# UNIFORM DATA SYSTEM

## Reporting Instructions for 2016 Health Center Data

HRSA Health Center Program

# UNIFORM DATA SYSTEM REPORTING INSTRUCTIONS

## For use to submit Calendar Year 2016 UDS Data

Bureau of Primary Health Care

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

Health Resources and Services Administration

Bureau of Primary Health Care

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# 2016 Uniform Data System Manual Contents

# Introduction

This manual describes the annual Uniform Data System (UDS) reporting requirements for all health centers that receive federal award funds ("grantees") under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as Health Center Program look-alikes ("look-alikes"). Look-alikes do not receive federal funding under section 330 of the PHS Act but must meet the Health Center Program requirements for designation under the program (42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii)) Certain health centers funded under the Health Resources and Service Administration's (HRSAs) Bureau of Health Workforce (BHW) also are required to complete annual UDS reporting.

Detailed table-specific instructions follow and include a set of table-specific 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. Four appendices are included:

- A list of personnel by category and identification of personnel by job title who may be able to produce countable "visits" for the purpose of the UDS;
- A set of tables that describe how to address specific issues that affect multiple tables;
- Sampling methodologies for selecting patient charts for clinical reviews; and

- Reporting instructions for the Health Center Health Information Technology (HIT) Capabilities and Quality Recognition form.

## About UDS

The UDS is a standardized reported data set that provides consistent information about health centers. It is a core set of information, including patient demographics, services provided, clinical processes and outcomes, patient's use of services, costs, and revenues appropriate for documenting the operation and performance of health centers. Much of these data and related analyses, are routinely reported back to the health centers in HRSA's Electronic Handbook (EHB) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website at http://bphc.hrsa.gov/datareporting/index.html.

A small number of health centers may have "dual status" by having both Health Center Program grantee sites and look-alike sites (or Health Center Program grantee sites and BHW sites). Dual status

occurs when a health center receives Health Center Program grant funding for sites in the grant's approved scope of project and, at the same time, operates at least one other site under the scope of project of a look-alike (or BHW) designation. These sites are required to have separate scopes of project. These "dual status" health centers will complete both a grantee UDS Report and a look-alike (or BHW) UDS Report, covering the approved scope of each separately. Health Center Program grant funds are not permitted to be used to operate sites and services included in the look-alike (or BHW) scope of project, however, some costs — especially of corporate executives and other non-clinical support staff, their space, etc. — may need to be allocated between the two 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 (or BHW) sites.

*NOTE: In this document, unless otherwise noted, the term "health center" is used all inclusively to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended (also referred to as "grantees"), look-like organizations, which are recognized by BPHC as meeting all the Health Center Program requirements but do not receive Health Center Program grants, and primary care clinics funded under the BHW which receive funding through other HRSA funding streams. Some health centers may also be sponsored by tribal or Urban Indian Health Organizations supported by the HRSA programs referenced above or by other federal state or local government programs.*

# General Instructions

## What is Submitted

The UDS is comprised of 12 tables and one form designed to yield consistent clinical, operational, and financial data. Health centers must complete each:

- Patient Origin: Patients served reported by ZIP code and by primary third party medical insurance source, if any
- Table 3A: Patients by age and gender
- Table 3B: Patients by race, Hispanic/Latino ethnicity, language barriers, sexual orientation and gender identity
- Table 4: Patients by income (percentage of Federal Poverty Guideline) and primary third-party medical insurance source; the number of "special population" patients receiving services; and managed care enrollment
- Table 5: The annualized full-time equivalent of program staff by position; visits by provider type; and patients by service type
- Table 5A: Tenure for selected health center staff
- Table 6A: Selected diagnoses for medical, mental health, and substance abuse visits; and selected medical, mental health, substance abuse, vision, and dental services provided
- Table 6B: Clinical quality of care measures
- Table 7: Health outcomes measures by race and ethnicity
- Table 8A: Direct and indirect expenses by service categories with costs
- Table 9D: Full charges, collections, and allowances by payer type as well as sliding discounts and patient debt written off
- Table 9E: Other, non-patient service income
- Healthy Information Technology (HIT) Capabilities and Quality Recognition: Quality recognition and health information technology (HIT) capabilities, including the system exchange, use of electronic health record (EHR) information, telehealth, and medication-assisted treatment

  Note: Look-alikes and BHW primary care clinics are to follow all the same reporting requirements that are provided in this manual for Health Center Program funded grantees. In some cases, the reporting cell details of special populations and receipt of a BPHC grant will be visible on some forms, but be grayed out and data may not be entered by look-alikes and BHW primary care clinics.

## Which Report(s) to File

The UDS includes two components, which are submitted by health centers through the EHB:

- The **Universal Report**, which is *completed by all reporting health centers*. The Universal Report consists of each of the UDS tables and the HIT form and provides data on patients, services, staffing, and financing *for the entire scope across the grant/designation*. It is the source of

unduplicated health center data for the reporting year within the scope of project supported by the grant/designation. If a health center had services or sites that were brought into scope during the calendar year, data for these sites and services are to be included for the full year, not just for the period after the date of the scope change.

- The **Grant Reports**, are *completed by Health Center Program grantees that receive section 330 grants under multiple program funding authorities (i.e., sections 330(g), (h), and (i))*. Only Health Center Program grantees with multiple funding authorities complete Grant Reports. The Grant Report consists of one or more additional copies of Tables 3A, 3B, 4, 6A, and part of Table 5. The Grant Reports provide data comparable to the Universal Report, but for only that portion of the program that falls within the scope of a project *funded under a particular funding authority*. Separate Grant Reports are required for each funding authority when grantees receive grant support under the Migrant Health Center (330(g)) program, Health Care for the Homeless (330(h)) program, and/or Public Housing Primary Care (330(i)) program, *unless* a grantee is funded under one and only one of these program authorities. No Grant Report is submitted for the scope of project supported under the Community Health Center (330(e)) program.

Because a patient can receive services through more than one BPHC funding authority and not all grants are reported separately, totals from a health center's multiple Grant Reports cannot be aggregated to generate any meaningful total. Generally, the number of patients in Grant Reports will not equal the total on the Universal Report. 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.*

If a patient has been identified as a recipient of a *sections 330(g), (h), or (i)* funding authority, *all the data for that patient are reported on the tables for that Grant Report.* Thus, if a patient who is homeless is seen in the homeless medical van for medical services, all their dental services and diagnoses will be counted on Tables 5 and 6A, even if the dental program is not specifically funded with BPHC section 330(h) funds or identified in the budget for the homeless program.

**Health centers that receive funds under only one BPHC funding authority are required to complete only the Universal Report and do not submit Grant Reports. Health centers 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 Community Health Center (CHC) grantee (section 330(e)) that also has Health Care for the Homeless (HCH) funding (section 330(h)) completes a Universal Report and a Homeless Grant Report, but does not complete a Grant Report for the CHC funding.
- A CHC grantee (section 330(e)) that also has Migrant Health Center (MHC) (section 330(g)) and HCH (section 330(h)) funding completes a Universal Report, a Grant Report for the Homeless program, and a Grant Report for the Migrant program.
- A HCH grantee (section 330(h)) that also receives Public Housing Primary Care (PHPC) (section 330(i)) funding completes a Universal Report and two Grant Reports—one for Homeless and one for Public Housing.
- A HCH grantee (section 330(h)) that receives no other Health Center Program funding will file only a Universal Report, and will not file a Grant Report.

*NOTE: The EHB reporting system will automatically identify the reports that must be filed and prompt the health center if some or all of the Universal Report or Grant Report is left blank. Conversely, if a health center is not required to submit a specific Grant Report that report will not appear in the EHB for completion. Apparent errors in reports shown should be communicated to the* ***UDS Support Center at 866-UDS-HELP or udshelp330@bphcdata.net****.*

## Tables Shown in Each Report

The table below indicates which tables are included in the Universal Report and Grant Reports.

| Table | Data Reported | Universal Report | Grant Reports |
|---|---|---|---|
| Service Area | | | |
| ZIP Code Table | Patients by ZIP Code by Health Insurance | X | Not reported for grant reports |
| Patient Profile | | | |
| Table 3A | Patients by Age and by Sex | X | X |
| Table 3B | Patients by Hispanic/Latino Ethnicity and Race; Patients best served in a language other than English; Patients by Sexual Orientation; and Patients by Gender Identity | 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 | Not included in grant reports |
| Clinical | | | |
| Table 6A | Selected Diagnoses and Services | X | X |
| Table 6B | Quality of Care Measures | X | Not included in grant reports |
| Table 7 | Health Outcomes by Race and Ethnicity | X | Not included in grant reports |
| Financial | | | |
| Table 8A | Costs | X | Not included in grant reports |
| Table 9D | Patient-related Charges, Collections, and Adjustments | X | Not included in grant reports |
| Table 9E | Other Income | X | Not included in grant reports |
| Other Form | | | |
| HIT Form | HIT Capabilities and Quality Recognition | X | Not included in grant reports |

## Calendar Year Reporting Period

The UDS report is a calendar year report. Health centers must report on the entire calendar year. This is true even for health centers whose designation or funding begins, either in whole or in part, after the beginning of the calendar year, or whose designation or funding is terminated, again either in whole or in part, before the end of the calendar year. Similarly, health centers with a fiscal year or grant period other than January 1 to December 31 will still report on the calendar year, not on their fiscal year. (Health centers designated or funded for the first time during the calendar year and those that were terminated during the year should discuss any issues with calendar year reporting with their assigned UDS Reviewer.)

