Health Resources and Services Administration
Bureau of Primary Health Care
UDS for New Submitters
October 15, 2014 2 to 4:30 p.m. ET

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen-only mode until the question and answer session of today's call. At that time you may press Star 1 to ask a question from the phone lines. I'd like to inform all parties that today's call is being recorded. If you have any objections you may disconnect at this time. I'd now like to turn the call over to Alek. Thank you sir, you may begin.

Alek Sripipatana: Thank you very much operator. Good afternoon on the east coast and good morning for those tuning in from all parts west. Welcome to our introduction to the Uniform Data System or UDS for new submitters webinar. I'm Doctor Alek Sripipatana, the Chief of the data branch in the office of quality and data at HRSA's Bureau of Primary Healthcare.

First and foremost I want to thank you all for the great work that you do. Thank you, thank you, thank you. Your work and services are critical of the first line of care for America's healthcare safety net providing healthcare services to some of America's most vulnerable population groups.

Now on to the UDS; the UDS is an incredibly important activity of the bureau. It provides empirically-based information for strategic planning, directing resource allocation, tracking for quality of care to our nearly 23 million patients as well as highlights the terrific and innovative work of health centers.

Using the UDS we've compared how health centers have met prominent national benchmarks like Healthy People 2020. In fact in 2013 all of our health centers met or exceeded at least one Healthy People objectives. Now the UDS is a robust data collection activity and can appear intimidating at first glance but don't fret, you're in good hands. We have an incredibly talented UDS team some of whom will be presenting in today's webinar including our office's senior clinical advisor Doctor Laura Makaroff and our talented contractors Terri Tobin, Art Stickgold and Diane Lewis.

So welcome to this esteemed group of healthcare providers that is the health center program family. So the purpose of this webinar is to provide those of you who are new to the UDS reporting a cursory overview of the UDS. This webinar does not substitute for in-person day-long trainings that will be taking place this fall but it's designed to complement them.

You will need to attend an all-day training to get step-by-step instructions on how to complete all of the UDS tables correctly. Additionally and more importantly the in-person trainings provide a more dynamic interaction with UDS pros. During this webinar we'll be introducing you to the UDS including why it's important, expectations for submitting your UDS report, available assistance to help you with the reporting, an overview of the reporting table.

Now I want you to keep in mind that as we review the UDS during this webinar it's important to understand the interrelatedness of all of the tables. And finally towards the end of the webinar we'll share strategies for successfully completing your UDS report. That being said don't tune out until those successful reporting strategies are presented. There are gems to providing quality UDS reporting methods throughout this presentation. So let's get started.

So why is the Uniform Data System important? The Bureau of Primary Healthcare has a long tradition of collecting program data from funded programs. This information has been invaluable in documenting the effectiveness of this program to funders. The UDS data is reported annually to congress to demonstrate how federal dollars are used to meet programmatic mandates.

In addition the UDS is used by the Bureau of Primary Healthcare to ensure that your programs are meeting their legislative and regulatory requirements to identify areas for technical assistance to ensure program effectiveness and to report overall program accomplishment. UDS data are used to identify trends over time enabling HRSA to expand or establish targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations.

UDS data are also compared with national data to review differences between the US population at large and those individuals and families who rely on the healthcare safety net for primary care. And the UDS data informs health center programs, partners and communities about patient service by health centers. In fact you can use your UDS data to evaluate your health center's performance, to identify opportunities for program and healthcare quality improvements.

These data can be used to set baselines and goals and to track performance improvement over time. So now that we've highlighted how UDS data is used and why UDS reporting is so important let's look at a brief snapshot of what the UDS tells us. The info graph on your screen is a nice summary of 2013 UDS data. It allows us to answer key questions such as how many patients were served by health centers and what sort of services they receive.

So here we see in 2013 our 330 health centers served over 21 million patients. Eighty-six percent of those were medical patients. Our look-a-like health centers served about one million. Looking at patient visits all of the health center programs conducted nearly 90 million visits. 330 programs reported about 85.6 million. Look-a-like conducted about 3.8 million.

