on Table 6A, it is not reported. All visits are entered into clinic practice management/billing systems, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc. Each diagnosis made at a visit may be counted on Lines 1 – 20d regardless of the number of diagnoses listed for the visit. Thus, a patient visit with a primary diagnosis of hypertension and a secondary diagnosis of diabetes will be counted once on Line 11 for hypertension and once on Line 9 for diabetes. Note that this is a change instituted effective January 1, 2012.

LINES 21 – 34: Service Data

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

- One visit may involve more than one of the identified services in which case each should be reported. For example, if during a visit both a Pap test and an HIV test were provided then a visit would be reported on both Lines 21 (HIV Test) and 23 (Pap test.)
- If a patient receives multiple immunizations at one visit, only one visit should be reported on line 24.
- Services are reported ***in addition to*** diagnoses. A hypertensive patient who also receives an HIV test would be counted once on the hypertension Line 11 and once on Line 21, HIV test.
- Services are also reported where no diagnosis is reported. A patient who comes in for intense head aches who also gets a flu shot would be counted on the flu shot line (Line 24a), but not on any diagnostic line.
- If a patient had more than one tooth filled during a visit, only one visit for restorative services (Line 32) should be reported, not one per tooth.

NUMBER OF PATIENTS, COLUMN B

LINES 1 – 20d: Diagnostic Data

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

LINES 21 – 26d: Services Data

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

LINES 27 – 34: Dental Services Data

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

QUESTIONS AND ANSWERS FOR TABLE 6A

1. **Are there changes to this table?**
   YES. Effective with CY 2012 data Table 6A will collect applicable data on *all* diagnoses coded for a given visit, not just the primary diagnosis. It is now possible that a visit that has a primary diagnosis that is not on the list will still be coded if the secondary diagnosis is one of those listed. Similarly, a single visit may generate more than one countable diagnosis. ALSO, Line 26a, H1N1 flu vaccine has been deleted. This antigen no longer exists as a mono-valiant vaccine.

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

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

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

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

5. **The instructions specifically say that the source of information for Table 6A is "billing systems." There are some services for which I do not bill and/or for which there are**

no visits in my system. What do I do?
Referrals for which you do not pay (e.g., sending women to the County Health Department for a mammogram) are *not to be counted.* While grantees are only required to report data derived from billing systems, the reported data may understate services in the circumstances described below. In order to more accurately reflect your level of service, grantees are encouraged to use other codes in their system to enable the tracking. For example, if a child is given a vaccination which the clinic does not charge for because they received it free from the Vaccine for Children program, the regular code with an extension may be used to indicate that it is not to be billed or the code may have a zero charge attached to it.

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

Reporting Period: January 1, 2012 through December 31, 2012

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

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

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

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

TABLE 6A – SELECTED SERVICES RENDERED

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

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
24a.	Seasonal Flu vaccine	**CPT-4:** 90655 - 90662		
25.	Contraceptive management	**ICD-9:** V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99391-99393; 99381-99383;		
26a.	Childhood lead test screening (9 to 72 months)	**CPT-4:** 83655		
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408-99409		
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406 and 99407; S9075		
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

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

Sources of codes:

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
- Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
- Current Dental Terminology, (CDT) 2010/2011. American Dental Association.

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

INSTRUCTIONS FOR TABLE 6B – QUALITY OF CARE INDICATORS

Table 6B is included only in the Universal Report. It is completed by all grantees *and* all look-alikes.

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

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

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

patients with established coronary artery disease receive lipid lowering therapy *then* the likelihood of CAD related clinical events will be reduced.

- **Ischemic Vascular Disease (IVD) and aspirin therapy:** *If* clinicians ensure that patients with established ischemic vascular disease (IVD) use aspirin or another antithrombotic drug, *then* the likelihood of the myocardial infarctions, and other vascular events can be reduced.
- **Colorectal cancer screening:** *If* patients 50 to 75 years old receive appropriate colorectal screening *then* early intervention is possible and premature death can be averted.

While the selected quality of care measures give a good overall description of the overall quality of primary care being provided at the center, it is clear that this is a *subset* of possible quality of care indicators. Individual health centers may use *additional* indicators, including modified versions of these indicators in their grant applications, or for other purposes if they so choose provided that these indicators described in this manual *must* be used by all health centers.

SECTIONS A AND B: DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

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

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

Report the total number of patients who received prenatal care services *at any time during the reporting period* by age group. Be sure to include all women receiving any prenatal care during the reporting year, including the delivery of her child, regardless of when that care was initiated, including women:

- who began prenatal care during the previous reporting period and continued into this reporting period; and
- who began care and delivered during the reporting year; and
- who began their care in this reporting period but will not/did not deliver until the next year.
- "Total prenatal patients" includes patients:
  - who receive all their prenatal care from the grantee
  - who began prenatal care with another provider but transferred to the grantee
  - who began prenatal care with the grantee but were transferred to another provider at some point during their prenatal care
  - who were delivered by another provider.

To determine the appropriate age group, use the woman's age on June 30 of the reporting period. As many as half of all patients reported will usually have been reported in the prior year or will be reported in the next year. The total number of women reported in Section A on line 6 *must be equal to* the total women reported in section B – Trimester of Entry into Prenatal Care.

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

PERFORMANCE MEASURE: The performance measure is "Proportion of prenatal care patients who entered treatment during their first trimester." The measure itself, which is not dependent on which category of non-compliance an woman might falls into, is

calculated as follows:

- **Numerator:** Number of women entering prenatal care during their first trimester (Line 7, Columns a+b)
- **Denominator:** Total number of women seen in prenatal care during the year (Line 7 + Line 8 + Line 9, Columns a+b)

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

FIRST TRIMESTER (Line 7) Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be pregnant anytime through the end of the 13th week after conception[2]. If the woman began prenatal care during the first trimester at the grantee's service delivery location, she is reported on Line 7 in Column A; if she received prenatal care from another provider during the first trimester before coming to the grantee's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with grantee.

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

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

THIRD TRIMESTER (Line 9) Includes women who received prenatal care during the reporting period and whose "first visit" occurred when she was estimated to be 27 weeks or more after conception. If the woman began prenatal care during the third trimester at the grantee's service delivery location, she is reported on Line 9 in Column A; if she received prenatal care from another provider starting the third trimester before coming to the grantee's service delivery location, she is reported on Line 9 in Column B, regardless of when she begins care with grantee. (Note that it is highly unusual for the number in column B to be very large or larger than that in column A since it would require women to have begun care and then transferred in a very short period of time.)

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

SECTIONS C THROUGH K: OTHER QUALITY OF CARE INDICATORS

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

SECTION C: CHILDHOOD IMMUNIZATION (Line 10)

Children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, and who were first seen ever by the grantee prior to their second birthday are reported on Line 10. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 2010 and December 31, 2010.

SECTION D: PAP TESTS (Line 11)

Women aged 21 through 64 with at least one medical visit during the reporting period, who were first seen by the clinic at some point prior to their 65th birthday are reported on Line 11. For the purposes of this year's reporting this includes women whose date of birth is between January 1, 1948 and December 31, 1988. (NOTE: This is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 in the reporting period should be included in the calculation of this measure.)

SECTION E: WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS (Line 12)

Children and adolescents aged 2 through 17 with at least one medical visit during the reporting period, who had their third birthday during the reporting period, and who were first seen ever by the grantee prior to their 17th birthday are reported on Line 12. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 1995 and December 31, 2009.

SECTION F: ADULT WEIGHT SCREENING AND FOLLOWUP (Line 13)

Adults age 18 or older with at least one medical visit during the reporting period and seen after their 18th birthday are reported on Line 13. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1994.

SECTION G1: TOBACCO USE ASSESSMENT (Line 14)
Adults age 18 or older, seen after 18th birthday, with at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 14. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1994.

SECTION G2: TOBACCO CESSATION INTERVENTION (Line 15)
Adults age 18 or older, seen after 18th birthday, who used tobacco products within the past 24 months who had at least *one* medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 15. For the purposes of this year's reporting this includes all tobacco using medical patients who were born on or before December 31, 1994.

SECTION H: ASTHMA PHARMACOLOGIC THERAPY (Line 16)
Patients age 5 through 40 with at least one medical visit during the reporting period and at least two visits ever, with a diagnosis of mild, moderate or severe persistent asthma are reported on Line 16. For the purposes of this year's reporting this includes all persistent asthmatic patients born between January 1, 1972 and December 31, 2007.

SECTION I: CORONARY ARTERY DISEASE (CAD) AND LIPID LOWERING THERAPY (Line 17)
Adults age 18 or older, seen after their 18th birthday, who had at least one medical visit during the reporting period, and with at least two medical visits ever, who have an active diagnosis of CAD including myocardial infarction (MI) or who have had cardiac surgery, are reported on Line 17. For the purposes of this year's reporting this includes medical patients meeting the clinical profile who were born on or before December 31, 1994.

SECTION J: ISCHEMIC VASCULAR DISEASE (IVD) AND ASPIRIN OR OTHER ANTI-THROMBOTIC THERAPY (Line 18)
Adults age 18 or older, seen after 18th birthday, who had at least one medical visit during the reporting period who, (1) during the current or prior year, were diagnosed with IVD ***OR*** (2) were discharged after coronary artery bypass surgery (CABG) or percutaneous transluminal coronary angioplasty (PTCA) or acute myocardial infarction (AMI) between January 1 and November 1 *of the year prior to the measurement year* are reported on Line 18. For the purposes of this year's reporting this includes all medical patients meeting the clinical profile who were born on or before December 31, 1994.

SECTION K: COLORECTAL CANCER SCREENING (Line 19)
Adults age 51 through 74, who had at least one medical visit during the reporting period, are reported on Line 19. For the purposes of this year's reporting this includes medical patients whose date of birth is between January 1, 1938 and December 31, 1961.

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

For each of the populations being surveyed, rigid and specific definitions are to be used in order to identify the universe from which the sample will be drawn. These are described in

detail below and must be carefully followed to avoid misreporting findings. (Special care must be taken since mistakes in this area may potentially portray a higher or lower quality of care than is actually the case.)

COLUMN INSTRUCTIONS

COLUMN a: NUMBER OF PATIENTS IN THE "UNIVERSE"

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

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

COLUMN b: NUMBER OF CHARTS/RECORDS SAMPLED OR EHR TOTAL

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

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

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

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

COLUMN c: NUMBER OF CHARTS/RECORDS IN COMPLIANCE

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

discussed below. The number in Column C (patients in compliance) may never exceed the number in Column B (patient records reviewed).