All health centers that were funded or designated in whole or in part before October 1 are required to report even if they did not draw down any grant funds during the calendar year. Health centers that are funded or designated for the first time on or after October 1, are not required to submit a 2016 UDS report and will not have access to the reporting in the EHB.


## In Scope Reporting

All reporting health centers must submit data for all activities that are considered "in scope," as defined in the health center's notice of award/designation.

*Note: New Access Points (NAPs) awarded to new entities after October 1 ("New Starts") will not report. An existing health center receiving NAP funding for an additional site or expansion after October 1 report all activity for that site during the year in addition to any activity which may have occurred at other sites within scope prior to the date of NAP funding.*

Health centers that had a look-alike designation only, and one or more look-alike site(s) received NAP funding prior to October, must exclude the data related to the NAP site(s) from the look-alike UDS report for 2016 AND report the data related to the NAP site(s) in the grantee UDS report for 2016.

## Due Dates and Revisions to Reports

The time period for submission of UDS Reports is January 1 through ***February 15***.

Between February 15 and March 31, health centers work with a UDS reviewer. The UDS reviewer is a HRSA-representative who works with reporting health centers to identify and correct potential data errors. Final, corrected submissions are due by March 31. Changes identified after this date are not accepted.

Under extenuating circumstances (e.g., the physical destruction of the health center) an exemption to the submission requirement may be granted. Health centers must request such exemptions directly from the BPHC Office of Quality Improvement through the UDS Support Center.

To request assistance at any time, please contact the UDS Support Center at *1-866-UDS-HELP* or *udshelp330@bphcdata.net*.

## How and Where to Submit Data

UDS data are reported through an online process using a web-based data collection system that is a part of the HRSA Electronic Handbooks (EHBs). Health center staff will utilize their EHB user name and password to log into the EHB at https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to complete and submit their UDS Report(s). Health center staff with EHB access is able to submit the UDS Report using standard Web browsers[1]. The system provides electronic forms that will guide health center staff in completing their reports.

Health center staff with EHB access can 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 is not submitted until the health center takes this final action. This is usually performed by the chief executive officer (CEO)/Project Director at the health center but the authority may be delegated to another party. Official UDS submission carries with it the acknowledgement that the health center has reviewed and verified the accuracy and validity of the data. Health centers may distribute the data entry responsibilities to multiple individuals, each using his/her own login and password credentials. However, one individual must be designated as the UDS Contact. Her/his name is entered into a field in the report and they become the recipient of all communications about the UDS Report. This point of contact is expected to explain all the tables during the review process. Health center staff may be assigned either "view" or "edit" privileges; however, these privileges are for the entire UDS, not just specific tables.

The EHB will check for potential inconsistencies or questionable data to ensure accuracy. Incomplete reports must not be filed. The EHB will provide a summary of which tables are complete, as well as a list of audit questions that must be reviewed. Audit questions are general and may not apply to some health centers' unique circumstances. Data audit findings must be addressed or, if the submitter thinks there is no error in the data reported, the accuracy of the data must be clearly explained. This includes details about the unique circumstances.

1 While most browsers should work with the EHB, it is certified to work with Internet Explorer (IE) Version 8.0 through 11.0 or Firefox 3.6 or higher. Health centers having a problem with other browsers should consider using IE-8, 9, 10, or 11 or Firefox 3.6 for this task. More information about EHB's Recommended Settings are available at https://grants.hrsa.gov/2010/WebEPSExternal/Interface/Common/BrowserSettingsExt.aspx?IsPopUp=false.

# Definitions of Visits, Providers, and Patients

## Visits

Visits are used to determine who is counted as a patient on the ZIP Code Table, Tables 3A, 3B, 4, 5, 6A, 6B, and 7; to report visits by type of provider on Table 5; and to report visits where selected diagnoses were made or where selected services were provided on Table 6A.

To be counted as having met the visit criteria, the interaction must be documented, face-to-face contact between a patient and a licensed or credentialed provider who exercises independent, professional judgment in the provision of services to the patient. Each element of these criteria must be satisfied.

To count visits, the services rendered must be documented in a chart in the possession of the health center (see further details below). Health center staff must be considered a provider for purposes of providing countable visits. Please note: Not all health center staff who interact with patients qualify. 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 that are provided by contractors and **paid for by the health center** are considered to be visits to be counted in the UDS to the extent that they meet all other criteria. These include Migrant Voucher visits or outpatient or inpatient specialty care associated with an at-risk managed care contract. In these instances, if the visit is not documented in the patient's medical record, a summary of the visit (rather than the complete record) must appear in the patient's medical record, including all appropriate CPT and ICD-10-CM codes, in order to ensure that the HIT, including EHR, can be used by the health center for reporting in the UDS.

Definitions and criteria for defining and reporting visits are included below. Table 5 provides further clarifications to these definitions. See page 65.

### Documentation

To meet the criterion for **documentation**, the service (and associated patient information) must be recorded in written or electronic form in a system that permits ready retrieval of current data for the patient. The patient record does not have to be a 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 may not be complete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary note upon discharge indicating activities for each of the dates for which a visit is claimed.

### Independent Professional Judgment

To meet the criterion for **independent professional judgment**, the provider must be acting on his/her own when serving the patient and not assisting another provider.

Independent judgment implies the use of the professional skills gained through formal training and experience 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.

For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history or drawing a blood sample *is not* credited with a separate visit. Eligible medical visits usually involve one of the "Evaluation and Management" billing codes (99201–05 or 99211–15) or one of the health maintenance codes (99381-87, 99391-97).

### Behavioral Health Group Visits

When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously in a group, 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.

Examples of "**group visits**" include family therapy or counseling sessions, and group mental health counseling and group substance abuse counseling during which several people receive services and the services are noted in each person's health record.

Other Considerations:

- Each patient is normally billed for the service (though the cost may be covered by another grant or contract).
- If only one person is billed (for example, where a relative participates in a counseling session for a patient), only the patient who is billed is counted as a patient and only that patient's visit is counted.
- When a behavioral health provider conducts services via telemedicine/telehealth, the provider can be credited with a visit only if the service is noted in the patient's record. The session will normally be billed to the patient or a third party.
- Medical visits must be provided on an individual basis in order to be counted in the UDS.

### Location of Services Provided

A visit must 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 that may be approved include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Visits at these sites count when they occur on a regularly scheduled basis and the site *is* an approved site within the scope of the health center's grant/designation.

Other Considerations:

- Visits also include contacts with existing patients who are hospitalized, where health center medical staff 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 health center for these services and the patient is billed either for the specific service or through a global fee.
- A reporting health center 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's first encounter is in a hospital, respite care, or a similar facility, *which is not specifically approved as a service delivery site under the scope of the grant/designation by BPHC*, none of the services for that patient are reported on the UDS.

### Counting Multiple Visits by Category of Service

**Multiple visits** occur when a patient has more than

one visit at the health center in a day. The number of visits per service delivery location per day is limited in UDS reporting as follows. On any given day a patient may have, at a maximum one visit per service category, as described below:

| Maximum Number of Visits per Patient per Day | | |
|---|---|---|
| # of Visits | Visit Type | Provider Examples |
| 1 | Medical | physician, nurse practitioner, physician assistant, certified nurse midwife, nurse |
| 1 | Dental | dentist, dental hygienist, dental therapist |
| 1 | Mental Health | psychiatrist, licensed clinical psychologist, licensed clinical social worker, other mental health providers |
| 1 | Substance Abuse | alcohol and substance abuse specialist, psychologist, social worker |
| 1 for each provider type | Other Professional | nutritionist, podiatrist, speech therapist, acupuncturist |
| 1 | Vision | ophthalmologist, optometrist |
| 1 for each provider type | Enabling | case manager, health educator |

Other Considerations:

- If multiple medical providers deliver multiple services on a single day (e.g., an Obstetrician/ Gynecologist [Ob/Gyn] who provides prenatal care to a patient and an Internist who treats that same patient's hypertension) only one of these visits may be counted on the UDS, even if some third party payers may recognize these services as separate billable services.
- An exception to this rule of 'a patient may only have a maximum of one visit per service category per day', 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., in parks or migrant camps), by non-physician medical providers, to be seen later in the same day at the health center's fixed clinic site by a different, generally higher-level, provider.
- A provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they are provided.