These visits included medical, dental, mental health, substance abuse, vision, other professional and enabling services. We can also do comparisons here, for instance what percent of patients were uninsured. If we look at our 330s about 35% were uninsured in comparison to our look-a-likes which were 32%. We can look at the proportion of patients that were Medicaid beneficiaries. Our 330s are about 41%, our look-a-likes about 46%.

We can also look at clinical indicators, what percentage of women age 24 to 64 had a current pap test. For a 330 program 58% in comparison to 52% for look-a-likes. So these summary points are just the tip of the data iceberg. All of this information and much more is available with the UDS. So what is the Uniform Data System?

The UDS is a core standardized data set that is appropriate for reviewing the operation and performance of health centers. It's reported by various federally-supported programs including Section 330 grantees, look-a-likes and urban-Indian health programs. The UDS report reports your scope of project for the 12 month period from January 1 to December 31.

For many of you your scope of service is likely your entire program however for some of you your scope of project may not include all of your activity. If you don't already know you can look to your grant application and your notice of grant award to see what is included in your scope. If you are a part of

a larger organization such as a health department or a medical center your scope of service is not defined by your organization.

Alternatively you may have one or more service site that has not been approved in your scope. For these organizations you will only report on that portion of your program that is approved. It's critical that you consistently report your activity across all tables when you are reporting only a portion of your program.

So here is a quick snapshot of the 12 tables in the UDS. These tables collect information on patients you served and some of their socio-demographic characteristics. They collect information on the types and quantity of services you provide to those patients, information on your organization staffing mix and tenure, measures on quality of care you delivered, the associated cost of providing services and revenue sources.

So critical dates in the UDS process; your UDS report is due February 15 every year. I know Art is also going to be on this call and I'm sure he will reiterate that fact that come rain or shine the reporting is due on February 15 of every year. You will be able to start entering your data into the electronic handbook or EHB beginning January 1. If you are new to the EHB you can refer to the online training available at the technical assistance Web site which you will learn more about on the next slide.

The EHB also includes a help function which you can access in the application for assistance. The expectation is that you will submit a complete and accurate report by February 15. This year the due date happens to fall on a Sunday. You are still expected to submit a complete and accurate UDS report on or before February 15. Please do not submit a partially vetted report on February 15 just to meet the deadline. You'll need to plan ahead and start your

data entry early so that you have time to review your submission and address any potential problems before the February 15 deadline.

To assist you with making sure that your report is complete and accurate over 1000 edits are built into the EHB. These edits are designed to flag when there appear to be problems or questions with your data. It's important to review these edits and address them by either correcting your errors or commenting on why the data is correct as reported. So a little bit about the review process; you'll be paired with a reviewer to make sure that your UDS report is complete and accurate.

Reviewers are assigned to specific states such that those reviewers are experts in the nuances of reporting for those states. After you submit your report your reviewer will analyze your data and check for data validity. What your reviewer is looking for are potential data inconsistencies in the UDS that may suggest errors in reporting. So providing thoughtful commentary in the EHB will assist your reviewer in troubleshooting potential errors in your report.

After reviewing your table your reviewer will prepare a summary of possible problems with your report and e-mail them to you within a few weeks of you submitting your report. Please review and address all the issues your reviewer identifies to the best of your ability. Now not all issues that your reviewer identifies are necessarily errors with your data. Sometimes you simply need to confirm with your reviewer that your data is correct however there are other times you will actually need to go back and review your data source and correct the data that you have submitted.

Your reviewer will work with you by phone and e-mail. Your report data must be finalized by March 31. If you submit your data late -- that is after February 15 -- that leaves less time for your reviewer to work with you to correct your

data. Your reviewer's last task will be to rate your data. If you have not corrected or provided explanations for issues raised by your reviewer they may conclude that your data is not complete and may rate your data questionable.