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

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

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

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

DETAILED INSTRUCTIONS FOR CLINICAL MEASURES

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

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

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

CHILDHOOD IMMUNIZATIONS (Line 10)

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

- **Numerator:** Number of children among those included in the denominator who were fully immunized on or before their 2nd birthday[3]. A child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2 Hib, 3 HepB, 1VZV (Varicella), 4 Pneumoccocal conjugate, 2 HepA, 2 or 3 RV (rotavirus) and 2 seasonal flu prior to or on their 2nd birthday.
- **Denominator:** Number of all children with at least one medical visit during the reporting period, who had their 2nd birthday during the reporting period or a sample of 70 of these children. For measurement year 2012, this includes all children with date of birth between January 1, 2010 and December 31, 2010. Children who were never seen by the clinic prior to their second birthday are to be excluded. There will no doubt be a number of children for whom no vaccination information is available and/or who were first seen at a point when there was simply not enough time to fully immunize them prior to their second birthday. They should still be included in the universe and thus in the denominator.

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

Enter number of children who:

- Were born between January 1, 2010 and December 31, 2010, *and*
- Had at least one medical visit during the reporting year, including children who were seen only for the treatment of an acute or chronic condition and those who were never seen for well child care *and*
- Were seen for the first time ever prior to their second birthday. (This could have been in 2010 or 2011.)

Include all children meeting this criterion regardless of whether they came to the clinic for well child services[4] or other medical services which include vaccinations or they came for treatment of an injury or illness. *Note that children whose only service was receipt of a vaccination, and who never received other medical services, are not to be counted as patients on any of the demographic tables and are not included in the universe for this table.*

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

- **Any particular vaccine:** Allergic reaction to the vaccine or its components: ICD-9: 999.4.
- **DTaP:** Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine).
- **VZV, MMR, Rotavirus, and Flu:**

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

[4] Grantees should add to their universe those patients whose only visits were well child visits (99381, 99382. 99391. 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added as well.

- ❖ Immunodeficiency, including genetic (congenital) immunodeficiency syndromes ICD-9: 279.
- ❖ HIV-infected or household contact with HIV infection ICD-9: Infection V08, symptomatic 042 or 079.53.
- ❖ Cancer of lymphoreticular or histiocytic tissue ICD-9: 200-202.
- ❖ Multiple myeloma ICD-9: 203. Leukemia ICD-9: 204-208.
- ❖ Allergic reaction to neomycin.

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

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

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

- **DTaP/DT:** An initial DTaP vaccination followed by at least three DTaP, DT or individual diphtheria and tetanus shots, on or before the child's second birthday. Any vaccination administered prior to 42 days after birth cannot be counted.

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

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

- **HIB:** Two H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted. Meaningful use requirements call for two doses of HiB in this population, however three doses of the HiB vaccine may be given in accordance with the CDC vaccination schedule. And while administration of two doses shall be considered compliant with this measure, HRSA continues to recommend that three HiB vaccines be

used (per CDC recommendation). Additionally, please note, certain other products which combine the HiB vaccine and the HepB vaccine may, in fact, require only two doses.

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

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

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

- **Hepatitis A:** At least two HepA vaccinations on or before the child's second birthday.[5]

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

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

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

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

[5] CDC issued a clarifying restatement of this requirement whichstates that the second dose should be provided no sooner than six months after the first. Since the first dose may be given as early as month 12, there is still up to seven months before the child's second birthday in which to provide the second dose.

Seasonal Flu: CPT (90654, 90655, 90657. 90660-90662); ICD-9 (99.52 [6])

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

For immunization information obtained from the medical record, count patients as compliant for a given vaccine where there is evidence that the vaccine was given from (1) a chart note indicating the name of the specific antigen and the date of the immunization, or (2) a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. Immunization information may also be obtained from an immunization registry maintained by the State or other public body as long as it shows comparable information, but immunization registries typically cannot be used to identify compliance for the universe of patients.

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

Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator for some immunizations. This applies only to those vaccines that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of immunization agents does not constitute sufficient evidence of immunization for this measure, nor does verbal assurance from a parent or other person that a vaccine has been given.

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

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

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

To be counted as compliant, a child must be documented as being compliant for each and every vaccine.

PAP TESTS (Line 11)

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

- **Numerator:** Number of female patients 24 - 64 years of age receiving one or more

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

documented Pap tests during the measurement year or during the two years[7] prior to the measurement year among those women included in the denominator. Because of the difficulty in obtaining records from third parties, it is likely that a number of women will not be able to be counted as compliant, even though the grantee has referred the patient for services.

- **Denominator:** Number of all female patients age 24 - 64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women. For measurement year 2012, this includes patients with a date of birth between January 1, 1948 and December 31, 1988.

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

Criteria: Enter the number of all female patients who:

- Were born between January 1, 1948 and December 31, 1988 *and*
- Were first seen by grantee prior to their 65th birthday *and*
- Had at least one medical visit in a clinical setting[8] during 2012.

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

If a system cannot determine exclusions from the universe, "excludable" women may be included in the universe and only later excluded from the sample, if identified. In these cases, a replacement record will be used[9].

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

Enter the total number of health center patients from the universe (Column a) for whom data have been reviewed. This will be all patients who fit the criteria (if an EHR is used to report, copy the number from Column a), or a scientifically drawn sample of 70 patients selected from all patients who fit the criteria. If a sample is to be used it ***must*** be a sample of 70 and ***must*** be drawn from the entire patient population who fit the criteria (the universe reported in

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[7] The United States Preventive Services Task Force (USPSTF) has recently concluded that, for women over 30, a Pap test accompanied with an HPV test could be done every five years as opposed to every three years. *For the purpose of the UDS and CMS Meaningful Use criteria* this change has not yet been implemented. Grantees implementing the USPSTF's recommendations may find a decrease in their compliance rate and should explain this in their annual grant applications.

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

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

Column a). Larger samples will not be accepted. Grantees ***may not*** choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.
If a woman in the random selection is found to meet the exclusion criteria, the record is removed from the sample and another woman should be randomly selected to replace her. This can best be accomplished by selecting replacement cases at the same time that the random sample is identified.

NUMBER OF PATIENTS TESTED, COLUMN (c)
Enter the total number of female patients included in the sample who received one or more Pap tests in a three year period from 2010 through 2012. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. A patient is counted as having had a Pap test if a visit contains any one of the following codes or if a copy of a lab test performed by another provider is in the chart. A chart note which documents the name, date, and results from a test performed by another provider which is based on communications between the clinic and the provider is also acceptable.

The following ICD-9 and/or CPT codes are evidence of compliance:
CPT (88141-88155, 88164-88167, 88174-88175)
ICD-9-CM (91.46, V72.32)

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

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

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 2[10] through 17 who had evidence of BMI *percentile* documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year." Note that, while this indicator is titled "2 through 17," grantees should only review the charts of children who were at least 3 years old during the measurement year. This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.
- **Denominator:** Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting year, and seen prior to their 17th birthday

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

OR a sample of these patients. For measurement year 2012, this includes patients with a date of birth between January 1, 1995 and December 31, 2009.

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

- Were born between January 1, 1995 and December 31, 2009 **AND**
- Were first seen ever by grantee prior to their 17th birthday **AND**
- Had at least one medical visit[11] in a clinical setting[12] during 2012.

Exclusions: Pregnant patients.

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

NUMBER OF PATIENTS WITH DOCUMENTED COUNSELING AND BMI PERCENTILE, COLUMN (c)
Enter the total number of patients identified in column b whose 2012 record demonstrates that their BMI percentile (not just height and weight or numeric BMI score from which the BMI percentile can be calculated) was documented during the measurement year **AND** that they received counseling on nutrition during the measurement year **AND** counseling on physical activity during the measurement year.

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

- Codes V85.5x are for recording BMI Percentile. Presence is sufficient, but not necessary.
- Codes 97802-97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary.
- ICD-9 code V65.41 is sufficient, but not necessary for physical activity counseling.

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

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[11] Grantees should add to their universe those patients whose only visits were well child visits (99382, 99383. 99392. 99393) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added as well.

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

ADULT WEIGHT SCREENING AND FOLLOW-UP (Line 13)

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

- **Numerator:** Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit **OR** within six months of the most recent visit **AND** if the most recent BMI is outside parameters, a follow-up plan is documented
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994.

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

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1994 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit in a clinical setting[13] during 2012.

Exclusions:

- Pregnant women
- Terminally ill patients

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

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

NUMBER OF PATIENTS WITH DOCUMENTED BMI AND COUNSELING IF WEIGHT IS OUTSIDE PARAMETERS, COLUMN (c)

Enter the total number of patients identified in Column b whose 2012 record demonstrates that their BMI (not just height and weight) was documented during their last visit or within six months prior to that visit, **AND** they received a follow-up plan to address their weight if they

- were under age 65 **AND** their BMI was over 25 **OR**
- were age 65 or older **AND** their BMI was over 30 **OR**
- were under age 65 **AND** their BMI was under 18.5 **OR**
- were age 65 or older **AND** their BMI was under 22

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

The following codes are evidence of compliance:
CPT: (CPT-II: 3008F = BMI documented) *sufficient but not necessary*
ICD-9: V65.3 = dietary surveillance and counseling *sufficient but not necessary* for follow-up plan

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

TOBACCO USE ASSESSMENT (Line 14)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months." This is calculated as follows:

- **Numerator:** Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **OR** within 24 months of the most recent visit**.**
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least *two*[14] medical visits ever, **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994.

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

- Were born on or before December 31, 1994 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit during 2012 **AND**
- Had at least two medical visits ever.

Exclusions:

- (None)

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

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

NUMBER OF PATIENTS QUERIED ABOUT TOBACCO USE, COLUMN (c)
Enter the total number of patients identified in column b whose 2012 record demonstrates that they had been asked about their use of any and all forms of tobacco at their most recent visit or at a visit within 24 months of the last visit.

The following codes will be useful in identifying compliance:
CPT / ICD-9: (CPT-II codes):

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

TOBACCO CESSATION INTERVENTION (Line 15)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year (i.e., during 2011 or 2012) who received tobacco use intervention (cessation counseling and/or pharmacological intervention)." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received tobacco cessation counseling or smoking cessation agents during their most recent visit **OR** within 24 months of the most recent visit**.**
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty four months who had at least one medical visit during the reporting period, and at least *two*[15] medical visits ever, **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994. Note that identifying tobacco users is often difficult. If this is the case, see the discussion on identifying tobacco users in Appendix C (page 65).

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

- Were born on or before December 31, 1994 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit during 2012 **AND**
- Had at least two medical visits ever **AND**
- Used any form of tobacco including smoked and smokeless tobacco

Exclusions:

- (None)

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

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

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

NUMBER OF PATIENTS WHO RECEIVED TOBACCO CESSATION INTERVENTION, COLUMN (c)

Enter the total number of patients identified in Column b whose 2012 record demonstrates that they had, within the past 24 months,

- Received tobacco use cessation **OR**
- Received an order for (a prescription or a recommendation to purchase) a smoking cessation medication. This medication may be a prescription or an Over the Counter (OTC) product. **OR**
- Been on (using) a smoking cessation agent.