## Patient

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

The **Universal Report** includes all patients who had at least one visit during the year that is within the scope of activities supported by the grant/ designation.

- These patients and their visits are reported on Tables 5 and 6A for each type of service (e.g., medical, dental, enabling) received during the year.
- On the ZIP Code Table, Tables 3A and 3B, and in each section of Tables 4 and 6A , each patient may

be counted once and only once, even if she or he received more than one type of service (e.g., medical, dental, enabling) or received services supported by more than one program authority (i.e., section 330(g), section 330(h), section 330(i)).

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 section 330 program authority. 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 cell of the Universal Report.

During the course of addressing the health care needs of the community, health centers see many individuals who are not reportable as patients on the UDS Report 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 health center, whether or not documentation is done on an individual basis.

**Services and Persons Not Reported on the UDS Report**

There are a number of services that health centers provide that, while important, ***do not constitute a visit for purposes of UDS reporting***, regardless of the level of documentation or the level or quantity of supportive services that attend such services.

Similarly, an individual whose only contact is through one of these services described below ***is not considered a patient for purposes of UDS reporting***.

These exceptions include:

### Health screenings

- Screenings frequently occur as part of community meetings or group sessions that involve conducting outreach and/or group education, but are *not* designed to provide clinical services
- Examples of health screenings include information sessions for prospective patients; health presentations to community groups, information presentations about available health services at the center; services conducted at health fairs or at schools; immunization drives; services provided en masse to groups, such as dental varnishes or sealants provided at schools; or similar public health efforts

### Group visits

- Visits conducted in a group setting, except for behavioral health group visits
- Examples of non-behavioral health group visits include patient education or health education classes (e.g., people with diabetes learning about nutrition)

### Tests and other ancillary services

- Tests are provided to support the services of the clinical programs
- Examples of tests include laboratory (including purified protein derivatives (PPDs), pregnancy tests, Hemoglobin A1c tests, blood pressure tests) and imaging (including sonography, radiology, mammography, retinography, or computerized axial tomography)
- Services required to perform such tests, such as drawing blood or collecting urine

### Dispensing or administering medications

- Dispensing medications, including dispensing, from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as Buprenorphine or Coumadin)
- Giving any injection (including vaccines, allergy shots, and family planning methods) regardless of education provided at the same time

- Providing narcotic agonists or antagonists or mixes of these, regardless of whether or not the patient is assessed at the time of the dispensing and regardless of whether these medications are dispensed on a regular basis, such as daily or weekly

### Telemedicine

- Telemedicine/telehealth, except for behavioral health telemedicine

### Health status checks

- Follow-up tests or checks (such as patients returning for HbA1c tests or blood pressure checks)
- Wound care (which are following up to the original primary care visit)
- Taking health histories
- Making referrals for or following up on external referrals

### Services under the Women, Infants, and Children (WIC) program

- An individual whose only contact with a health center is to receive services under a WIC program

## Provider

A provider is defined as an 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 for services rendered to the patient during a visit.
- Only one provider who exercises independent judgment can be 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 physician [FP] and a pediatrician both see a child or an Obstetricians/Gynecologists [ObGyn] and an FP both see a pregnant woman for different purposes) only one provider may be credited with a visit.
    - In cases where a preceptor is following and supervising a licensed resident, credit would be given to the resident *(see Table 5 for further instruction on counting interns and residents)*.
- When health center staff are following a patient in the hospital, the primary center staff person in attendance during the visit is the provider credited with a visit, even if other staff from the health center and/or hospital are present.
- With the exception of physicians, staff time should be allocated by function among the major

service categories based on time dedicated to other roles or functions (e.g., a nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split the 1.0 full-time equivalent (FTE) between a medical nurse and health educator).

- Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate visits for purposes of UDS reporting.
- Table 5 provides further clarifications to these definitions. See page 65.
- Providers may be employees of the health center, contracted staff, or volunteers.
- Contract providers, who are part of the scope of the approved grant/designation, are paid by the health 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 these criteria.)
- 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 or BHW grant (e.g., under a Migrant Voucher program or homeless grantees with sub-grantees) or designation are considered providers and their activities are to be reported by the direct recipient of the BPHC or BHW grant/designation. Since such providers often have no time basis in their report, no FTE would be reported for them if time data is not collected.
- Providers who volunteer to serve patients at the health center'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.
- Individuals or groups who provide services under agreement or contract where the health center does not pay for the visit are not credited as providing a health center visit, regardless of whether or not they provide discharge summaries or report the service in the patient's medical chart, unless they are working at an approved site under the supervision of the and credentialed by the health center. *Note: These providers are generally noted in column III of the grant application Form 5A. An example of Form 5A is accessible at http://bphc.hrsa.gov/programrequirements/scope.html.*

# Instructions for ZIP Code Data

The ZIP Code Table provides demographic data on patients in the program, cross tabulating location (ZIP Code) by primary medical insurance status.

## Patients by ZIP Code

All health centers must report the number of patients served by ZIP code. This information enables BPHC to better identify areas served by health centers and potential service area overlap. Although patients may be mobile during the reporting period, health centers will report patients as of the most recent (last) ZIP code on file.

The goal is to identify residence by ZIP code for all patients served, but it is understood that residence information may not be available for some patients. This is particularly true for health centers that serve transient groups. Special instructions cover the following groups:

- **Homeless Patients:** Although many patients who are homeless live doubled up or in shelters, transitional housing, or other locations *for which a ZIP code must be obtained*, others—especially those living on the street—do not know or will not share an exact location. When a ZIP code location cannot be obtained, or the location offered is questionable, health centers 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 in a mobile van, the ZIP code of the location where the van was parked that day should be used. Health centers might collect the address of a contact person to facilitate communication with the patient; however, while appropriate from a clinical and service delivery perspective, this contact address *is not to be used* as the address for the patient.
- **Migratory Agricultural Worker Patients:** Migratory agricultural workers may have both a temporary address that reflects where they live when they are working in the community, as well as a permanent or "downstream" address that may be far from the location of their current work and the site where they are receiving care. *For the purpose of the UDS report*, health centers are to report the ZIP code of where the patient was housed when they received care by the health center. Note that migratory agricultural worker patients may *also* be seen by health center providers in their home, or "downstream" community and will still be considered migratory agricultural workers. For patients where a precise ZIP code is unavailable (e.g., living in cars or on the land), the ZIP code for the location (fixed site or mobile camp outreach) where they received services should be used.
- **Foreign Nationals:** Persons from other countries who are residing in the United States either permanently or temporarily are to be reported with their current US ZIP code. Tourists and other persons that may have a permanent residence outside the country, are to be reported under other ZIP code."

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 health centers are expected to report residence by ZIP code for all patients, some health centers may draw a significant number of patients from a large number of ZIP codes outside of their service area. To ease the burden of reporting, *ZIP codes with **ten or fewer** patients may be aggregated and reported in the "other" category.*

## Source of Insurance

**Medical insurance status must be obtained for all persons included as patients by the health center regardless of what services are provided**. This means that individuals who only receive case management services, for example, must be queried as to their current medical insurance. Health centers may not report patients as uninsured, because they are receiving a service that is not covered by health insurance. Children served in school-based health center settings must have complete clinic intake forms that show insurance status and, ideally, family income, to be reported as patients in the UDS. They must not be considered uninsured unless they are receiving minor consent services *only*.

### Insurance Definitions

Health centers will report the patient's ***primary** health insurance covering **medical care**,* if any, ***as of the last visit*** during the reporting period. Primary medical insurance is defined as the insurance plan/program that the health center would typically bill first for medical services. The categories for this table are slightly different than those on Table 4, combining Medicaid, CHIP, and Other Public into one category. Some specific rules guide reporting:

- Patients who have both Medicare and Medicaid are to be reported as Medicare patients because Medicare is billed before Medicaid. In addition to being reported as Medicare patients, patients will also be reported as Dually Eligible. 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.
- Medicaid, Medicare, and CHIP patients enrolled in a managed care program that is operated by a private insurance company are to be reported as Medicaid, Medicare, or CHIP, as appropriate.
- In rare instances, a patient may have an insurance that the health center 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 health centers' providers have not been credentialed to bill that payer. In these instances, the health center *will report the patient as being insured* and will report the type of insurance, even if they cannot or did not bill this insurance.
- Health centers receiving section 330 grant funds to serve special populations (i.e., Migrant Health Center, Health Care for the Homeless, Public Housing Primary Care) is not considered a form of medical insurance. Special population patients may also carry third-party insurance and are to be reported appropriately.
- Patients in correctional facilities may be classified as uninsured, whether seen in the correctional facility or at the health center and at the ZIP code of the jail or prison. Patients in residential drug programs, college dorms, military barracks, etc. are not classified as uninsured. In these instances, report the patient by type of insurance and record the ZIP code of the residential program, dorm, or barrack.
- 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.