Questionable data simply means that the reviewer is not confident that the data accurately reflects your performance. It's very important that the data in the UDS are accurate. As highlighted earlier we take several measures to try and assure the accuracy and validity of UDS data. So don't feel like you're going it alone. There are several resources available to help you complete an accurate UDS report. In addition to this webinar there are regional in-person trainings held in 45 states in partnership with state primary care associations.

Please refer to the Bureau of Primary Healthcare training Web site for a complete list of training dates and locations. There are also a series of online training modules which you can download, a UDS manual and UDS fact sheets that provide step-by-step instructions for completing your UDS tables. There's also an archive of previous UDS webinars. Additionally there is a help line which is available year-round.

The UDS help line can assist you with questions about where to report your data, clarification of UDS definition and interpretation of edits. If you are having trouble accessing the EHB or if you have problems with the system you can contact the HRSA call center. The number is located towards the bottom of the screen.

Upcoming webinars to help provide more information on the UDS include the introduction to UDS clinical measures and this will help review the clinical performance measures in tables 6B and 7, the introduction to the UDS for look-a-likes and the UDS sampling methods. Again if you missed any of these

webinars or want to refer to them later the slides, audio and transcripts will be archived at the UDS reporting and technical assistance Web site.

Wow, okay so with that I'm going to hand the presentation over to (Doctor Terri Tobin) to go over the UDS tables in a little more detail. (Terri)?

Terri Tobin: Thanks Alek. For this next section of the webinar, We'll cover a brief overview of the twelve tables that make up the UDS report. As Alek mentioned, the UDS is reported by federally-funded health centers, look-a-likes and the Bureau of Health Workforce primary care clinics. Reporting requirements differ slightly for these three categories of reporting entities. This slide shows which tables are submitted by which types of organizations. All 330-funded and BHW primary care programs complete the universal report which includes all 12 tables.

For those 330-funded programs that receive more than one funding stream -- for example Healthcare for the Homeless or HCH, Migrant Health Center or MHC, public housing primary care or PHPC and/or community health center or CHC -- you will need to complete additional information for some tables. This information will be reported on a copy of the tables called the grant report.

More specifically, programs that receive multiple funding streams will complete tables 3A, 3B, 4, 6A and parts of Table 5 for each of the additional grant programs. By separately reporting your special population activity, the Bureau is able to aggregate and report national activity for the homeless, migrant and public housing programs to funders.

This year, look-alike programs will also report all 12 tables. In the past, look-a-likes have not had to report Table 6A but they will complete that for this

year. These programs will also report Table 9D in its entirety this year. Look-alike programs should note however that Tables 4 and 9D have selected fields shaded out for data elements that aren't applicable to them.

A separate webinar focused on look-alikes will be conducted in the afternoon on October 22nd so I encourage you to attend if you need more information related to these reporting details.

Now that we know who is reporting what, let's turn to the 12 tables that make up the UDS report. Briefly the data you report in each can be grouped together to develop profiles for four important areas.

More specifically a patient profile, which provides an overview of the patients served by the health center program including number of patients served and socio-demographic characteristics. It includes patient residence and third-party medical insurance in the ZIP Code table, age and gender in Table 3A, Hispanic or Latino ethnicity, race and language in Table 3B and income, primary third-party medical insurance including managed care member months and identification as a member of a special population in Table 4.

Also a utilization and staffing profile, that describes your staffing model and the quantity of services you provide including the types and quantities of services provided to health center patients and the staff who provide these services including information about full-time equivalents or FTEs, visits and patients in Table 5 and the length of time specific staff have been in their respective roles in Table 5A.

Then we have a clinical profile that reports about the number of visits by selected diagnosis in Table 6A, quality of care measures such as access to prenatal care, childhood immunizations, health screenings, treatment for

health issues and identification of and follow-up care for newly-diagnosed HIV patients in Table 6B. And health outcome measures for birth weight, hypertension and diabetes by race and ethnicity in Table 7.