The following codes will be useful in identifying compliance:
CPT / ICD-9 (CPT-II codes):

- 1000F = Tobacco use assessed
- 1034F = Current tobacco smoker
- 305.1, 649.00-649.04 = Tobacco use disorder – sufficient, but not necessary
- 1035F = Current smokeless tobacco user (e.g., chew, snuff)
- 1036F = Current tobacco non-user (indicative of patient to be excluded from universe)
- 4000F = Tobacco use cessation intervention counseling
- 99406-07 = Smoking and tobacco use cessation counseling – sufficient, but not necessary
- 4001F = Tobacco use cessation intervention – pharmacologic therapy

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ASTHMA PHARMACOLOGIC THERAPY (Line 16)

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

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided inhaled corticosteroid or an accepted alternative medication**.**
- **Denominator:** Number of patients who were 5 through 40 years of age at some point during the measurement year, who have been seen at least twice in the practice and who had at least one medical visit during the reporting year, who had an active diagnosis of persistent asthma **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth between January 1, 1972 and December 31, 2007.

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

Criteria: Enter the number of all patients who:

- Were born on or after January 1, 1972 and on or before December 31, 2007 **AND**
- Were last seen by grantee while they were age 5 through 40 years **AND**

- Have been seen at least twice (not necessarily in the current year) **AND**
- Had at least one medical visit during 2012 **AND**
- Were diagnosed with *persistent*[16] asthma **OR** have persistent asthma as a current diagnosis on a chronic illness form or template.

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

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

NUMBER OF PATIENTS WITH PERSISTENT ASTHMA WITH PHARMOCOLOGIC TREATMENT DOCUMENTED, COLUMN (c)
Enter the total number of patients identified in Column b whose 2012 record demonstrates that they had
- Received a prescription for or were using an inhaled corticosteroid **OR**
- Received a prescription for or were using an acceptable pharmacological agent, specifically: Cromolyn, a leukitriene modifier, nedocromil, or sustained release theophylline

The following codes will be useful in identifying compliance:
CPT / ICD-9 (CPT-II codes):
- 493.x = Asthma
- 1038F = Persistent asthma (mild, moderate or severe)
- 1039F = Intermittent asthma (indicative of patient to be excluded from universe)
- 4015F = Persistent asthma, appropriate pharmacologic treatment prescribed

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

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

CORONARY ARTERY DISEASE (CAD): DRUG THERAPY FOR LOWERING LDL CHOLESTEROL (Line 17)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided or were taking lipid lowering medications**.**
- **Denominator:** Number of patients who were seen during the measurement year after their 18th birthday, who had at least one medical visit during the reporting year, with at least two medical visits ever, and who had an active diagnosis of coronary artery disease (CAD) including any diagnosis for myocardial infarction (MI) or who had had cardiac surgery in the past – **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth on or before December 31, 1994.

TOTAL NUMBER OF PATIENTS AGE 18 AND OLDER WITH CAD DIAGNOSIS, COLUMN (a)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1994 **AND**
- Were last seen by grantee after their 18th birthday **AND**
- Had at least one medical visit during 2012 **AND**
- Had at least two medical visits ever **AND**
- Have an active diagnosis of coronary artery disease (CAD) **OR** were diagnosed as having had a myocardial infarction (MI) **OR** have had cardiac surgery[17].

Exclusions:

- Individuals whose last LDL lab test was less than 130 mg/dL
- Individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL lowering medications.

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

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

NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY. COLUMN (c)

Enter the total number of patients identified in Column b whose 2012 record demonstrates that they had

- Received a prescription for or were using a lipid lowering therapy.

[17] A large number of surgical CPT codes relating to the *performance* of a CABG. or PTCA are included in the specifications for cardiac surgery, however these may be difficult to find. Health centers should instead search for a history of these surgeries in appropriate parts of their records.

The following codes will be useful in identifying the universe:
CPT / ICD-9 (CPT-II codes):

- CAD = 410.xx, 411.xx, 412.xx, 413.xx, 414.0x, 414.8, 414.9,
- History of surgeries = V45.81, V45.82

Do not count as compliant patients who are receiving a form of treatment other than pharmacologic treatment. Persons involved in therapeutic lifestyle changes and/or control of non-lipid risk factors *without* concomitant pharmaceutical treatment are considered to be out of compliance.

ISCHEMIC VASCULAR DISEASE (IVD): USE OF ASPIRIN OR ANOTHER ANTI-THROMBOTIC: (Line 18)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1, 2011 to November 1, 2011 **OR** who had a diagnosis of ischemic vascular disease during 2012 who had documentation of use of aspirin or another antithrombotic." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed or used.
- **Denominator:** Number of patients who were aged 18 and over at some point during the measurement year, who had at least one medical visit during the reporting year, who had an active diagnosis of ischemic vascular disease (IVD) during the current or prior year OR had been discharged after AMI or CABG or PTCA between January 1, 2011 and November 1, 2011 --- **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth before December 31, 1994.

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

- Were born on or before December 31, 1994 **AND**
- Were last seen by grantee while they were 18 years of age or older **AND**
- Had at least one medical visit during 2012 **AND**
- Had an active diagnosis of ischemic vascular disease (IVD) during 2011 or 2012 **OR** had been discharged after AMI or CABG or PTCA between January 1, 2011 and November 1, 2011

Exclusions:

- None

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

number of charts from each site or the same number for each provider or use other stratification mechanisms that result in oversampling some group of patients.

NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTI-THROMBOTIC USE, COLUMN (c)

Enter the total number of patients identified in Column b whose 2012 record demonstrates that they had

- Received a prescription for, were given, or were using Aspirin or another antithrombotic drug.

The following codes will be useful in identifying the universe:

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

- ICD-9 = 411.xx, 413.xx, 414.0x, 414.8, 414.9, 429.2, 433.0, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.8, 445.81, V45.81, V45.82
- CPT = 33510 – 33536

COLORECTAL CANCER SCREENING: (Line 19)

PERFORMANCE MEASURE: The performance measure is "Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer." This is calculated as follows:

- **Numerator:** Number of patients aged 51 through 74 with appropriate screening for colorectal cancer.
- **Denominator:** Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year[18]. (NOTE: Though age 50 to 74 is in the title of this measure, the detail calls for persons to be screened within a year of turning 50 and prior to reaching age 75.) For measurement year 2012, this includes patients whose date of birth is between January 1, 1938 and December 31, 1962.

Documented colonoscopy conducted during the measurement year or the previous 9 years or flexible sigmoidoscopy conducted during the measurement year or the previous 5 years meet the compliance criteria. Though codes are shown for colonoscopy and flexible sigmoidoscopy it is possible that these CPT codes may not be found in the clinic's EHR or other computerized system. It *is* possible that the procedures were performed elsewhere, but confirmation of this is required by having in the chart either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results of the test. Fecal occult blood test (FOBT), including the fecal immunochemical test (FIT), can also be used to document compliance. Because the FOBT is to be conducted annually, it is required that there be evidence of a test during the measurement year. Thus, a patient who had an FOBT in November of 2011 (for example) would still need one in 2012, even if the patient did not present in the clinic after June of 2012. Test kits can be mailed to patients during the year.

[18] The Meaningful Use criteria for this measure includes persons seen at any point within the last two years, however, for the purposes of reporting in UDS Table 6B, medical patients must have had one medical visit during the current measurement year.

TOTAL NUMBER OF PATIENTS AGE 51 through 74, COLUMN (a)
Criteria: Enter the number of all patients who:

- Were born between January 1, 1938 and December 31, 1961 **AND**
- Had at least one medical visit during 2012

Exclusions:

- Patients who have or who have had colorectal cancer

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

NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER. COLUMN (c)
Enter the total number of patients identified in Column b whose 2012 record demonstrates that they had

- a colonoscopy after January 1, 2003 **OR**
- a flexible sigmoidoscopy after January 1, 2008 **OR**
- a fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test *during* the measurement year

The following codes will be useful in identifying compliance:
CPT / ICD-9 (CPT-II codes):

- ICD-9 = 45.22 - 45.25, 45.42 - 45.43, V76.51
- CPT = 45330 - 45345, 44388 - 44397, 45355 - 45392, 82270, 82274

QUESTIONS AND ANSWERS FOR TABLE 6B

1. **Are there any changes to the table this year?**
   Yes, three new clinical measures have been added. No changes were made to any of the other measures.

2. **The CDC released revised information on the Hep-A vaccine this year. Has the immunization measure changed?**
   No. The information released was only a clarification of the current schedule. Hep-A vaccines should still start at month 12. The clarification was that the second dose should not be given until at least six months after the first dose. This would still be in the second year.

3. **A child came in only once in 2012 for an injury and never returned for well child care. If her record is selected for the immunization measure sample do we have to consider her chart to be out of compliance?**
   Yes. Once a patient enters a health center's system of medical care, the center is expected to be responsible for providing all needed preventive health care and/or document that they have received it.

4. **What if a woman we treat for hypertension and diabetes goes to an ObGyn in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not do Pap tests?**
   Once the patient has been seen in your clinic, you are responsible for providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to document Pap tests by contacting providers of Pap tests directly in order to obtain documentation by FAX, or by requesting that health center patients mail a copy of their test history, or through other appropriate means. The woman would be considered to be a part of your universe if she received *any* medical service(s) in 2012. If there is no copy of the results of her Pap test included in her chart, she would be considered out of compliance.

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

6. **The United States Preventative Services Task Force (USPSTF) has changed the time frame for Pap tests. If we have adopted the new schedule can we use it to measure compliance?**
   No. The measure is established in meaningful use rules. If you feel that this is resulting in a lower compliance rate be sure to document this in your grant application progress report.

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

illness for all required vaccines.

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

9. **Some of the immunization details are different than those used by CDC in the CASA or CO-CASA reviews of our clinic. May we use these CDC standards to report on the UDS?**
   No. In order to align the data from the UDS with data nationally, HRSA uses the vaccination specifics set forth by the National Quality Forum. Using a different set of standards will distort the data. Because data are being compared to Table 3A data, such misalignment may be detected in which case grantees will be asked to resample their data. A center *may* use a different set of standards for its own internal Quality Assurance program, but these may not be substituted for the HRSA rules defined for the UDS reporting on Table 6B.

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

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

12. **Is the Pap test review for women starting at age 21 or at age 24?**
    For this measure you will look only at women who were 24 years or older (up to age 65) at some point in 2012. You will *not* look at any women who were 21, 22, or 23 years old at the end of 2012. Because the measure asks about Pap tests *administered* in 2012 *or* in 2011 or in 2010, it is possible that a 24 year old woman would have been 21 in 2010. If she received a Pap test in that year she would be considered to be in compliance. So we are looking only at women who are 24 through 64, but their qualifying test may have been received when they were 21 through 64. Grantees should take care to review charts *only* for women who were 24 through 64 in 2012 and should *not* select any charts for women who were younger.