- No special category is to be used for patients whose insurance may be subsidized through the Affordable Care Act. They are classified in the insurance category of their third-party payer.

## Questions and Answers for ZIP Code by Medical Insurance 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 our patients?**
   Yes. Although health centers are expected to report residence by ZIP code for all patients, it is recognized that some centers 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 10 or fewer patients may be aggregated and reported in the "other" category.

3. **Do we need to collect information on and report on the primary medical insurance of all our patients?**
   Yes. Although the ZIP code of a patient may be reported as "unknown," medical insurance information must be obtained for every person counted as a patient in the UDS report.

4. **If a patient is not receiving medical care, do we still need their *medical* insurance information? What about dental patients?**
   Yes, *medical* insurance information is needed for all patients, even dental-only patients. To understand the patient population being served, the medical insurance of all patients must be reported.

5. **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. Several tables and sections must match:

   - The total number of patients reported by ZIP code (including "unknown" and "other") on the ZIP Code Table must equal the number of total unduplicated patients reported on Tables 3A, 3B, and 4.
   - The insurance totals reported on the ZIP code table must equal insurance reported on Table 4. Specifically,
     - the total for Column B (Uninsured) must equal Table 4, Line 7, Column A + Column B;
     - the total for Column C (Medicaid, CHIP, Other Public) must equal the sum of Table 4, Line 8, Column A + Column B and Line 10, Column A + Column B;
     - the total for Column D (Medicare) must equal Table 4, Line 9, Column A + Column B; and
     - the total for Column E (Private) must equal Table 4, Line 11, Column A + Column B.

## Table Patients by ZIP Code

Reporting Period: January 1, 2016, through December 31, 2016

| ZIP Code (a) | None/Uninsured (b) | Medicaid / CHIP / Other Public (c) | Medicare (d) | Private (e) | Total Patients (f) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Other ZIP Codes | | | | | |
| Unknown Residence | | | | | |
| **Total** | | | | | |

Note: This is a representation of the form. The actual online input process looks significantly different, and the printed output from EHB may also be modified.

# Instructions for Tables 3A and 3B

Tables 3A and 3B provide demographic data on patients who accessed services by the program authority (e.g., section 330(g), section 330(h)). This information is to be collected from patients at least once a year as part of the patient registration or intake process.

# Table 3A: Patients by Age and by Sex Assigned at Birth

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. Health centers are to report patients according to their sex at birth. This is normally the sex reported on a birth certificate. In states that permit this to be changed, the birth certificate sex may still be used. Note that on the non-prenatal portion of Tables 6B and 7, age is essentially defined as age on December 31. Thus, even if all the patients at a health center were medical patients, the numbers on Table 3A will not be the same as those on Tables 6B and 7, though they may be similar.

# Table 3B: Demographic Characteristics

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.

## Patients by Hispanic or Latino Ethnicity and Race (Lines 1-8)

### Hispanic or 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 Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Column B (Non-Hispanic/Latino): Report the number of all other patients except those for whom there are neither racial nor Hispanic/Latino ethnicity data. If a patient has chosen a race (described below) but has not made a selection for the Hispanic /non-Hispanic question, *the patient is presumed to be non-Hispanic/Latino*.
- 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 blank.

Patients who self-report as Hispanic/Latino but do not separately select a race must be reported on Line 7, Column A as Hispanic/Latino whose race is unreported or refused to report. Health centers may not default these patients to "White," "Native American," "more than one race," or any other category.

### Race

All patients must be classified in one of the racial categories (including a category for persons who are "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 or Latino, are presumed to be non-Hispanic/Latino and are to be reported on the appropriate race line in Column B.

Patients sometimes categorized as "Asian/Other Pacific Islander" in other systems are divided on the UDS into three separate categories:

- 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, Indonesia, Thailand, or Vietnam
- Line 2a, Native Hawaiian: Persons having origins in any of the original peoples of Hawaii

- Line 2b, Other Pacific Islander: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other Pacific Islands in Micronesia, Melanesia, or Polynesia
- Line 2, Total Native Hawaiian/Other Pacific Islander: Must equal lines 2a+2b

American Indian/Alaska Native (Line 4): 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 that 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 Hispanics/Latinos who do not check a separate race. They are to be reported on Line 7 (Unreported/Refused to Report), as noted above.

*NOTE: Health centers are required to report race and ethnicity for all patients. Some health centers' patient registration systems were originally configured to capture data for patients who were asked to report race or ethnicity. Health centers that 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 to include them in the count of those with Hispanic or Latino ethnicity. Health centers must take steps to enhance their registration system to permit the capture and reporting of these data in the future.*

## Linguistic Barriers to Care (Line 12)

This section of Table 3B identifies the patients who have linguistic barriers to care.

Report on Line 12 the number of patients who are best served in a language other than English, including those who are best served 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, Patients Served in a Language other than English, may be estimated if the health center does not maintain actual data in its Health Information Technology (HIT). If an estimate is required, the estimate should be based on a sample where possible.* ***This is the only place on the UDS where an estimate is accepted.***

## Patients by Sexual Orientation (Lines 13 – 19)

Sexual orientation is how a person describes their emotional and sexual attraction to others. Collecting sexual orientation data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers. This section helps to characterize the lesbian, gay, bisexual, transgender (LGBT) population served by health centers.

Health centers are encouraged to establish routine data collection systems to support patient-centered, high-quality care for LGBT individuals. As with all demographic data, this information is generally self-reported by patients or their caregivers if the patient cannot answer the questions themselves.

Health centers are encouraged to collect demographic data for every patient, but collecting sexual orientation data from patients less than 18 years of age is not mandated. In the event that sexual orientation information is not available, the patient is to be reported on Table 3B as "don't know" on Line 17. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 13 – Lesbian or Gay**: A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender.
- **Line 14 – Straight (not lesbian or gay)**: A sexual orientation that describes a person who is emotionally and sexually attracted to people of the opposite gender.
- **Line 15 – Bisexual**: A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender and people of other genders.
- **Line 16 – Something else**: A person who is emotionally and sexually attracted to people of another sexual orientation other than the three categories described above. In addition, include in this category persons who identify themselves as queer, asexual, or pansexual.
- **Line 17 – Don't know**: A person who self-reports that they do not know what their sexual orientation is. Also use this category to report patients where the health center does not know the patient's sexual orientation (i.e., health center did not have systems in place to routinely ask about sexual orientation).
- **Line 18 –Chose not to disclose**: A person who chose not to disclose their sexual orientation.
- **Line 19 – Total Patients**: Sum of Lines 13 + 14 + 15 + 16 + 17 + 18

## Patients by Gender Identity (Lines 20 – 26)

Gender identity is a person's internal sense of their gender. A person may be a male, female, a combination of male and female, or of another gender. Collecting gender identity data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers. This section helps to characterize the LGBT population served by health centers. Note that the gender identity reported on Table 3B is the patient's current gender identity and a patient's sex assigned at birth is reported on Table 3A.

Health centers are encouraged to establish routine data collection systems to support patient-centered, high-quality care for LGBT individuals. As with all demographic data, this information is generally self-reported by patients or their care-givers if the patient cannot answer the questions themselves. Health centers are encouraged to collect demographic data for every patient, but collecting gender identity data from patients less than 18 years of age is not mandated. In the event that gender identity information is not available, the patient is to be reported on Table 3B as "other" on Line 24. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 20 – Male:** A person who identifies themselves as a man/male.
- **Line 21 – Female:** A person who identifies themselves as a woman/female.
- **Line 22 – Transgender Male / Female-to-Male:** A transgender person whose gender identity is man/male may use these terms to describe themselves. Some may just use the term man.
- **Line 23 – Transgender Female / Male-to-Female:** A transgender person whose gender identity is

woman/female may use these terms to describe themselves. Some may just use the term woman.