Finally, a financial profile that describes the cost of delivering services and amount of income generated by health centers including financial costs accrued by costs center in Table 8A, patient-related revenue including charges, collections, allowances, sliding discounts and bad debt by payer type in Table 9D and other or non-patient generated income such as grants and contracts in table 9E.

It is important to see that together, these 12 tables provide a holistic picture of your organization. The tables are all interrelated and need to be consistent and work together. The numbers and types of patients you serve impacts the staff you need to deliver services and the types of services you provide.

Your staffing levels are also related to your program costs the volume of services you provide is related to revenues you generate. Since the tables are all interrelated you can’t complete the patient clinical and financial tables in isolation. For example it won’t work to have your CFO prepare the financial tables, your IT staff complete demographic information and your clinical staff complete the clinical tables independently and still hope to have a complete and consistent report.

How you report data on one table really impacts how data is reported on the others and for this reason it is important that you work as a team to prepare your report. The next set of slides are a brief introduction to each of the tables. Again for details on how to correctly complete each please attend a day-long in-person training in your region and that schedule has just been finalized recently and posted on the bureau’s training website also refer to the UDS manual.

You can also access online training modules, fact sheets and other resources for more detailed information.

First, who counts as a patient on the UDS report? Not every person who has contact with the health center during the reporting year is considered a patient on the UDS. To count as a patient the individual must have received one or more visits that count on Table 5 during the reporting year. The patient count is a head count meaning that each patient counts once and only once regardless of how many visits they have.

Let’s take a look at the first four tables which describe the patients you serve. As I mentioned, in the first of these -- patients by zip code -- you’ll report the total number of patients you serve by where they live and by their primary medical insurance. In the second table -- Table 3A, you will report these same patients by age and gender.

The third patient table -- or Table 3B -- describes your patients by race and ethnicity and finally Table 4 reports your total patients by income, insurance and membership in special populations. Since these tables are all counting the same patients each time you report the total the number must be the same. The last part of table 4 asks how many of your patients are agricultural workers, homeless, school-based, veterans and/or live in public housing.

Please note that the public housing count is new for calendar year 2014. For those of you who received more than one Section 330 funding stream -- that is a community health center, homeless, migrant and/or public housing grant -- you will need to complete an additional copy of Tables 3A, 3B and 4 for each special population grant program for which you receive funding. There is no grant report for the community health center grant.

So for example if you receive a health center and a homeless grant you will report the total number of patients on the universal report and you will report the subset of your patients in your homeless healthcare program on the grant report. As an example a health center reported 1000 total patients on their universal tables 3A, 3B and 4 and of these 1000 patients let's say 200 are in their homeless program.

They will complete a second set of tables 3A, 3B and 4 in the grant report for the 200 patients in the homeless program. Note that the homeless patients are included on the "universal" table and reported again on the grant table. In this way, the Bureau is able to calculate the total number of patients served by all 330-funded programs by totaling the Universal table and the total number of patients in the homeless, agricultural workers, and public housing programs. Also note that since the grant table is a subset of the universal table, it is not possible for any field on the grant table to exceed the number in the same field that is reported on the universal table. In other words you can't report more homeless children with Medicaid than you report total children with Medicaid.

In summary, four tables; patients by zip code, tables 3A, 3B and 4 describe the patients you serve. Your patient profile data has a number of important uses. First this information is helpful for comparing your patient population with census data in your service area to see if you are serving vulnerable populations who are a priority for the bureau. Your patients by zip code data is used to map your service area and is the data used to populate the tool the UDS Mapper.

And finally your total number of patients served is used to calculate many important indicators such as cost per patient. If you are misrepresenting your patient count these indicators will not be correct and you will not be able to

rely on these data for decision making. Before you submit your report you should make sure that your data is complete.

Some simple checks include making sure that you have accounted for the same total number of patients on all patient tables and grant tables and since the grant table is a subset of the total table, no field on the grant table can exceed the number reported in that field on the total or universal table. The EHB will do the validation of the counts across these tables for you!