13. **When the listing of CPT codes says "sufficient, but not necessary" what does this mean?**

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

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

15. **I have a patient who turned 2 in November of 2012. Should she be included in the Child and Adolescent weight measure? Does this measure start at age 2 or age 3?**
    No – do not include the child. The measure looks at children who were two, but allows the measurement to be recorded up to one year after her second birthday. Since she still has ten months for her BMI percentile to be charted and for her parents to receive counseling, she would not be included in the universe. For this measure you will look only at children who were 3 years or older (to age 17 – one year after 16th birthday) at some point in 2012. You will *not* look at any child who had not yet turned 3 or who was over 17 years old at the end of 2012. For children who are 3, the documentation for weight assessment and counseling may have been when they were 2.

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

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

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

TABLE 6B – QUALITY OF CARE INDICATORS

(No prenatal care provided? Check here: □)

SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS (GRANTEES WHO PROVIDE PRENATAL CARE ONLY)		
DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS		
AGE		NUMBER OF PATIENTS (a)
1	LESS THAN 15 YEARS	
2	AGES 15-19	
3	AGES 20-24	
4	AGES 25-44	
5	AGES 45 AND OVER	
6	TOTAL PATIENTS (SUM LINES 1 – 5)	

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

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

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

SECTION E – WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS				
CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING		TOTAL PATIENTS AGED 3 – 17 ON DECEMBER 31 (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12	MEASURE: Children and adolescents aged 3 – through 17 during measurement year (on or prior to 31 December) with a BMI percentile, ***and*** counseling on nutrition and physical activity documented for the current year			
SECTION F – ADULT WEIGHT SCREENING AND FOLLOW-UP				
ADULT WEIGHT SCREENING AND FOLLOW-UP		TOTAL PATIENTS AGED 18 AND OVER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	MEASURE: Patients aged 18 and over with (1) BMI charted ***and*** (2) follow-up plan documented ***if*** patients are overweight or underweight			
SECTION G1 – TOBACCO USE ASSESSMENT				
TOBACCO ASSESSMENT		TOTAL PATIENTS AGED 18 AND OVER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE (c)
14	MEASURE: Patients queried about tobacco use one or more times in the measurement year or prior year			
SECTION G2 – TOBACCO CESSATION INTERVENTION				
TOBACCO CESSATION INTERVENTION		TOTAL PATIENTS USING TOBACCO (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ADVISED TO QUIT (c)
15	MEASURE: Tobacco users aged 18 or older who have received cessation advice or medication			
SECTION H – ASTHMA PHARMACOLOGICAL THERAPY				
ASTHMA TREATMENT PLAN		TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16	MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

SECTION I – CORONARY ARTERY DISEASE (CAD): LIPID THERAPY				
LIPID THERAPY		TOTAL PATIENTS AGED 18 AND OVER WITH CAD DIAGNOSIS (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY (c)
17	MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy			
SECTION J – ISCHEMIC VASCULAR DISEASE (IVD): ASPIRIN OR ANTITHROMBOTIC THERAPY				
ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY		TOTAL PATIENTS 18 AND OVER WITH IVD DIAGNOSIS OR AMI, CABG, OR PTCA PROCEDURE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY (c)
18	MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI,CABG, or PTCA procedure with aspirin or another antithrombotic therapy			
SECTION K – COLORECTAL CANCER SCREENING				
COLORECTAL CANCER SCREENING		TOTAL PATIENTS 51 THROUGH 74 YEARS OF AGE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER (c)
19	MEASURE: Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer			

INSTRUCTIONS FOR TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

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

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

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

The table is included only in the Universal Report.

HIV POSITIVE PREGNANT WOMEN, TOP LINE

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

DELIVERIES PERFORMED BY GRANTEE PROVIDER (Line 2)

Report the total number of deliveries *performed by center clinicians* during the reporting period on line 2. (This line is not reported by the race or Hispanic/Latino ethnicity of the women delivered.) On this line ONLY, the health center is to include deliveries of women who were *not* part of the grantee's prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor's patients when the clinic provider participates in a call group and is on call at the time of delivery; emergency deliveries when the clinic provider is on-call for the emergency room; and deliveries of patients who are assigned to the provider as a requirement for privileging at a hospital. Include as "health center clinicians" any clinician who is paid by the center while doing the delivery, regardless of the method of compensation. Do *not* include deliveries where a clinic doctor bills separately, receives, and retains payment for the delivery.

DELIVERIES AND LOW BIRTH WEIGHT INDICATOR BY RACE AND HISPANIC / LATINO ETHNICITY, SECTION A (Columns 1a – 1d)

Only health centers that provide, or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the grantee does the delivery, are required to complete Section A. All health center prenatal care patients who delivered during the reporting period, and all children born to them, are reported in Columns 1a – 1d.

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

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

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

PERFORMANCE MEASURE: The performance measure is "Proportion of patients born to health center patients whose birthweight was *below* normal (less than 2500 grams). Note that this is the only "negative" measure, i.e., a measure where the higher the number the *worse* the performance on the measure. While data are provided for each racial and ethnicity category, the performance measure looks only at the totals. The measure itself, which is not dependent on which category of non-compliance an infant falls in, is calculated as follows:

- **Numerator:** Number of children born with a birthweight of under 2500 grams (Line i, columns 1a+1b)
- **Denominator:** Number of children born (Line i, Column 1a)

Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or referral provider during the reporting period, according to the appropriate birthweight group. (Do not report still-births or miscarriages.) These columns collect data on "infants born." If the delivery is of twins or triplets, the grantee will report the birthweight of the two or three children.

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

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

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

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

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

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

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

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

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

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

PERFORMANCE MEASURE: The performance measure is "Proportion of patients born between January 1, 1928 and December 31,1994 with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading." (NOTE: Many health centers use a different measure for their quality assurance process for their diabetic or dialysis patients. This may well be appropriate, but for the purposes of UDS reporting, the 140/90 measure must be used.) This is calculated as follows:

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

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

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

- Were born between January 1, 1928 and December 31, 1994 **AND**,
- Have been seen at least twice during the reporting year for *any* medical service **AND**,
- Have been diagnosed with hypertension (HTN) before June 30 of the measurement year as evidenced by an ICD-9 code of 401.xx - 405.xx. It does not matter if hypertension was treated during the measurement year or is currently being treated. The notation of hypertension may appear during or prior to 2012.

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

Exclusions: Pregnant Patients, Patients with end state renal disease (ESRD).

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

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

If the EHR is to be used, the number in Column 2b will be equal to the number in Column 2a. NOTE: Health centers who have I2I-Track, PC-DEMS, PECS, or other disease tracking systems may use them to report the universe ONLY IF it can be limited to a calendar year report and **only** if it includes all required data elements, e.g., it includes data for the required time frame for *all* hypertensive patients from *all* service sites.

PATIENTS WITH CONTROLLED BLOOD PRESSURE, COLUMN 2c
Hypertensive patients born between January 1, 1928 and December 31, 1994 whose charts have been reviewed (those identified in Column 2b) whose systolic blood pressure measurement was less than 140 mm Hg *and* whose diastolic blood pressure was less than 90 mm Hg at the time of their last measurement in 2012 are reported in Column 2c by race and Hispanic/Latino ethnicity. (Patients who have not had their blood pressure tested during the reporting year will be considered to have failed the performance measure. They are counted in columns a and b, but not in column c.)

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS

1. Comparisons are made between the universe reported on Table 7, Column 2a, and the

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

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

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

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

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

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

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

PERFORMANCE MEASURE: The performance measure is "Proportion of adult patients born between January 1, 1938 and December 31, 1994 with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year." Health Centers report results in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%. The measure itself, which is not dependent on which category of compliance a patient falls in, is calculated as follows:

- **Numerator:** Number of adult patients whose most recent hemoglobin A1c level during the measurement year is $\leq$ 9% among those patients included in the denominator.
- **Denominator:** Number of adult patients aged 18 to 75 as of December 31 of the measurement year
  - with a diagnosis of Type I or II diabetes **AND**,
  - who have been seen in the clinic for medical services at least *twice* during the reporting year **AND,**
  - do not meet any of the exclusion criteria

  OR a statistically valid sample of 70 of these patients

TOTAL PATIENTS AGED 18 TO 75 WITH TYPE I OR II DIABETES, COLUMN 3a

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

- Were born between January 1, 1938 and December 31,1994 **AND**,

- Have been seen at least *twice* for medical care during the reporting year, **AND,**
- have a diagnosis of diabetes. It does not matter if diabetes was treated or is currently being treated or when the diagnosis was made. The notation of diabetes may appear during or prior to the 2012 measurement year. To confirm the diagnosis of diabetes, one of the following must be found in the medical record:
  - ICD-9-CM Codes 250.xx, or 648.0, or
  - diabetic patients may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics / antihyperglycemics.

Exclusions:
Exclude any patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year.[19] Note that patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Code 962.0 or 251.8) reported during the measurement year are ***not*** to be included.

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

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

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

REPORTED HEMOGLOBIN A1c LEVELS, COLUMNS 3c through 3f
For this report, the last hemoglobin A1c (HbA1c) level taken in the measurement year as documented through laboratory data or medical record review, is reported. ***If there is no record of an HbA1c level being obtained during the measurement year, the chart will be reported in Column 3f: "greater than 9.0% or no test during the year."*** Patients with no test during the measurement year are included as non-compliant along with those who have poor HbA1c control.

- **Patients with HbA1c < 7% (Column 3c):** Number of patients included in Column 3b whose most recent HbA1c was less than 7%.
- **Patients with 7% ≤ HbA1c < 8% (Column 3d):** Number of patients included in Column

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

3b whose most recent HbA1c was greater than or equal to 7%, but less than 8%.

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

Note that the combined total of Columns 3c through 3f must equal the number of charts sampled or EHR total reported in Column 3b.

IMPORTANT NOTES ABOUT RACE AND HISPANIC/LATINO ETHNICITY NUMBERS:

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

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

QUESTIONS AND ANSWERS FOR TABLE 7

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

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

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

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

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

Reporting Period: January 1, 2012 through December 31, 2012

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

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

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

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

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Section B: Hypertension by Race and Hispanic/Latino Ethnicity

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

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Section C: Diabetes by Race and Hispanic/Latino Ethnicity

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

INSTRUCTIONS FOR TABLE 8A – FINANCIAL COSTS

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

DIRECT COSTS, ALLOCATED COSTS, AND COSTS AFTER ALLOCATION (COLUMN DEFINITIONS)

Column A - Accrued Costs: This column reports the accrued direct costs associated with each of the cost centers/services listed. See Line Definitions for costs to be included in each category. Column A also reports the total cost of facility and non-clinical support services separately on Lines 14 and 15.