- **Line 24 – Other:** A person who does not think that one of the four categories above adequately describes them. Include in this category persons who identify themselves as genderqueer or non-binary. Also use this category to report patients where the health center does not know the patient's gender identity (i.e., health center did not have systems in place to routinely ask about gender identity).
- **Line 25 –Chose not to disclose:** A person who chose not to disclose their gender.
- **Line 26 – Total Patients:** Sum of Lines 20 + 21 + 22 + 23 + 24 + 25

## Questions and Answers for Tables 3A and 3B

1. **Have the data elements for Tables 3A or 3B changed?**
   Yes. On Table 3A, patients are to be reported based on sex at birth. Additionally, two new sections have been added to Table 3B to capture the sexual orientation and gender identity of patients using categories that align with the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program.

2. **Our health center collects more robust race and ethnicity data than is required on the UDS. Why is the data limited?**
   The UDS classifications are 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 a minimum of five 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. Line 6 permits reporting of those people who have chosen to report two or more races.

3. **How are patients of Hispanic or Latino ethnicity reported?**
   Table 3B, race and ethnicity data is reported in a matrix. Patients who in other systems might be reported as Hispanic or Latino independent of race are reported in Column A of the UDS as Hispanic or Latino where you 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.

4. **Can we just have a choice on our registration form of "more than one race"?**
   No. 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.

5. **How are individuals who receive different types of services or use more than one of our health centers' 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. Health centers 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 18). Note the following:

- Persons who receive WIC services and no other services at the health center *are not* to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).
- Persons who only receive imaging or 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).

6. **Our HIT/EHR changed during the year. Can we just add the information from the two systems together to report this table?**
No. Because the same patient might be counted in each system, it would result in a potentially massive over-count this year, followed by a huge apparent reduction in patients the following year. It is the health center's responsibility to ensure there is no duplication of data. Because this may be a time-consuming process, it should be initiated as soon as the year ends to ensure sufficient completion time prior to the initial submission date.

7. **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 by sex assigned at birth) must equal Table 3B, Line 8, Column D (total patients by Hispanic or Latino ethnicity and race); Total Patients by ZIP Code; Table 3B, Line 19 (total patients by sexual orientation); Table 3B, Line 26 (total patients by gender orientation); 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 1-18, Column A + B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0-17 years). The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).

8. **Does race and Hispanic or 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 follows the standards established by OMB. Health centers 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.

9. **I have a separate data system for my mental health patients. How do I include their data on these tables?**
Health centers are required to ensure their data is not duplicated 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 merging 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.

10. **For patients that were seen in 2016 before the sexual orientation and gender identity elements were added to the intake form, what is the appropriate reporting?**
    If a patient was seen prior to the implementation of the sexual orientation and gender identity data gathering, the patient should be reported on Table 3B as 'Don't know' on Line 17 (sexual orientation) and as 'Other' on Line 24 (gender identity).

11. **How can I communicate a hardship in reporting sexual orientation and gender identity data?**
    Any health center can contact the UDS Support Center regarding UDS content and reporting, including hardships at 866-UDS-HELP or udshelp330@bphcdata.net. A health center must report a potential hardship by making a note in the comments section of Table 3B of the health center's UDS submission. The comment should include an explanation of the hardship experienced. The health center's assigned UDS reviewer will be notified of the comment documenting the hardship upon submission. Health centers are expected to notify the Bureau of any potential UDS reporting hardship every reporting cycle (i.e., calendar year).

12. **Will UDS require health care providers to ask minors for sexual orientation and gender identity data?**
    The collection of sexual orientation and gender identity data is not mandated from patients less than 18 years of age. Health centers are encouraged to have established data collection systems in place in the event that a patient prefers to offer clarification on his/her sexual orientation and gender identity.

13. **Will parents be able to access their child's response to a UDS sexual orientation and gender identity inquiry?**
    There are specific provisions about protecting confidentiality of minors for patient visits related to sexual health (in some instances state laws, in other instances institutional policy). For instance, Massachusetts state law allows clinicians to designate a minor as a "mature minor" and not have to disclose certain information to a parent. It is the expectation that health centers would adhere to state laws and/or institutional policies. Although discretion may be exercised between the provider and minor patient, parents may still be privy to information about health services obtained by their child through the insurance explanation of benefits (EOB) process.

## Table 3A: Patients by Age and by Sex Assigned at Birth

Reporting Period: January 1, 2016, through December 31, 2016

| Line | 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: Demographic Characteristics

Reporting Period: January 1, 2016, through December 31, 2016

**Patients by Hispanic or Latino Ethnicity**

| Line | Patients By Race | Hispanic/ Latino (a) | Non-Hispanic/ Latino (b) | Unreported/ Refused to Report Ethnicity (c) | Total (d) (Sum Columns a+b+c) |
|---|---|---|---|---|---|
| 1. | Asian | | | | |
| 2a. | Native Hawaiian | | | | |
| 2b. | Other Pacific Islander | | | | |
| 2. | Total Native Hawaiian/Other Pacific Islander (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 race | | | | |
| 8. | **Total Patients** (Sum Lines 1+2 + 3 to 7) | | | | |

| Line | Patients by Language | Number (a) |
|---|---|---|
| 12. | Patients Best Served in a Language Other Than English | |

| Line | Patients by Sexual Orientation | Number (a) |
|---|---|---|
| 13. | Lesbian or Gay | |
| 14. | Straight (not lesbian or gay) | |
| 15. | Bisexual | |
| 16. | Something else | |
| 17. | Don't know | |
| 18. | Chose not to disclose | |
| 19. | **Total Patients** (Sum Lines 13 to 18) | |

| Line | Patients by Gender Identity | Number (a) |
|---|---|---|
| 20. | Male | |
| 21. | Female | |
| 22. | Transgender Male/ Female-to-Male | |
| 23. | Transgender Female/ Male-to-Female | |
| 24. | Other | |
| 25. | Chose not to disclose | |
| 26. | **Total Patients** (Sum Lines 20 to 25) | |

# Instructions for Table 4: Selected Patient Characteristics

Table 4 provides descriptive data on selected characteristics of health center patients.

## Income as a Percent of Federal Poverty Guideline, Lines 1-6

Health centers are required to collect income data on all patients 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. Although it may be known that a patient is homeless, is a migratory agricultural worker, or is on Medicaid, it is not adequate to classify that patient as having an income below the Federal Poverty Guideline.

BPHC accepts 'self declaration' of income from patients who are unable to document their income, consistent with Board-approved policies and procedures. This is particularly important for those patients whose wages are paid in cash who have no other means of proving their income. Health centers may not assume that a homeless patient, an agricultural worker, or a student seen at a school-based health center is below poverty. If documentation consistent with Board policy is lacking, report them as having "unknown" income.

Income is defined in ranges relative to the Federal Poverty Guidelines (e.g., 100 percent and below the Federal Poverty Guideline). In determining a patient's income relative to the Federal Poverty Guideline, health centers should use official Federal Poverty Guidelines defined and revised annually. The official Federal Poverty Guidelines are published in the Federal Register during the first quarter of each year. The guidelines for CY 2016 are available online at https://aspe.hhs.gov/poverty-guidelines.

## Principal Third Party Medical Insurance Source, Lines 7-12

This portion of the table provides data on patients classified by their age and the primary source of insurance for *medical* care. A patient's health insurance may change during the year. Report on this table the primary 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 any or all of the visit services*. (Other forms of insurance, such as dental or vision coverage, are never to be reported.) Patients are divided into two age groups: 0–17 (Column A) and age 18 and older (Column B) based on their age on June 30. Primary patient medical insurance is divided into seven types as follows. (Note that states often rename federal programs, especially the State Children's Health Insurance Program [S-CHIP], Medicaid, Early Periodic Screening Detection and Treatment [EPSDT], Breast and Cervical Cancer Control program [BCCCP], and Title X [Title Ten].) In rare instances a patient may have insurance that the health center cannot or does not bill. In these instances, the health center will still report the patient as being insured and report the type of insurance.

## Uninsured (Line 7)

Patients who did not have *medical insurance* at the time of their 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 or indigent care programs. *Do not count* patients as uninsured if their medical insurance did not *pay for* their visit. Some examples follow:

- A patient with Medicare who was seen for a dental visit that was not paid for by Medicare is still classified as having Medicare for this table.
- A patient with Private insurance that has a $2,000 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.
- Children seen in a school-based program who do not know their parent's health insurance status must obtain that information if they are to be included in the count of patients. *The only exception is for a student seeking minor-consent service permitted in the State, such as family planning or mental health services*, in which case the minor child's status may be recorded as uninsured if they do not have access to the parent's information. (Note that a minor receiving these same services with parental consent must be reported under the parent's insurance.)
- A patient with Medicaid, Private, or Other Public dental insurance may be presumed to have the same kind of medical insurance. If a patient does not have dental insurance, you *may not* assume that they are uninsured for medical care, and the health center must obtain this information from the patient.
- Health centers must obtain the coverage information of patients in facilities such as residential drug programs, college dorms, and military barracks, (but not correctional facilities), and may not be assumed to be uninsured.