Now let's take a few minutes to focus on several definitions that are necessary to understand the content for the tables. First, it's important to understand what counts as a visit. Not only must the visit be performed by eligible staff, but additional requirements must be met for a visit to count.

A visit must be face-to-face between a provider and a patient. In general telemedicine and group visits do not count on the UDS. The exception to this rule is for behavioral health including substance abuse and mental health services. Providers must be appropriately licensed and credentialed to generate visits. To count the visit must be documented in the patient's record and the provider must be acting independently and using professional judgment. The list goes on! A few more rules. You can count only one visit per patient per provider type per day. That means that if a patient saw a nurse, an NP, PA or a CNM and a physician for medical care on the same day it only counts as one medical visit.

Similarly, a dental hygienist and dentist seeing the patient counts as just one dental visit. The exception to this rule is if a patient sees two different providers in two different locations such as a nurse in a homeless shelter and a physician in a clinic. In this case she would count two medical visits for the same patient on the same day.

Note that the rule says one visit per patient per provider type per day
The same patient can be seen by multiple provider types and credited with a visit for each. So the same patient could have a medical, dental, mental health, substance abuse and nutrition visit all on the same day and would be credited with one visit for each service. The next rule says that you can only count one visit per provider, per patient, per day. What this rule says is that a physician who does a medical exam provides a brief mental health intervention and oral screening is providing a comprehensive medical visit you cannot count this as a medical, dental and mental health visit. Be sure to count all paid referral visits and account visits provided by staff regardless of whether they are salaried, contracted or volunteer.

We covered what counts now let's be specific about what doesn't count per visit. There are certain visits that never count on the UDS. These include contacts that only include an immunization, a lab test, dental varnishing or fluoride treatments, mass screenings, health fairs, outreach visits and pharmacy visits. Group health education visits also aren't counted. Remember, not all staff report visits either. Staff who cannot generate visits include medical assistants, lab and x-ray, transportation, interpretation, eligibility, and non-clinical support staff.

A third definition that is important for reporting correctly is full-time equivalent or FTE. Table 5 asks you to report your full-time equivalent staff. So, who and how do you count FTEs? A full-time equivalent is a person who works full-time for the entire year at your health center. This includes all staff who contribute to the operation of your organization regardless of whether you pay them. You should include employees as well as contracted staff, residents and volunteers as staff on Table 5.

Because there is no way to count paid referral providers who see your patients at their place of business they are excluded. As I said a full-time equivalent is a person who works full-time for the entire year. If staff work less than full-time or part-year you need to prorate their time to calculate their FTE. Be careful to remember that you cannot use your staffing list as of December 31 to complete Table 5 since your staff list at that time only tells you who was working the last day of the year.

You need to look at payroll records for the entire year actually to identify all staff who worked and how many hours they worked. For volunteer staff you need to refer to volunteer records for hours worked. Another important staffing definition is tenure. Table 5A asks you to report a head count of personnel. So who and how do you count tenure? Tenure is the head count of persons as of December 31 of consecutive months in their current position.

You will use your staffing list as of December 31 to complete Table 5A. Full and part-time staff will be reported separately from other service providers. Also be sure to include persons who have a regular working schedule even if they are off on the day of the census but do not include individuals who do not have a regular work schedule.

Now, let’s take a look at the two tables that include the definitions just went over. These tables describe your staff and utilization. Table 5 reports your staff full-time equivalents, patient visits, and patients by service. This report is also completed for each additional funding stream. However only visits and patients are reported not staff for each grant program. It looks simple but it has a number of data inputs that cross-relate to other tables reported please pay careful attention to avoid errors and always consult the manual and the other supports that we were talking about for help when you need it.

The second staffing table. Table 5A describes the number of individuals and the number of consecutive months these selected staff have worked at your organization in their current position. This table is split by employed staff in Columns A and B and those under other service provider arrangements in Columns C and D. Staff tenure is reported for most clinical staff and health center leadership including the CEO, CFO, CMO and CIO.