Column B - Allocation of Facility and Non-Clinical Support Services: This column shows the allocation of facility and non-clinical support services costs (from Lines 14 and 15, Column A) to each of the direct cost centers.

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

The allocation of non-clinical support services and facility costs should be done as follows, unless your center has a more accurate system:

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

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

should be included on Table 9E under Other Revenue (Line 10).

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

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

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

BPHC MAJOR SERVICE CATEGORIES (LINE DEFINITIONS)

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

MEDICAL STAFF COSTS (Line 1) – Report all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, for medical care staff except lab and x-ray staff. The costs for staff dedicated to the operation of the EHR are also included on Line 1. (See further discussion of EHR staff on Table 5.) The accrued cost (if any) of interns and residents who were paid or paid for, either directly or through a contract with their teaching institution, are reported on Line 1. The costs of intake, medical records, and billing and collections are considered non-clinical costs that are reported on Line 15 and then allocated in Column B. Include the cost for vouchered or contracted medical services on Line 1. Include the cost of

any medical visit paid for directly by the center, such as at-risk specialty care from an HMO contract or other specialty care on Line 1.

Beginning in 2011 grantee providers became eligible for the Meaningful Use EHR Incentive Payments. In the event a health center opts to permit one or more provider to retain these payments, the amounts retained by the provider should be shown on this line as well. The Meaningful Use EHR payments received from Medicare or Medicaid are reported on Table 9E Line 3a.

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

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

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

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

DENTAL (Line 5) – Report all costs for the provision of dental services including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, dental lab services and dental x-ray. Non-clinical support services and facility costs associated with the dental practice should be shown first on Lines 14 and 15 Column A and then allocated to dental in Column B.

MENTAL HEALTH (Line 6) – Report all direct costs for the provision of mental health services, *other than substance abuse services,* including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology but must be consistent withTable 5 time allocations. Non clinical support services and facility costs associated with the mental health practice should be shown first on Lines 14 and 15 Column A and then allocated to Mental Health in Column B. (See also Q & A discussion for Table 5 on page 45.)

SUBSTANCE ABUSE (Line 7) – Report all direct costs for the provision of substance abuse services including but not limited to staff, fringe benefits, supplies, equipment

depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs, as should associated staff on Table 5. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology but must be consistent with the reporting on Table 5. Non-clinical support services and facility costs associated with the substance abuse program should be shown first on Lines 14 and 15 Column A and then allocated to Substance Abuse in Column B. (See also Q & A discussion for Table 5 on page 45.)

PHARMACY (NOT INCLUDING PHARMACEUTICALS) (Line 8a) – Report all direct costs for the provision of pharmacy services including but not limited to staff, fringe benefits, non-pharmaceutical supplies, equipment depreciation, related travel, contracted purchasing services, etc., *but excluding the cost of pharmaceuticals*. All non-clinical support services and facility costs for *both* Lines 8a and 8b should be shown first on Lines 14 and 15 Column A and then allocated to Pharmacy on line 8a Column B. Include 100% of the cost of clinical pharmacists on this line.

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

OTHER PROFESSIONAL (Line 9) – Report all direct costs for the provision of other professional and ancillary health care services including but not limited to: podiatry, chiropractic, acupuncture, naturopathy, speech, occupational and physical therapy, etc. (A more complete list appears at Appendix A.) Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Non-clinical support services and facility costs should be shown first on Lines 14 and 15 Column A and then allocated to “Other Professional” in Column B. Note that there is a cell to "specify" the other professional costs reported on this line.

VISION (Line 9a) – Report all direct costs for the provision of vision services including optometry, ophthalmology, and vision support staff. Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Non-clinical support services and facility costs should be shown first on Lines 14 and 15 Column A and then allocated to “Vision” in Column B.

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

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

ENABLING (Line 11) – Enabling services include a wide range of services which support and assist primary medical care and facilitate patient access to care. Line 11 is calculated automatically as the total of the detail lines. It includes all direct costs for the provision of enabling services including but not limited to costs such as staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Non-clinical support services and facility costs should be reported first on Lines 14 and 15 Column A and then allocated to enabling in Column B.

Lines 11a – 11g are used to detail six specific types of enabling services as well as an "other" category for all other forms of enabling services:

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

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

OTHER PROGRAM RELATED (Line 12) – Report all direct costs for the provision of services not included in any other category here. This includes services such as WIC, childcare centers, adult day healthcare centers, and training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel and contracted services. (Staff for these programs are reported on Line 29a of Table 5.) Non-clinical support services and facility costs should be reported first on Lines 14 and 15 Column A and then allocated in Column B to other program related costs. Grantees are asked to describe the program costs in the “specify” field provided.

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

FACILITY AND NON-CLINICAL SUPPORT SERVICES COSTS (Lines 14 - 16) – This includes all traditional facility and non-clinical support services costs that are later allocated to other cost centers. Specifically:

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

NON-CLINICAL SUPPORT SERVICES COSTS (Line 15) – Non-Clinical Support Services costs include the cost of all non-clinical support services staff, billing and collections staff, medical records and intake staff, and the costs associated with them including, but not limited to, supplies, equipment depreciation, travel, etc. In addition, include other corporate costs (e.g., purchase of insurance, audits, legal fees, interest payments on non-facility loans, Board of Directors' costs, etc.). The cost of all patient support services (e.g., medical records and intake) should be included in non-clinical support services costs. Note that the "cost" of bad debts is **NOT** to be included or shown

on this table in any way. Instead, the UDS reduces gross income by the amount of patient bad debt on table 9D.

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

TOTAL FACILITY AND NON-CLINICAL SUPPORT SERVICES (Line 16) – The sum of lines 14 + 15.

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

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

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

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

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

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

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

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

CONVERSION FROM FISCAL TO CALENDAR YEAR

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

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. EXAMPLE: A grantee whose fiscal year ends March 31, 2012, allocates 25 percent of costs in each cost category to the 2012 calendar year.

Step 2: Using the trial balance for the end of December, determine the total cost for the remainder of the calendar year for each column. For example, a grantee whose fiscal year ends March 31, 2012 would use the nine-month trial balance for December 31. (NOTE: Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.)

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

QUESTIONS AND ANSWERS FOR TABLE 8A

1. **Are there any changes to this table?**
   No. Only a term change has occurred. The term "non-clinical support services" is being used in places where "administrative" was used in the past however the definitions and numbers being reported are exactly the same as they would have been with the old language.

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

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

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

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

6. **What part of my ARRA grant is reported on Table 8A?**
   Table 8A reports on your total accrued costs including all costs supported by ARRA. But, because it is an accrual process, it will generally *not* include the cash outlays for capital expenses supported by your ARRA CIP and/or FIP grants. It *will* include the 2012 depreciation on those capital projects which have been placed in use, consistent with the health center's usual depreciation rules. Do *not* include the new funds received from the

ACA CHC fund to offset the expiration of the ARRA support of NAP or IDS funds. These new funds are reported on Line 3a of Table 9E.

7. **My doctors were paid the EHR Incentive Payments directly by CMS. If I let them keep some or all of these dollars are they reported anywhere on Table 8a?**
   Yes. Health centers are expected to establish reporting mechanisms for their providers to inform them of payments received and to account for all of these funds. If providers are permitted to retain some or all of these funds they are to be reported on line 1. In addition, the Meaningful Use EHR payments received from Medicare or Medicaid are reported on Table 9e Line 3a.

TABLE 8A – FINANCIAL COSTS

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

INSTRUCTIONS FOR TABLE 9D – PATIENT RELATED REVENUE

Table 9D must be completed by all BPHC grantees covered by the UDS. (A modified version, excluding details on retroactive payments and managed care is used by look-alikes. See Appendix E.) It is included only in the Universal Report. This table collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off. The statute requires that ***all*** health centers have a fee schedule and that they charge patients and/or their third party payors. This does not preclude the center from discounting these fees (see discussion regarding Sliding Discounts below, page 114) but there must be charges.

ROWS: PAYOR CATEGORIES AND FORM OF PAYMENT

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

MEDICAID – LINES 1 - 3. Grantees should report as **"Medicaid"** all services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. For example, in States with a capitated Medicaid program, where the grantee has a contract with a private plan like Blue Cross, the payor would be considered to be Medicaid, even though the actual payment may have come from Blue Cross. Note that EPSDT (the childhood Early and Periodic Screening, Diagnosis and Treatment program), which has various names in different States, is a part of Title XIX and is included in the numbers reported here – almost always on Line 1. Note also that CHIP (or CHIP-RA), the Children's Health Insurance Program, which also has many different names in different States, is sometimes paid through Medicaid. If this is the case, it should be included in the numbers reported here. Also included here will be a portion of the charges for "cross-over" services that are reclassified to Medicaid after being initially submitted to Medicare. In a small number of cases Medicaid patients are enrolled in a “share of cost” program where they pay some portion of the fee as a co-payment or a deductible. In this case, the patient’s share of the cost is reclassified to self pay. With the implementation of health reform, we also anticipate a potential growth in pilot programs with services to the uninsured paid by Medicaid. Although the patients will continue to be reported as uninsured on Table 4, the charges and reimbursement of services covered by Medicaid are reported on Line 1.

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

OTHER PUBLIC – LINES 7 - 9. Grantees should report as **"Other Public"** all services billed to and paid for by State or local governments through programs *other than indigent*

care programs. The most common of these would be CHIP, the Children's Health Insurance Program, which has many different names in different States, *when it is paid for through commercial carriers.* (See above, Medicaid - lines 1 – 3 if CHIP is paid through Medicaid.) Other Public also includes family planning programs including but not limited to Title X programs, BCCCP (Breast and Cervical Cancer Control Programs with various State names), and other dedicated State or local programs. With the implementation of health reform, we also anticipate a potential growth in State insurance plans, which will join plans such as Washington's Basic Health Plan or Massachusetts' Commonwealth Plan. **Other Public does not include State or local indigent care programs.** Patients whose only payment source is one of these State or local indigent care programs are reported as "uninsured" on Table 4 and their charges, collections, etc., are reported on the self-pay line, Line 13.

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

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

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

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

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

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

FULL CHARGES THIS PERIOD – COLUMN A. Record in Column a the total charges for each payor source. This should always reflect the total full charges (per the fee schedule) for services rendered to patients in that payor category during the calendar year. Charges should only be recorded for services that are billed to **<u>AND</u>** covered in whole or in part by a payor, or the patient, even if some of all of the latter are

written off with sliding discounts. Full gross charges should always be reported. The difference between these and contracted payments are then adjusted as "contractual allowances" (see below). Some patients have more than one source of payment for their services. In these instances, a charge will initially be made to one carrier, who may deny some or all of the charge. The unpaid portion will then be moved to the secondary payor, and to a tertiary payor if one exists and, eventually, to the patient as a self-pay charge.