Note: Patients served in correctional facilities may be classified as uninsured unless they have some form of insurance such as Medicaid or Medicare, whether seen in the correctional facility or at the health center.

## Medicaid (Line 8a)

Medicaid is a State-run program 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 who are ineligible for Federal matching funds (e.g., general assistance recipients, children, pregnant women).

Notes: 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. Patients enrolled in both Medicaid and Medicare are reported on lines 9 and 9a, *not on any of the Medicaid lines even if Medicaid pays the majority of the bill.*

## S-CHIP or CHIP or CHIP-RA (Line 8b or 10b)

The State Children's Health Insurance Program (S-CHIP), covered in statute by the Children's Health Insurance Program Reauthorization Act (CHIP-RA) provides primary health care coverage for children and, on a state-by-state basis, others—especially pregnant women, 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.) In some states, Medicaid has been expanded by using state/federal funds to purchase private health insurance. Patients with such coverage are to be classified as Medicaid patients.

### CHIP-Medicaid (Line 8b)

In States that make use of Medicaid to handle the CHIP program, 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 appearing 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 and Medicaid or Medicare and a private ("MediGap") insurance are reported on line 9. *In addition*, those who have both Medicare and Medicaid (but *not* those with MediGap insurance) will be reported on line 9a (see below). Persons enrolled in "Medicare Advantage" products may have their services paid for by a private insurance company, but are counted as Medicare on line 9. A Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare will have an employer-based insurance plan, which is billed first.

### Dually Eligible Medicare and Medicaid (Line 9a)

Patients who have both Medicare and Medicaid insurance are to be reported on line 9a. Do not include MediGap enrollees. This line is a subset of line 9 (Medicare) and patients who are dually eligible are to be reported on line 9a *and* included in the total on line 9, Medicare.

### Other Public Insurance (Line 10a)

State and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, provide a broad set of benefits for eligible individuals and include public paid or subsidized private insurance not listed elsewhere. Medicaid expansion programs using Medicaid funds to help patients purchase their insurance through exchanges are classified as Medicaid (line 8a) if it is possible to identify them, otherwise, they are to be reported as Private (line 11). 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, the Breast and Cervical Cancer Control Program (BCCCP), AIDS Drug Assistance Program (ADAP) providing pharmaceutical coverage for HIV patients, etc. Also, ***do not include*** persons covered by workers' compensation because 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 payer, 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 payer such as Blue Cross. CHIP programs that are run through the private sector, are often covered through health maintenance organizations (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. Do not include patients who have insurance

through the State insurance exchange regardless of whether or not their premium cost is subsidized in whole or in part.

### Private Insurance (Line 11)

Health insurance provided by commercial and not-for-profit companies; individuals may obtain insurance through employers or on their own. This includes persons who purchase insurance through the Federal or State exchanges. In states making use of Medicaid expansion to support the purchase of insurance through exchanges, the patients covered under these plans are to be reported as Medicaid, line 8a. If patients are not otherwise identifiable as Medicaid patients, they are to be reported as Private on line 11. Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.

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—health centers are required to obtain medical insurance information from all patients to maximize third-party payments.

## Managed Care Utilization, Lines 13a-13c

This part of table 4 provides data on managed care enrollment during the calendar year and, specifically, reports on patient member months in managed care plans. Do not report in this section enrollees in Primary Care Case Management (PCCM) programs or the Centers for Medicare and Medicaid Services (CMS) patient-centered medical home (PCMH) Demonstration grants or other third party plans which pay a small monthly fee (usually $5 or less 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 one member being enrolled in a managed care plan for one month. An individual who is a member of a plan for a full year generates 12 member months; a family of five enrolled for six months generates 30 member months (5 × 6); etc. Member month information is most often obtained from monthly enrollment lists generally supplied by managed care companies to their providers. Health centers should always save these documents and, in the event they have not been saved, should request duplicates early 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 health center and the HMO, Accountable Care Organization (ACO), or other similar plans stipulates that for a flat payment per month, the health center will provide that patient all the services on a negotiated list. (Oregon programs should include enrollees in coordinated care organizations [CCOs] on this line.) 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, it is common for there to be a second "wrap-around" payment for managed care visits to adjust total payment to federally qualified health center (FQHC) prospective payment system (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 health center

or health center service delivery provider for one month, during which time the patient may receive basic primary care services only from the health center but for whom the services are paid on a fee-for-service basis.

It is common for patients to have their primary care covered by capitation, but other services, such as behavioral health or pharmacy, are 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.

If patients are enrolled in a managed care program that permits them to receive care from any of a number of providers, including providers other than the health center and its clinicians, this is not to be considered managed care, and no member months are reported in this situation.

**Total Member Months (Line 13c)**: Enter the total of Lines 13a + 13b.

It would be unusual (though not impossible) for the number of member months for any one payer (e.g., Medicaid) to exceed 12 times the number of patients reported on the corresponding insurance line above (for example, Medicaid, Line 8). 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. The capitated member months reported on Line 13a relate to the net capitated income reported on Table 9D on Lines 2a, 5a, 8a, and/or 11a. Similarly, one can generally expect a relationship between the fee-for-service member months reported on Line 13b and the income reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.

***NOTE:*** It is possible for an individual to be enrolled in a managed care plan, assigned to a health center, and yet never seen or not seen during the calendar year. The member months for such individuals are still to be reported in this section. *This is the only place in the UDS where an individual may be reported who is not being counted as a patient.*

## Targeted Special Populations, Lines 14-26

This section 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, public housing patients, and patients who are veterans. Grantees who receive targeted funding for these special populations (i.e., section 330 (h) - Health Care for the Homeless, section 330(g) - Migrant Health Center, and/or section 330(i) – Public Housing Primary Care), must also provide additional information on their agricultural employment and/or housing characteristics. Housing status must be collected at the first visit of the year where the patient was identified to be homeless. Migratory or seasonal agricultural workers status must be verified at least every two years. All health centers report these populations, regardless of whether or not they directly receive special population funding.

### Migratory or Seasonal Agricultural Workers and their Family Members, Lines 14–16

All health centers are required to report either on Line 16 or on Lines 14 and 15 the number of patients seen during the reporting period who were either migratory or seasonal agricultural workers, family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B) and the definitions below). Only health centers that receive section 330(g) - Migrant Health Center funding, 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* 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 *principal employment* within 24 months of their last visit, as well as their *dependent* family members who have also used the center. The 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 classified as migratory workers in their home community, as are those who migrate *to* a community to work there.

  **Aged and Disabled Former Migratory Agricultural Workers**: As defined in section 330 (g)(1)(B), aged and disabled former agricultural workers are individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of age or disability. These individuals and family members of such individuals are included in Line 14.

- **Seasonal Agricultural Workers**: Seasonal agricultural workers are individuals *whose principal employment is in agriculture* on a seasonal basis (e.g., picking fruit during the limited months of a picking season) but who *do not* establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within 24 months of their last visit and their family members who may be patients of the health center.

For both categories of workers, the term agriculture means farming in all its branches, as defined by the Office of Management and Budget (OMB) - developed North American Industry Classification System (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 health centers 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 Lines 17 – 22 or on Line 23. Only health centers receiving section 330(h) - Homeless Health Center (HCH) funding provide separate totals for patients by housing location on Lines 17 - 22.

**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 or permanent supportive housing.

HCH grantees will provide separate totals for homeless patients by the type of shelter arrangement the patient had when they were *first encountered during the reporting year*. For HCH grantees, Line 23 will be automatically calculated and will equal the sum of Lines 17 through 22. The following applies when 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.
- Patients currently residing in a jail or an institutional treatment program are not considered homeless until they are released to the street with no housing arrangement.
- **Line 17 – Shelter**: Patients who are living in an organized shelter for homeless persons at the time of their first visit; shelters that 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 or the hours of the day that 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 a greater level of independence than traditional shelters and may require the resident to pay some or all the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, the military, schools, or other institutions.
- **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. Do not count the person who invites a homeless person to stay in their home for the night as homeless.
- **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 may continue to serve patients who are no longer homeless as a result of becoming residents of permanent housing for 12 months after their last visit as homeless.) Patients who reside in single room occupancy (SRO) hotels or motels, patients who reside in other day-to-day paid housing, and residents of permanent supportive housing or other housing programs that are targeted to homeless populations should also be classified as "other" on Line 21.

### School-Based Health Center Patients, Line 24

All health centers that identified a school-based health center as a service delivery site in their scope of project (grant or designation) are to report the total number of patients who received primary health care services at the approved school service delivery site(s). 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. Do not include students who receive screening services or mass treatment, such as vaccinations or fluoride treatments at a school, as patients.