In summary, Tables 5 and 5A describe the staff it takes to serve your patients, the volume of services provided, the number of patients seen by type of service and the tenure of your staff. Data reported on Table 5 is used to calculate many efficiency indicators such as staffing levels, visits per provider, patients per provider and cost per visit.

Again if you are underestimating or overestimating your patients and visits calculated indicators will not be correct and you will not be able to rely on this data for decision making. The tenure table is used to evaluate continuity of staffing which is important for patient satisfaction and practice stability. Before you submit your report make sure that your data is complete.
Some simple checks include checking to be sure that total patients on Tables 3A, 3B and 4 make sense relative to the number of patients recorded by service on Table 5. Similarly staff full-time equivalents on Table 5 should relate to costs reported on the cost table, Table 8A and visits on Table 5 should relate to charges reported on the patient revenue table or Table 9D.

A couple more quick mentions before we turn to Laura for the clinical profiles tables: be careful with the important differences in reporting head count on Table 5A versus FTE on Table 5. Remember to report cumulative months employed on Table 5A, which may exceed 12 months. And, finally, since the grant table is a subset of the total table, no field on the grant table can exceed

the number reported in that field on the total table. Laura will now cover the next set of tables.

Laura Makaroff: Hello this is Laura Makaroff. I'm having a hard time hearing some of the things. I'm hoping you all can hear me okay. As Alek mentioned I'm Laura Makaroff, I'm the Senior Clinical Advisor in the Bureau of Primary Healthcare and I'm here today to talk with you a little bit about the clinical tables in the UDS. I work closely with Alek and the UDS team on the clinical aspects of the UDS. So this will be just a brief introduction to Tables 6A, 6B and 7 and we'll also talk a little bit about the EHR questions and the quality recognition questions that are a part of the UDS. Can someone please advance to the next slide for me?

Great, thank you. Excuse me, hold on one second. We're having all kinds of Internet problems here today. Okay, so Table 6A reports visits and patients for selected diagnosis and services. For those of you with multiple funding streams you will complete a copy of this table for each special population. And remember look-a-like health centers will report this table on Table 6A for the first time this year.

You can also note in Table 6A that there is a new line in the table which asks the health centers to report the number of patients that are newly-diagnosed with HIV. So most of table 6A as you can see on the slide is a count of ICD9 codes both by number of visits by diagnosis and by number of patients with a diagnosis.

The line for the newly-diagnosed HIV patients will be further described in the UDS manual and I encourage you to take a look at that as you begin filling out this table. So the next slide; Table 6B which is slide 31. Table 6B and 7 describe on the quality of care provided to patients through process and

outcome measures. Table 6B reports 12 process measures as indicators of good quality care. So these routine and preventive clinical measures are called process measures because they reflect the service you provide to your patients. Process measures are a proxy for quality of care because we know that patients who receive timely routine chronic disease management and preventive services are more likely to have better health outcomes as a result of these services. For example if a child receives all child immunizations in a timely manner then the child is less likely to develop a vaccine-preventable disease and will stay healthy.

Similarly if a woman receives timely pap tests and cancer is detected she can be treated earlier and will be less likely to suffer adverse outcomes from HPV infection or cervical cancer. Please also note that in this table Table 6B that there are two new measures to be reported in calendar year 2014. Those two new measures are depression screening and follow-up and HIV linkage to care.

Also note that all health centers who provide prenatal care or refer for prenatal care are to report on the prenatal and perinatal outcome activities. These definitions will be further described at the upcoming in-person trainings and the clinical measures webinar next week. Also the UDS manual will have detailed instructions on how to fill these parts out. So next slide, Table 7.

So Table 7 reports health outcomes by race and ethnicity as shown on this slide. These clinical measures are called intermediate outcome measures because they are not the ultimate outcome which is a long, healthy life but they are a quantifiable outcome which is predictive of a good long-term prognosis. Specifically Table 7 reports on three outcome measures, low birth weight, blood pressure control for those with hypertension and diabetes control.