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

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

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

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

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

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

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

COLLECTION OF RECONCILIATION/WRAP AROUND, PREVIOUS YEARS – COLUMN C2. Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level –common in managed care programs and used generally in some states) from Medicare, Medicaid, or Other Public payors that cover services provided during previous reporting periods. Include the prior-year component of multi-year settlements here.

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOLS, INCENTIVES, AND WITHHOLDS – COLUMN C3. Enter other cash payments including managed care risk pool redistribution, incentives including "pay for performance" incentives, and withholds, from any payor. CMS patient care medical home (PCMH) demonstration funds may include payment for a person being enrolled in the grant. These payments are also included here, regardless of whether or not there is a visit involved. Include settlements which may result from a court decision which requires a payor to make a settlement including a multi-year settlement. These payments may apply to either a managed care or non-managed care payor.

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

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

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

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

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

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

Under FQHC programs, where the grantee is paid based on cost, it is possible that the cash

payment will be greater than the charge. In this case, the adjustment recorded in Column d would be a negative adjustment. (Financial adjustments received under FQHC are reported in Columns c1 and c2.)

> EXAMPLE: The State Title XIX Agency has paid grantee's negotiated FQHC rate of $113 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column a as a full charge to Medicaid. After payment was made, the $113 payment is recorded on Line 1 Column b. The $38 payment over the actual charge is reported as a negative allowance (-$38) on Line 1 Column d.
>
> NOTE: Amounts for which another third party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payors for co-payments) are not considered adjustments and should be recorded or reclassified as charges due from the secondary source of payment. These amounts will only be classified as adjustments when all sources of payment have been exhausted and further collection is not anticipated and/or possible.

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

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

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

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

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

> Reductions to the collectable amount for the Self-Pay category based on the patient's income and family size should be made on Line 13, Column e. If the health center has not verified the patient's income and family size, it must not write off the amount as a

sliding discount. It must either be collected or written off as a bad debt. Bad debt write off (Line 13, Column f) may occur due to the grantee's inability to locate persons, a patient's refusal to pay, or a patient's inability to pay even after the sliding fee discount is granted.

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

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

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

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

TOTAL PATIENT RELATED INCOME (Line 14). Enter the sum of Lines 3, 6, 9, 12, and 13. (The EHB will calculate this line automatically.)

QUESTIONS AND ANSWERS FOR TABLE 9D

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

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

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

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

5. **If we have not received any reconciliation payments for the reporting period what do we show in Column c1 (current year reconciliations)?**
   You would then report only current wrap-around payments in Column c1. If you have no reconciliation payments *or* wrap-around payments, enter zero (0) in Column c1.

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

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

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

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

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

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

INSTRUCTIONS FOR TABLE 9E – OTHER REVENUE

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

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

BPHC GRANTS

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

During 2011, ARRA funds for Increased Demand for Services (IDS) and for certain new access points (both "new starts" and "expansions") came to an end. At that point BPHC awarded funds out of the ACA CHC fund to continue those programs. These funds are now reported on Lines 1a through 1e as 330 funds.

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

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

CAPITAL DEVELOPMENT GRANTS (Line 1k) – Enter the amount of Affordable Care Act (ACA) Capital Development grant dollars drawn down. This includes funds from the major Health Center facility program *as well as* funds from the HRSA administered

School Based Health Center capital grants program.

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

OTHER FEDERAL GRANTS

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

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

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

ARRA CIP and FIP GRANT FUNDS (Line 4a) –Enter the amount of ARRA Capital Improvement and/or Facility Investment grant funds which were drawn down in 2012 on Line 4a. Note that ARRA grants were given for a multi-year period and that the grant period has generally expired. Only a small number of grantees who received extensions on this grant will report on this line. It is not expected that the amount reported will equal the amount awarded. Please review your PMS-272 forms to determine the draw-down

amount.

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

NON-FEDERAL GRANTS OR CONTRACTS

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

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

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

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

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

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

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

OTHER REVENUE (Line 10) – Other Revenue refers to other receipts included in the Federally approved scope of project that are not related to charge-based services or to grants and contracts described above. This may include fund-raising, interest income, rent from tenants, medical records fees, individual monetary donations, vending machines, **public** pharmacy, etc. Grantees are asked to describe these sources of "other revenue." *Do not* enter the value of in-kind or other donations made to the grantee – these are shown only on Table 8A, Line 18. Also, *do not* show the proceeds of any loan received, either for operations or in the form of a mortgage. The receipt or recognition of “community benefit” from a third party is not to be reported here or anywhere else on the UDS, nor may health centers recognize community benefit as an amount anywhere on the UDS.

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

QUESTIONS AND ANSWERS FOR TABLE 9E

1. **Are there any changes to this table?**
   Yes. Line 4, the line for ARRA New Access Point (NAP) and Increased Demand for Services (IDS) funds has been deleted. The new ACA CHC fund dollars which replaced them are reported as 330 funds on Lines 1a – 1e.
   Also – HRSA is now administering a School Based Health Center Capital Grants program that is funded through ACA. Those funds are to be reported on Line 1K along with the existing ACA Capital Development grants program.

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

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

TABLE 9E – OTHER REVENUES

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

APPENDIX A: LISTING OF PERSONNEL

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

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

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

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

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

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

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
Patient Records Supervisor		X
Patient Records Technician		X
Patient Records Clerk		X
Patient Records Transcriptionist		X
Registration Clerk		X
Appointments Clerk		X

APPENDIX B: SPECIAL MULTI-TABLE SITUATIONS

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

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

ISSUE	TABLES AFFECTED	TREATMENT
Contracted Care (Specialty, dental, mental health, etc.) *(Service must be paid for by grantee.)*	5	**Providers (Column A)** are counted if the contract is for a portion of an FTE (e.g., one day a week OB = 0.20 FTE). Providers are *not* counted if contract is for a service (e.g., $X per visit or $55 per RBRVU). **Visits (Column B)** are *always* counted, regardless of method of provider payment or location of service (grantee's site or contract provider's office).
	6A	Grantee receives encounter form or equivalent from contract provider, counts diagnoses and/or services provided as applicable.
	8A	**Column A: Net Cost.** Cost of provider/service is reported on applicable line. **Column B: Facility and non-clinical support services.** Grantee will generally use a lower Facility and non-clinical support services rate for off-site services.
	9D	**Charge (Column A)** is grantee's usual, customary and reasonable (UCR_ charge if on-site; is contractor's UCR charge if off site. **Collection (Column B)** is the amount received by *either* grantee *or* contractor from first or third parties. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12) **Sliding Discount (Column E)** if applicable, is the amount written off for eligible patients per center's fiscal policies (Line 13). Calculated as UCR charge minus amount collected from patient, minus amount owed by patient as their share of payment.
Services provided by a volunteer provider *(Service are not paid for*	Description	Volunteer staff (including AmeriCorps/HealthCorps, but not National Health Service Corps) who provide services on site on behalf of the grantee where there is a basis for determining their hours can be included in the UDS report.

ISSUE	TABLES AFFECTED	TREATMENT
by grantee, but <u>are provided on site</u>.)	5	**Providers (Column A)** are counted if the service is provided on site at grantee's clinic. FTE is calculated by using hours volunteered as the numerator. Because volunteers do not receive benefits, the denominator is the number of hours that a comparable *employee* spends performing their job. This means, most specifically, that a full time of 2080 hours (for example) will be reduced by vacation, sick leave, holidays and continuing education normally provided to employees. As a rule, the equation will be hours worked divided by a number somewhere around 1800. Providers <u>*are not counted*</u> if their services are provided at their own offices. **Visits (Column B)** are counted only if the service is provided at a site in the grantee's scope of service and under the grantee's control.
	6A	Grantee counts diagnoses and/or services provided on site, as applicable.
	9D	If the provider is on-site, the charges for their services are treated exactly the same as for staff. Do not include charges for volunteer providers who are off-site.
Interns and Residents	Description	Health centers often make use of individuals who are in training, referred to variously as interns or residents, depending on their field and their licensing. Medical Residents and some mental health interns are generally licensed practitioners who are training for a higher level of certification or licensing.
	Table 5	**Column A:** Licensed interns and residents are counted in the category of credentialing that the provider is *working toward*. Thus, a family practice resident is shown on Line 1 as Family Physician, etc. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the grantee) or like a volunteer (if they are *not* being paid). See volunteer providers, immediately above. **Column B:** Visits between a medical resident and a patient are recorded as visits *to that resident or intern. Under no circumstances are the visits credited to the supervisor of the resident or intern*. Visits of a *licensed* mental health provider will be counted on Lines 20a, 20a1, 20a2, or 20b. If the provider is not licensed, they will be counted on Line 20c.
	Table 8A	*If the intern or resident is paid by the grantee* ***or*** their cost is being paid through a contract which <u>pays</u> a third party for the interns or residents, the cost is shown in column a on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the intern or resident *is not being paid by the grantee* and the grantee is not paying a third party, then the *value of the donated time* is reported on Line 18. Be sure to describe the nature of the donation on the table at this line.

ISSUE	TABLES AFFECTED	TREATMENT
WIC	3A, 3B, 4	Clients whose only contact with the grantee is for WIC services and who do not receive another form of service counted on Table 5 from providers outside of the WIC program *are not counted as patients on any of these tables*. Do not count as patients because of nutritional, health education, or enabling services provided by WIC.
	5	**Staff (Column A)** are counted on Line 29a. **Visits and patients (Columns B and C)** are *never* reported.
	8A	**Column A: Net costs.** Total cost of program reported on Line 12 in Column a. **Column B: Facility and non-clinical support services.** Since much of the non-clinical support services cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
	9D	Nothing associated with the WIC program is to be reported on this table.
	9E	Income for WIC programs, though originally Federal, comes to grantees from the State. Unless the grantee *is* a State government, the grant/contract funds received are reported on Line 6.
In-house pharmacy or dispensary services for grantee's patients *(including only that part of pharmacy that is paid for by the grantee and dispensed by in-house staff.)* [see below for other	5	**Column A: Staff.** Pharmacy staff are reported on Line 23. To the extent that the pharmacy staff have only an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs (PAPs), they are included on Line 23. Staff (generally not including pharmacists) who spend a readily identifiable portion of their time with PAP programs should be counted on Line 27a, Eligibility Assistance. **Column B: Visits.** The UDS does not count interactions with pharmacy staff as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for Clinical Pharmacists as well.