### Veterans, Line 25

All health centers 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 nations' military are not counted here, even if they served in wars in which the United States was also involved. This category is not exclusive and an individual who is classified as a homeless patient (for example) can also be classified as a veteran.

### Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site, Line 26

All health centers are to report all patients seen at a site that is located in or immediately accessible to public housing, regardless of whether or not the patients are residents of public housing or the health center receives funding under section 330(i) - Public Housing Primary Care (PHPC). Patients should be counted on this line if they are served at health center sites that meet the statutory definition of PHPC (located in or immediately accessible to public housing) regardless of whether the health center site receives PHPC funding and regardless of whether or not the patient actually lives in public housing (location-based reporting). Public housing means agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than section 8 housing vouchers. For information on public housing, please see the Housing and Urban Development (HUD) website at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph.

## Questions and Answers for Table 4

1. **Are there any changes to this table?**
   No, although a line title change has been made to provide further clarification and to emphasize the location-based reporting expected on line 26, Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site.

2. **If we do not receive direct funding under the Health Care for the Homeless, Migrant Health Center, or Public Housing Primary Care programs, do we need to report the total number of special population patients served?**
   Yes. All health centers that do not receive targeted grant funding for special populations are required to complete Line 16 (the total number of patients seen during the reporting period who were agricultural workers or their family members), Line 23 (total number of patients known to have been homeless at the time of any service during the year), Line 24 (patients of an approved, in-scope school based health center), Line 25 (Veterans), and Line 26 (total number of patients served at a health center located in or immediately accessible to a public housing site) . Health centers that did not receive HCH funding are not required (or able) to complete the shelter arrangement details on Lines 17-22. They enter the total only. Health centers that did not receive MHC funding are not required (or able) to complete the agricultural worker details on Lines 14 and 15. They enter the total only.

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

4. **We have never collected information on whether or not a patient is homeless, living in public housing, an agricultural worker, or a veteran. Do we have to do this now for reporting?**
Yes. All health centers are required to ask every patient who visits their health center whether or not she or he is homeless, an agricultural worker, or a veteran and to add this as an item on the patient's profile so it can be reported. Agricultural worker and homeless patients should be identified and individually counted. Public housing-based patients are identified by the site where they receive care that is in and/or immediately accessible to public housing.

5. **Who are we to report as Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site on line 26?**
Report the total number of patients who are served at any health center site located in or immediately accessible to public housing, regardless of whether or not the health center receives funding under section 330(i) - Public Housing Primary Care (PHPC).

6. **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 health centers 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 assume they have the same kind of medical insurance. If they *do not* have dental insurance, you *may not* assume they are uninsured for medical care and must obtain this information from the patient.

7. **Homeless and agricultural worker patients generally do not have income verification. Can we report them as having income below poverty?**
No. You can show them as having unreported income, but not as being below poverty unless you actually verify this at least annually. On the other hand, subject to your health center's financial policies and procedures, you may document their income in your system based on their verbal statement of their income. The requirement to check specific documents is governed strictly by the health center's internal policies.

8. **We serve students at a school-based health center. They often do not know what insurance they have, if any, and they have no information on their family's income. Can we report them as below poverty and uninsured?**
Not unless they are only receiving minor consent services. Minor consent services are limited to a very specific range of services such as contraception, STDs, and mental health services. These are defined in state law, and not all states provide for them. For all other services, the children will require parental consent, and the consent form should also obtain information about income and insurance. *Subject to the health center's policies and procedures,* it is acceptable to ask for this information and to assure parents that you will not bill the insurance without their knowledge. You may also accept their assertion of income without documentation or, if you do not get it, show the child as having unknown income. The patient's health insurance is *required,* even if it is not billed.

9. **Our state is using Medicaid Expansion provisions to assist patients with buying Private insurance. Should we count them as Medicaid or Private?**
As long as they can be identified as Medicaid expansion patients, they should be reported as Medicaid, line 8a. (This may require looking for specific plan numbers or other identifying characteristics in their insurance enrollment.) If and only if you are unable to identify Medicaid

Expansion patients, report them as Private, line 11. Health centers may contact the UDS Support Line to learn if your State has expanded Medicaid through use of exchanges.

**10. What timing is used to determine a patient's homeless status and shelter arrangement?**

For all health centers (irrespective of HCH funding), Line 23 must include the total number of patients who were homeless at any point of service during the year.

Grantees who receive HCH funding will also go one step further and report all of those patients reported on Line 23 by their sheltering arrangement on Lines 17-22. The statement that the health center should report homeless patients by their sheltering arrangements as of their first encounter during the reporting year is made in order to help health centers determine to which shelter arrangement they should report a patient as if they change shelter statuses throughout the year (as it did in the second example). A patient's shelter status should be reported on Lines 17-22 as of the first time they were documented by the health center as being homeless. Lines 17-22 are just a breakdown of the shelter status for all homeless patients who should be reported on Line 23 (the total number of patients who were homeless at any point of service during the year).

**11. Do the totals need to equal other sections or Tables?**

The following totals must be equal across tables and sections:

- *ZIP Code Table, Column B must equal Table 4, Line 7, Column A + Column B.*
- *ZIP Code Table, Column C must equal Table 4, Line 8 + 10, Column A + Column B.*
- *ZIP Code Table, Column D must equal Table 4, Line 9, Column A + Column B.*
- *ZIP Code Table, Column E must equal Table 4, Line 11, Column A + Column B.*
- *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 1-18, Column A + B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0-17 years).*
- *The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).*
- *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.

## Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2016, through December 31, 2016

| Line | Characteristic | Number of Patients |
|---|---|---|
| **Line** | **Income as Percent of Federal Poverty Guideline** | **Number of Patients (a)** |
| 1. | 100% and below | |
| 2. | 101–150% | |
| 3. | 151–200% | |
| 4 | Over 200% | |
| 5. | Unknown | |
| 6. | **TOTAL** (Sum Lines 1–5) | |

| Line | Principal Third Party Medical Insurance | 0-17 years old (a) | 18 and older (b) |
|---|---|---|---|
| 7. | **None/Uninsured** | | |
| 8a. | Regular Medicaid (Title XIX) | | |
| 8b. | CHIP Medicaid | | |
| 8. | **Total Medicaid (Line 8a + 8b)** | | |
| 9a. | Dually Eligible (Medicare and Medicaid) | | |
| 9. | **Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries) | | |
| 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) | | |

| Line | Managed Care Utilization Payer 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** (Sum Lines 13a + 13b) | | | | | |

## Table 4: Selected Patient Characteristics (cont'd.)

Reporting Period: January 1, 2016, through December 31, 2016

| Line | Special Populations | Number of Patients (a) |
|---|---|---|
| 14. | Migratory (330g grantees only) | |
| 15. | Seasonal (330g grantees only) | |
| 16. | **Total Agricultural Workers or Dependents** (All Health Centers 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 Health Centers Report This Line) | |
| 24. | **Total School-Based Health Center Patients** (All Health Centers Report This Line) | |
| 25. | **Total Veterans** (All Health Centers Report This Line) | |
| 26. | **Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All Health Centers Report This Line) | |

# Instructions for Table 5: Staffing and Utilization

This table provides a profile of health center staff (Column A), the number of visits they render (Column B), and the number of patients served in each service category (Column C). Unlike Tables 3A, 3B, and 4 w here 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. Although the patient count is unduplicated *within* service categories, it will often involve duplication *across* service categories.

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.

Staffing data are reported only on the Universal table, not the Grant Report tables. Grant Reports provide data on patients served in whole or in part with section 330 (h) - Health Care for the Homeless, section 330(g) - Migrant Health Center, and/or section 330(i) – Public Housing Primary Care funding, and the visits that they had during the year. This includes all visits supported with either grant or non-grant funds.

## 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 sites covered by the UDS. *All staff are to be reported in terms of* **annualized** *FTEs*.

Staff may provide services on behalf of the health center 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. 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 health center on a fee-for-service basis only are not counted in the FTE column because there is no basis for determining their hours, though their visits are still reported in Column B and the patients who received services are reported in Column C.

The following describe the basis for determining someone's **employment status** for purposes of reporting on FTEs:

- One full-time equivalent (FTE = 1.0) describes staff who individually or as a group worked the equivalent of full-time for one year. Each health center defines the number of hours for "full-time" work and may define it differently for different positions.
- The full-time equivalent is based on employment contracts for clinicians and other exempt employees. For example, a physician can be hired as a full-time employee but only required to work nine four-hour sessions (36 hours) per week. Similarly, clinicians may routinely stay late in the

clinic or see hospitalized patients before or after normal work days. In either case, the clinician would still be considered to be 1.0 FTE.