By choosing a good outcome of normal birth weight, controlled high blood pressure or diabetes control the risk of negative health outcomes is reduced. For example a patient with blood pressure well controlled is less likely to have cardiovascular damage, a heart attack or a stroke. Similarly a patient with diabetes control is less likely to develop organ damage or other complications of poorly controlled diabetes.

So the next slide in addition to the three clinical tables you will also answer some questions regarding your HIT capabilities and quality recognition when you complete your UDS reports. The questions in this part of the UDS include question on the implementation of EHR in your health center, the certification of your HIT system, how widely adopted the system is throughout the health center and its providers and any national or state quality recognition such as accreditation or patients that earn medical home recognition that your center may have.

Next slide. For all of the clinical measures you will be required to identify the universe of patients who meet the reporting criteria. You will need to attend the day-long training sessions and listen to the clinical measures and sampling webinars or refer to the manual for information on the reporting criteria for each of the clinical measures. For each of the clinical measures except the prenatal measures you will have the option of reporting on the universe of your patients or a sample of 70 patients who meet the reporting criteria.

It is important to understand that this is a random sample of 70 patients for each measure. It is not 70 patients per clinic location or per provider. It is a total of 70 patients for each measure you are reporting on as a sample. Again more detailed instruction and examples of how to do this will be presented in

the follow-up webinars that are planned as well as the in-person training sessions.

The third step in this process is to review the universe or the sample of 70 charts to determine how many patients meet the measure definition. Again you'll refer to the manual or the day-long training for details on what each measure definition is. For each measure your level of performance is calculated as the number of records that meet the measurement standard divided by the total number of records reviewed.

For example if you review 70 random charts and determine that 50 have met the measurement definition the rate is 50 divided by 70 or 71% of patient records have met the measurement standard. Moving on to the next slide, in summary, there are three clinical tables within the UDS that describe the services you provide and the quality of care provided to the patients served.

The clinical data submitted helps us and the bureau to identify trends in clinical performance among health centers and should also serve to help inform your quality improvement activities within your own health center. Remember before you submit your report make sure that your data is complete and accurate. Some simple checks include checking to see if the universes you report are reasonable compared with your patient population looking at age, gender or race.

In other words you should question when your data reports more women in the universe for a pap test than total women served or if only half the women were included in the universe count. Remember the patient universe count is all patients who meet the criteria and the number who meet the measurement standard should be some portion of that total.

So now I'll hand it back to Terri to continue on speaking about the financial tables. Thank you.

Terri Tobin: Thank you Laura and thanks everyone for sticking with us. The last category of tables is the financial profile which is comprised of three tables that describe the costs to operate your program and your sources of income.

Table 8A reports accrued cost by cost center. Note that the categories of costs are the same as the categories for staff FTEs on Tables 5 in completing tables 5 and 8A you must consistently report FTEs and personnel costs in the same categories. For example if you reported Sam Smith as an outreach worker on Table 5 you must report his personnel costs on the outreach line on Table 8A.

Table 9D reports all patient-related income on a cash basis. For each payer class Medicaid, Medicare, other public and private or commercial insurance you will report total gross charges, cash collections, FQHC reconciliation payments and allowances for calendar year 2014. For self-paid patients you will report gross charges, cash collection, sliding fee discounts and any self-paid bad debt.

As a reminder this table is now completed in its entirety by look-a-likes. The last table Table 9E reports non-patient-related income including grants, contracts and other income. Since total income is calculated by adding the income reported on Tables 9D and 9E you should not report anything on both tables.

This is also a cash table so you should report the amount you received or drew down in grants and contracts during the reporting year, not the total grant award. Also this table uses the last party rule which means that you report the last party to have the funds before you received them. If federal funds were

given to the state and then to you from the state then you would report the money as state funds.

If it goes from the state and then to the county and then to you, you would include it as county money. In summary, the financial tables provide a picture of your financial viability in terms of diversification of funding and cash flow. Before you submit your report again make sure that your data is complete. Some simple checks for these include checking total costs on Table 8A compared with the sum of income reported on Tables 9D and 9E to see if you are reporting a cash surplus or deficit. For example if you were reporting $5 million in costs and $2 million in revenues you should be able to confirm a serious cash flow problem.