ISSUE	TABLES AFFECTED	TREATMENT
situations].	8A	**Line 8b, Column A: Pharmaceutical Direct Costs.** The actual cost of drugs purchased by the pharmacy is placed on Line 8b. The value of donated drugs is *not* reported here. These costs *are* reported on Line 18 in Column c. **Line 8a, Column A: Other Pharmacy Direct Costs.** All other operating costs of the pharmacy are shown on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. **Line 11e, Column A: Eligibility Assistance Direct Costs.** Show (on line 11e) the cost of staff (full-time, part-time, or allocated time) assisting patients to become eligible for PAPs and all related supplies, equipment depreciation, etc. **Column B: Facility and Non-clinical Support Services.** All facility and non-clinical support services costs associated with Line 8a and 8b are reported on Line 8a. While there may be some facility and non-clinical support services cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. **Column C, Line 18:** Show the value of donated drugs (generally calculated at 340(b) rates) on this line *only.*
	9D	**Charge (Column A)** is grantee's full retail charge for the drugs dispensed. **Collection (Column B)** is the amount received from patients or insurance companies. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12). **Sliding Discount (Column E)** is amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge minus amount collected from patient, minus amount owed by patient as their share of payment.
	9E	The value of donated drugs is ***not*** reported on this table – it is reported on Table 8A. (See above.) The charges for drugs dispensed to patients are to be reflected on Table 9D, not this table.
In-house pharmacy for community (i.e., for non-patients)	Description	Many CHCs which own licensed pharmacies also provide services to members of the community at large who are *not* CHC patients. Careful records are required to be kept at these pharmacies to ensure that drugs purchased under section 340(b) provisions are not dispensed to non-patients. Some of these pharmacies are totally in-scope, while others have their "public" portion out of scope. If the public aspect is "out of scope," none of its activities are reported on the UDS. If it is in scope, the public portion should be considered an "other activity" and treated as follows:

ISSUE	TABLES AFFECTED	TREATMENT
	5	**Column A: Staff.** Report allocated public portion of staff on Line 29a: Other Programs and Services.
	8A	Report all related costs, including cost of pharmaceuticals, on Line 12: Other Related Services.
	9E	Report all income from public pharmacy on Line 10: Other, and specify that it is from "Public Pharmacy."

ISSUE	TABLES AFFECTED	TREATMENT
Contract Pharmacy **Dispensing to clinic patients, generally using 340(b) purchased drugs**	5	No staff, visits, or patients are reported. PAP staff all go to enabling services on line 27a. Eligibility assistance.
	8A	If the pharmacy is charging one amount for "managing" the program and/or an amount for "dispensing" the drugs; and another amount for the drugs themselves, the former charge is reported on Line 8a, the latter on Line 8b. If the CHC is purchasing the drugs directly [because of 340(b) regulations] the full amount it spends on purchasing goes on Line 8b, and any administrative or dispensing costs charged by the pharmacy go on Line 8a. If the pharmacy is reporting a flat amount for services including both pharmaceuticals and their services, *and there is no reasonable way to separate the amounts* report all costs on Line 8b. Associated non-clinical support services costs will go on Line 8a in Column B, even though Line 8a Column A is blank. If prepackaged drugs are being purchased, *and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs* report all costs on Line 8b. Associated non-clinical support services costs will go on Line 8a in Column B, even though Line 8a Column A is blank.
	9D	**Charge (Column A)** is grantee's full retail charge for the drugs dispensed or the amount charged by the pharmacy/pre-packager if retail is not known. **Collection (Column B)** is the amount received from patients or insurance companies or, under certain circumstances, the pharmacy. (NOTE: most CHCs have this arrangement only for their uninsured patients.) **Allowance (Column D)** is amount disallowed by a third party for the charge (if on Lines 1 – 12). **Sliding Discount (Column E)** is amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge (or pharmacy charge) minus amount collected from patient (by pharmacy or CHC), minus amount owed by patient as their share of payment.
	9E	No income would be reported on Table 9E. Do not use Table 9E to show net income from Pharmacy. Actual income must be reported on Table 9D.

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

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

ISSUE	TABLES AFFECTED	TREATMENT
	4	While patients may need to qualify for eligibility, these programs are not considered to be public insurance. Patients served are almost always to be counted on Line 7 as uninsured.
	9D	The UCR charges are to be considered charges directly to the patient (reported on Line 13, Column A). If the patient pays any co-payment, it is reported in Column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it collected or is written off as a bad-debt in Column f. All the rest of the charge (or all of the charge if there is no required co-payment) is reported as a sliding discount in Column E.
	9E	The total amount received during the calendar year from the State or local indigent care program is reported on Line 6a.
Workers Compensation	4	Workers Compensation is a form of *liability insurance for employers*, not a *health insurance for employees*. Patient's whose bills are being paid by Workers Compensation should have a related insurance and that is what is reported on Table 4 (even if it is not being billed or cannot be billed by the Health Center.) In general, if they had an employer paid/work-place based health insurance plan they would be reported on Line 11 (Private). If they do not have *any* health insurance, they are reported on Line 7 (Uninsured).
	9D	Charges, collections and allowances for Workers Compensation covered services are reported on Line 10 (Private Non-Managed Care.
Tricare, Trigon, Veterans Administration, Public Employees Insurance, etc.	4	While there are many individuals whose insurance premium is paid for by a government, ranging from military and dependents to school teachers to congressmen and HRSA staff, these are all considered to be private insurances. They are reported on Line 11 (Private), *not on Line 10a.*
	9D	Charges, collections, and allowances are reported on Lines 10 – 12 (Private), *not on Lines 7 – 9.*
Contract sites ***(In-scope sites in schools, workplaces, jails, etc.)***	Description	Some Health Centers have <u>included in their scope of service</u> a site in a school a workplace, a jail, or some other location where they are contracted to provide services to patients (students, employees, inmates, etc.) at a flat rate per session or other similar rate *which is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third parties.

ISSUE	TABLES AFFECTED	TREATMENT
	4	**Lines 1-6 – income:** In general, income should be obtained from the patients. In prisons, it may be assumed that all are below poverty (Line 1). In schools, income should be that of the parent or unknown or, in the case of minor consent services, below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). **Lines 7-12 – insurance:** Record the actual form of medical insurance the patient has, regardless of the clinic's ability to bill that source. (Children in school based clinics are often covered by a Medicaid program, but assigned to another provider. They are still shown as Medicaid patients.) Do not consider the agency with whom the clinic is contracted to be an insurer. (Schools and jails are not "other public" insurance.)
	5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
	8A	Costs will generally be considered medical (Lines 1-3) unless other services (mental health, case management, etc.) are being provided. *Do not report on Line 12—"other related services."*
	9D	*Unless the visit is being charged to a third party such as Medicaid* the clinic's usual and customary charges will appear on Line 10, Column A(Private). The amount paid by the contractor is shown in Column B. The difference (positive or negative) is reported in Column D (Allowances).
	9E	*Contract revenue is not reported on Table 9E.*
CHIP (CHIP-RA)	4	**Medicaid:** If CHIP is handled through Medicaid and the enrollees are identifiable, they are reported on Line 8b. *If it is not possible to differentiate CHIP from regular Medicaid,* the enrollees are reported on Line 8a with all other Medicaid patients. **Non-Medicaid:** CHIP enrollees in States which do not use Medicaid are reported as "Other Public CHIP" on Line 10b. Note that, even if the plan is administered through a commercial insurance plan, the enrollees are *not reported on Line 11.*
	9D	**Medicaid:** Report on Lines 1 – 3 as appropriate. **Non-Medicaid:** Report on Lines 7 – 9 as appropriate. *Do not report on Lines 10 – 12 even if the plan is administered by a commercial insurance company.*

ISSUE	TABLES AFFECTED	TREATMENT
Carve-outs	Description	**Relevant to capitated managed care only.** Grantee has a capitated contract with an HMO which stipulates that one set of CPT codes will be covered by the capitation regardless of how often the service is accessed, and another set of codes (or all other codes) the HMO will pay for on a fee-for-service basis (the carve outs) whenever it is appropriate. Most common carve-outs involve mental health, lab, radiology and pharmacy, but specific specialty care or diagnoses (e.g., perinatal care or HIV) may also be carved out.
	4	**Patient Member Months:** Member months are reported on Line 13a in the appropriate column, regardless of whether or not the patient made use of services in any or all of those months. *No entry is made on Line 13b ("Fee-for-service managed care member months") for the carved out services, even if payments were received for these services.*
	9D	**Lines 2a/b, 5a/b, 8a/b, 11a/b.** Capitation payments are reported on the "a" lines, carve out payments are reported on the "b" lines. Associated charges for the carve-outs must be reported on the "b" lines.
Incarcerated Patients	Description	Some grantees contract with jails and prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.
	4	Income for prisoners must be presumed to be below poverty (line 1). Individuals receiving health services under this contract are not considered to have insurance. The patient must be classified according to their primary health insurance carrier regardless of whether the services will be billed to the insurer, but are almost always uninsured.
	9D	The patient's services are paid for by the jail/prison. The clinic's usual and customary charge for the service is reported on Line 10 (Private) in Column A, and the payment is reported in Column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in Column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.
EHR Staff and Costs	Description	Electronic Health Record (EHR) systems (some of which have integrated Practice Management Systems) are designed to not only record clinical activities but also to be an aide to clinicians in the management and integration of patient services. As such, they are generally considered to be part of the clinical program, though some aspects are considered to be non-clinical support.

ISSUE	TABLES AFFECTED	TREATMENT
	5	The staff dedicating some or all of their time to the operation of the EHR are reported as medical on the appropriate line. This includes those involved in the design of medical forms, data entry, and analysis of EHR data, as well as help-desk, training and technical assistance functions. Staff managing the hardware and software of a PMS billing and collection system are reported as non-clinical support staff.
	8A	Staff noted above as being included in medical staff and reported on line 3, as are all costs associated with licenses, depreciation of the hardware and software, software support services and annual fees for other aspects of the EHR.
(Migrant) Vouchers	Description	**Voucher Programs** have traditionally been an exclusive part of the Agricultural worker program, though in recent years some Homeless and even CHC programs have made use of the mechanism. In this system, the center identifies services that are needed by its patients which cannot be provided by their in-house staff. Vouchers are written to authorize a third party provider to deliver the services, and the voucher is returned to the grantee for payment. Payment is generally at less than the providers full fee, but is consistent with other payors such as Medicaid.
	3A, 3B, 4	**Patients are counted** even if the only service that they receive is a paid vouchered service, provided that these services would make the patient eligible for inclusion if the center provided them. Thus a vouchered taxi ride would *not* make the patient "countable" because transportation services are not counted on Table 5, but an eye exam provided would count.
	5	**Column A:** There is no way to account for the time of the voucher providers. As a result, zero FTEs are reported with regard to these services. If there is a provider who works *at* the center, the FTE of *that* provider *is* counted. For example, the one-day-a-week family practitioner would be reported as 0.20 FTEs on Line 1. But the 125 vouchered visits to FPs would not result in an additional count on Line 1. **Column B:** Count all visits that are paid for by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (i.e., a "voucher" to a doctor who donates five visits per week does NOT generate a visit that is counted on Table 5).
	6A, 6B, 7	**Diagnoses and Services.** The Voucher program is expected to receive from the provider a bill similar to a HCFA-1500 which lists the services and diagnoses. These are to be tracked by the center and reported on Table 6A, 6B, and 7, where appropriate.

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

APPENDIX C: SAMPLING METHODODOLOGY FOR MANUAL CHART REVIEWS

INTRODUCTION

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

RANDOM SAMPLE

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

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

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

For each measure, perform each of the following steps.

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

Define the universe for each condition.

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

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

STEP 2: Determine the sample size for manual chart review

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

STEP 3: Select the random sample

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

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

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

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

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

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

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

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

- All measures – not a medical patient
- Childhood immunizations – none
- Pap tests – women who have had a hysterectomy
- Controlled hypertension – Pregnant patients, end stage renal disease
- Controlled diabetes – patients with a diagnosis of polycystic ovaries that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year; gestational diabetes (ICD-9-CM Code 648.8); or steroid-induced diabetes (ICD-9-CM Code 962.0, 251.8) during the measurement year
- Weight related measures – pregnancy or imminent demise
- Asthma – allergic response to asthma medication
- Tobacco use – patient is no longer a tobacco user
- CAD – LDL < 130mg/dL; or allergic response to LDL lowering medication
- IVD – none
- Colorectal cancer screening – patients who have or had colorectal cancer

METHODOLOGY FOR OBTAINING A RANDOM SAMPLE

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

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

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

Option #1: Random Number List

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

The Web site requires no password or subscription to access. To obtain a list of random numbers, complete the questions as documented below.

Identifying an Initial List

Request **1** list of **70** numbers. Complete the "Number Range" by entering the **1** as the first number and the **total number of patients** in the universe for the particular measure under consideration as "n." For example, if there are 628 children who turn two in the reporting year in the universe, enter 628 as **N**. It is often helpful, *but not necessary* to sort the selected random numbers.

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

Identifying a Replacement

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

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

Input	Initial Sample	Replacements
Set of Numbers	1	1
Number per set	70	At least 5 or as many as needed

Number range = 1-“n”	Last sequence number in list	Last sequence number in list
Unique numbers	Yes	Yes
Sort numbers	Yes, least to greatest	No

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

Option #2: Interval

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

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

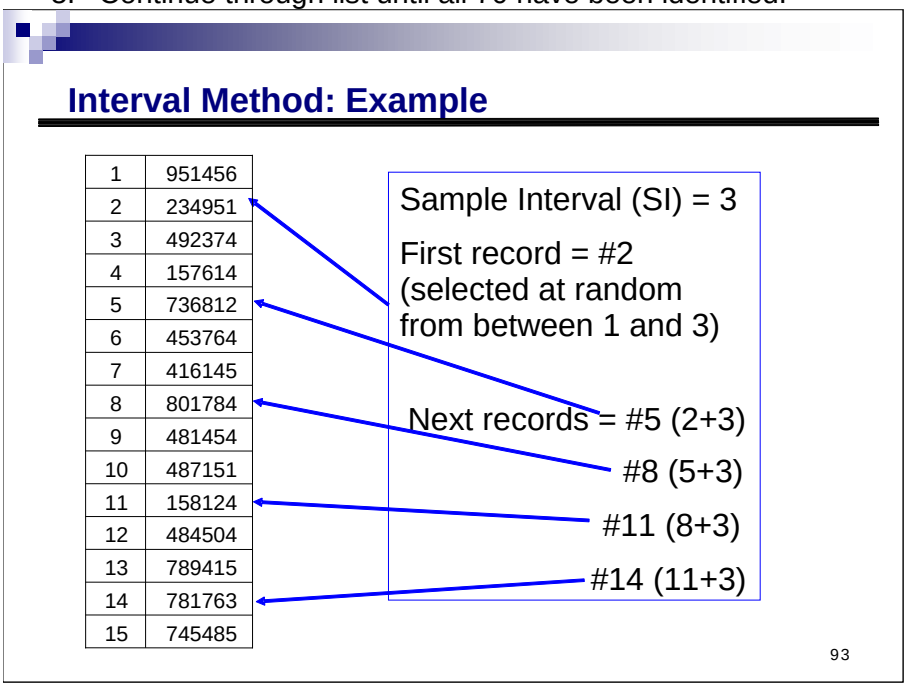
2. Calculate sampling interval (SI) by dividing number of patients in the universe by 70:

3. That will be your first record sequence number

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

first sequence # + SI = second #

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



Identifying a Replacement

If a selected patient should be excluded from the sample, return to the original list and substitute the next patient on the list for the excluded patient. If that patient should be excluded select the

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

Obtaining a Sample of 70 Patients

Under certain situations, a larger number of charts may need to be pulled to achieve a total of 70 charts. Specifically for CY 2012, for users unable to determine a universe using existing systems, alternative instructions for determining a universe and determining compliance are provided. This may include the two tobacco measures and the asthma measure. The steps below explain how to obtain a sample of 70 using the two tobacco measures:

Tobacco Assessment

1. Prepare a list of all patients born on or before 12/31/1994; with at least one medical visit in a clinic setting; who have been seen at least twice ever. This list is the universe for tobacco assessment reported on Table 6B Line 14 column a.

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

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

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

Tobacco Cessation Intervention

5. Continue to pull charts from the randomly ordered list until you have the charts of 70 tobacco users. Keep track of how many charts you had to review in the list to obtain 70 tobacco users.

6. Divide 70 by the total number of charts that were reviewed to achieve 70 tobacco users. This percentage will be used as the percent of the adult population who are tobacco users. Multiply this percentage by the total universe on Table 6B Line 14 Column a - this is the universe of tobacco users for the cessation measure (Table 6B Line 15 col a).

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

APPENDIX D: GRANTEE ELECTRONIC HEALTH RECORD (EHR) CAPABILITIES AND QUALITY RECOGNITION

INSTRUCTIONS

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

Question 1 seeks to determine whether or not an EHR has been installed by the grantee as of December 31, 2012 and, if so, which product is in use, how broad is access to the system, and what features are available and being used. While they can often produce much of the UDS data, do not include practice management systems or other billing systems. If the grantee has *purchased* an EHR, but had not yet placed it into use, answer question 1 "No." If it has been installed, indicate if it was being used, as of December 31, 2012, by:

a. All sites and all providers. For the purposes of this response, "providers" means all *medical* providers including physicians, nurse practitioners, physician assistants and certified nurse midwives. While some or all of the dental, mental health or other providers may also be using the system, as may medical support staff, this is not required to choose response 'a.' For the purposes of this response, "all sites" means all *permanent* sites where medical providers serve health center *medical* patients and *does not* include administrative only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis.
b. At some sites or for some providers. Select option b if one or more permanent site did not have the EHR installed or in use (even if this is planned) or if one or more medical providers (as defined above) does not yet use the system. When determining if all providers have access to the system, the grantee *should* consider part time and locum providers who serve clinic patients. D*o not* select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.
c. No. Select "no" if no EHR was in use on December 31, 2012, even if the system had been installed and staff were training on how to use the system.

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

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

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

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

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

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

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

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

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

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

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

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

QUESTIONS

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

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

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?
    a. Yes, at all sites and for all providers
    b. Yes, but only at some sites or for some providers
    c. No

i. IF (c), pop up and ask when:
    a. 3 months,
    b. 6 months,
    c. 1 Year or more
    d. not planned

ii. Pop-up if (a) OR (b)

Please select your vendor from the list of certified systems below and indicate the version number or name. If "other", please specify:

    a. Allscripts
    b. athena
    c. GE Centricity
    d. eClinicalWorks (eCW)
    e. e-MDs
    f. Epic
    g. Greenway
    h. CompuGroup (HealthPort)
    i. IMS
    j. Logician
    k. McKesson
    l. Medinformatix
    m. Medinotes
    n. MicroMD
    o. NextGen
    p. Resource Patient Management System (RPMS)
    q. Vitera
    r. Sevocity
    s. SuccessEHS
    t. Other - Specify: _____

iii. Pop-up if (b)

    1. How many sites have the EHR in use?
    2. How many providers use the EHR system?

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

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

1. Patient history and demographic information?

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

2. Clinical notes?

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

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

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

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

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

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

7. Notifiable diseases sent electronically?

8. Reporting to immunization registries done electronically?

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

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

11. Does the system protect electronic health information?

3. Do you use your EHR to electronically extract and submit data for your UDS clinical reporting (Table 6B and 7)
   a. Yes
   b. No

4. Are providers at your health center Meaningful Users of HIT?
   a. Yes. *Providers* are receiving Meaningful Use incentive payments from CMS due to their use of health center's EHR system.
   b. Not yet, but providers at my health center plan to apply to receive Meaningful Use incentive payments from CMS *in the coming year.*
   c. Providers at health center do not meet the requirements to receive Meaningful Use incentive payments from CMS, or do not plan to apply

5. Has your health center received national and/or state quality recognition, either accreditation or patient centered medical home recognition, for one or more sites?
    a. Yes
    b. No

    If yes, which third party organization(s) deemed recognition status? (Can identify more than one)
    1. AAAHC
    2. The Joint Commission
    3. NCQA
    4. State Based Initiative
    5. Private Payer Initiative
    6. Other Recognition Body (write in name)

APPENDIX E: FQHC LOOK-ALIKE DESIGNEE REPORTING

Look-alikes are health centers that have been determined to meet Health Center Program requirements under Section 330 of the PHS Act, although they do not receive Section 330 grant funding.

Look-alikes are required to submit UDS data to HRSA through the EHB rather than through paper applications. This will allow HRSA to bring together data and information used to monitor look-alikes, record program changes, and track program performance in one centralized system.

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

Special care must also be taken by the limited number of "dual status" agencies. "Dual status" occurs when a health center receives grant funding under section 330 for sites in the grant's approved scope of project and, at the same time, operates at least one other other site under a look-alike designation. Dual status health centers must maintain separate and distinct scopes of project for the look-alike and grant scopes of project within their health center. Administrative costs must be allocated when reporting on both the grantee and look-alike UDS. *Under no circumstances can the same cost be included in both the look-alike and Grantee reports.*

Data will be reported by look-alikes using the definitions and rules in this manual. General exceptions to the reporting for look-alikes from the grantee reporting outlined in this manual are:

- Look-alikes complete only a Universal Report.
- Look-alikes do not complete table 6A
- Discussion of grant tables is not applicable.
- Once in the UDS, Look-Alikes will see modified versions of BPHC Grantee tables with grayed-out fields for elements that do not apply or for which look-alikes are not required to report.

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

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