If this is not consistent with your expectations please review your data before submitting. Similarly charges reported on Table 9B should reflect your payer mix reported on Table 4 and your visit volume reported on Table 5. Of course this would not be perfectly true since Table 8A is an accrual table while Tables 9D and 9E are cash tables. And you will not be able to compare the charges and collections from uninsured persons with the number of such persons since copayments and deductibles will be reported in the self-pay category on Table 9D, but patients will show as insured on Table 4.

It’s also important to ensure that the charges which are not accepted by a payer in which need to be reclassified to another payer including deductibles and co-insurance of patients are adjusted and then transferred to the proper payer category.

Now let’s cover some strategies and reminders for successful reporting. This webinar is intended to give you a high-level overview and introduction to the tables and to key issues related to reporting correctly.

Clearly we can't cover all of the content that's included in a day-long training in this two-hour webinar so please just remember that it is important that you attend the day-long in-person training for more detailed step-by-step instructions. Hopefully this review has reinforced the idea that all of the tables are interrelated. That's a key take-away!

For most organizations, multiple people are involved in completing the tables including IT, finance and clinical staff. In order to successfully complete your report, you must work as a team to complete the various sections. You cannot hope to submit a consistent and accurate report if your clinical, administrative, and financial staff do not work collaboratively to complete the report.

Please remember also that there are a number of different resources to assist you with accurate reporting including the detailed manual other webinars, some coming up next week, fact sheets, e-learning modules and individual assistance via the help line and your reviewer.

Use these resources to help you with your reporting. It will end up saving you and your team time and effort. Finally take the time to review your report before you submit it. Be sure to address all edits that flag in the EHB with thoughtful explanations. Comments like, the data is correct just because it came from your system are really not sufficient and remember the very true saying garbage in garbage out. Often the true test of understanding of your data is whether the data is consistent with your expectations and if you can explain it to your reviewer who is looking at it with fresh eyes.

Thank you for staying with us for that introduction. At this time we would like to open the phones to any questions you may have.

Coordinator: Thank you. If you would like to ask a question from the phone lines please press Star 1. You will be prompted to unmute your phone and record your name. Your name is required to introduce your question. Again it's Star 1 to ask a question. One moment please for the first question.

Okay and we do have one question in queue. One moment please. Okay and our first question comes from Pat Linton. Sir your line is open.

Pat Linton: Yes, hi my name is Pat. Question: Is the 2014 UDS manual complete and available and if not when you do think that'll be available.

Alek Sripipatana: Diane, you probably have the best grasp of the schedule right now. Can you take that?

Diane Lewis: Sure. So the manual is in current draft format and is going through OMB approval at this point. It is the hope that by the end of the month or early in November that the final manual will be available but that being said also as you attend your in-person trainings that are coming up mainly starting in November, there may be one late in October, a draft manual would be provided but we do sort of caution that the draft manual is only a draft and it would be replaced by what is finalized and like I said hopefully by early November that will be available.

Pat Linton: All right, thank you.

Coordinator: Thank you and there are no other questions in queue at this time.

Terri Tobin: I'll just wait a couple more seconds to see if there are any other questions and then we can wrap up.

Laura Makaroff: I did want to mention that the information will be available through the link that's included on the sidebar and the PowerPoint can also be downloaded. I know there were some technical difficulties in terms of the audio so that information at least for the visual is available and also the in-person trainings and other resources should be able to supplement what might not have been heard during this presentation and certainly the support lines are available for any specific questions that you have.

Terri Tobin: Thank you again and good luck with your UDS report. Remember that we are here to help you—please access the resources we've mentioned and contact the Helpline by email at UDSHelp330@BPHCDATA.NET or by phone at 866-UDS-HELP (866-837-4357). Thank You

Coordinator: Thank you that concludes today's conference. Thank you for your participation you may disconnect at this time.

END