- In some health centers, 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. For example, if physicians work 36 hours per week, 36 hours 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.
- For exempt staff working fewer than 40 hours a week, their FTE can often be determined by their benefits status. It they get full-time benefits (e.g., eight hours pay for New Year's Day), then they would be considered full-time. For non-exempt employees, an FTE is calculated based on paid hours. FTEs are adjusted for part-time work or for part-year employment. For example, in a health center that has a 40-hour work week (2,080 hours/year), a person who works 20 hours per week (i.e., 50 percent time) is reported as 0.5 FTE.
- An 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).

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, the 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 collects vitals on a patient, who is then placed in the exam room, and later provides 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 paid leave for continuing education or other reasons are still considered full-time if that is how they were hired. (Similarly, providers who are routinely 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 quality improvement (QI) activities, supervising nurses, etc., is counted as part of their overall medical care services time and not in some non-clinical support category.

The one exception to this rule is when a Chief Medical Officer/Medical Director is engaged in non-clinical activities at the corporate level (e.g., attending Board of Directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), 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, or writing clinical protocols.

### Staff by Major Service Category

Staff members are distributed into categories that

reflect the types of services they provide as an independent provider. 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 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 (Lines 1–7)**: Medical doctors (MDs) and doctors of osteopathic medicine (DOs), including licensed residents, except psychiatrists, ophthalmologists, pathologists, and radiologists who are reported separately on Lines 20a, 22a, 13, and 14, respectively. Licensed interns and residents are reported on the line designated for the specialty designation they are working toward and credited with their own visits. (Thus, a family practice intern is counted as a family physician on Line 1.) Naturopaths, acupuncturists, community health aides/ practitioners, and chiropractors are not counted on these lines. These providers are reported on Line 22 as Other Professionals.
- **Nurse Practitioners (Line 9a)**: Nurse practitioners (NPs) and advanced practice nurses (APNs), except psychiatric nurse practitioners who are included on Line 20b, Other Licensed Mental Health Providers, and certified nurse midwives (CNMs) who are reported on line 10.
- **Physician Assistants (Line 9b)**
- **Certified Nurse Midwives (Line 10)**
- **Nurses (Line 11)**: Registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.

  *Nurse visit considerations:*

  - Services 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, NP, PA, or CNM who has no direct contact with the patient during the visit, but these services must still meet the requirement of exercising independent professional judgment.
  - Nurses providing triage services and visiting nurses who see patients on their own in the patients' homes to evaluate their condition are reportable.
  - To be counted in the UDS, the visits must be charged and are generally coded as 99211 visits using Current Procedural Terminology.
  - Most states prohibit a licensed vocational nurse (LVN) or a licensed practical nurse (LPN) from exercising independent judgment; thus, no visits would be counted for them.
- **Other Medical Personnel (Line 12)**: Medical assistants, nurses' aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with services provided by a physician, NP, PA, CNM, or nurse; no visits are recorded for these workers.

  *Other medical personnel considerations:*

  - Do not report staff dedicated to quality improvement or HIT/EHR informatics

here. They are reported on line 29b, Quality Improvement Staff.

- Do not report medical records and patient support staff here. They are reported on Line 32, Patient Support Staff.
- Do not count services provided by medical assistants, aides, or other non-nursing personnel as nursing visits.

- **Laboratory Personnel (Line 13)**: Pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. Some or all of the time of licensed nurses may be in this category if they are delegated to this responsibility, but none of the time of a physician should be included here. No visits are recorded for these workers.
- **X-ray Personnel (Line 14)**: Radiologists, X-ray technologists, and X-ray technicians; no visits are recorded for these workers. Physician time would not be included here even if they were taking X-rays or performing sonograms.

**Dental Services (Lines 16-19)**

- **Dentists (Line 16)**: General practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration. Note: dental therapists are not classified here— they are reported on Line 17a, Dental Therapists.
- **Dental Hygienists (Line 17)**
- **Dental Therapists (Line 17a)**: Only some states license dental therapists. Make sure that you are classifying staff to this line based on state licensing and function.

*Dentist, dental hygienist, and dental therapist visit considerations:*

- Only one visit per patient per day is reported, regardless of the number of clinicians who provide services or the volume of service (i.e., number of procedures) provided.
- The application of dental varnishes, fluoride treatments, and dental screenings, absent other comprehensive dental services, does not qualify as a visit.
- Services of dental students or anyone else other than a licensed dental provider may not be credited with dental visits, even if these individuals are working under the supervision of a licensed dental provider.
  - Exception: A supervising dentist (i.e., one who is overseeing dental students who are enrolled in a graduate education program leading to a license as a dentist) may count the visits of his or her students as long as he or she
    - Has no other responsibilities, including the supervision of other personnel at the time services are furnished by the students,
    - Has primary responsibility for the patients,
    - Reviews the care furnished by the students during or immediately after each visit, and
    - Documents the extent of their participation in the review and direction of the services furnished to each patient.

- Do not count medical providers who examine a patient's dentition or provide fluoride treatments as a dental visit.

- **Other Dental Personnel (Line 18)**: Dental assistants, aides, and technicians; no visits are recorded for these workers.

***Behavioral Health Services***

*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 health centers as "behavioral health" visits must be parsed out into mental health or substance abuse. Centers may choose to identify all services as Mental Health Services.*

**Mental Health Services**

Mental health services include psychiatric, psychological, psychosocial or crisis intervention 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 Master's Degree-prepared clinicians.
- **Other Mental Health Staff (Line 20c)**: Unlicensed individuals, including "certified" individuals, who provide counseling, treatment, or support to mental health providers.

  *Mental health service visit considerations:*

  - Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are counted on Line 20c, unless they possess a separate license that they are practicing under. (Thus, a licensed clinical social worker (LCSW) doing a psychology internship must be counted on the LCSW Line 20a2 until a license is received as a Psychologist.)
  - 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 services are provided by the following: Substance abuse workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, family therapists, and other individuals providing alcohol or drug abuse counseling and/or treatment services.

Substance abuse service visit considerations:

- Neither licenses nor credentials are required by the UDS – each center will credential its own providers according to its own standards.
- Medical providers treating patients with substance use diagnoses remain reported on Lines 1 through 10.
- Programs that include the regular use of narcotic agonists or antagonists or other medications on a regular (daily, every three days, weekly, etc.) basis are to count the counseling services as visits but not the dispensing of the drugs, regardless of the level of oversight that occurs during that activity.

- **Other Professional Health Services (Line 22)**

  Other Professional Health Services

includes a broad array of providers of care. Some common professions include occupational, speech, and physical therapists, registered dieticians, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and community health aides and practitioners. (A more complete list is included in Appendix A.)

*Other professional health service visit considerations:*

- These professionals are usually, but not always, licensed by some entity. They are also generally credentialed and privileged by the health center's governing board.
- WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff.
- Services must be described in a clear detailed statement. There is a "specify" box for this line that must be completed for all services.
- Health centers are encouraged to check the reporting of such services with the UDS Support Center or their UDS Reviewer.

- **Vision Services (Lines 22a-22d)**

  Eye exams performed for the purpose of early detection, care, treatment, and prevention for those with eye disease or issues that relate to chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses.

- **Ophthalmologists (Line 22a)**: Medical doctors specializing in medical and surgical eye problems
- **Optometrists (Line 22b)**: Optometrists (OD)

  *Ophthalmologist and Optometrist visit considerations:*

  - Do not count the services of students or anyone other than a licensed vision service provider with vision services visits.
  - Retinography (imaging of the retina), whether performed by a licensed vision services provider or anyone else, is not considered a vision visit absent of a comprehensive vision exam by a vision service provider.

- **Other Vision Care Staff (Line 22c)**: Ophthalmologist or optometric assistants, aides, and technicians; no visits are recorded for these workers. Fitting glasses is not considered as a visit regardless of who performs the fitting.

**Pharmacy Services (Line 23)**

Pharmacists (including clinical pharmacists), pharmacy technicians, pharmacist assistants, and others supporting pharmaceutical services; no visits are recorded for these workers.

*Pharmacy services considerations:*

- 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 [PAP]) are to be reported under "Eligibility Assistance Workers," on Line 27a.
- An individual employee who works as a pharmacy assistant (for example) and also provides PAP enrollment assistance should be allocated by time spent in each category.

- Some States license clinical pharmacists whose scope of practice may include ordering labs and reviewing and altering medications or dosages. Despite this expanded scope of practice, *no clinical pharmacist visits, nor interaction with patients, 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.

**Enabling Services (Lines 24-29)**

- **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 service needs, establishment of service plans, and maintenance of referral, tracking, and follow-up systems. Case managers may, at times, provide health education and/or eligibility assistance during the course of their 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.

  *Case manager visit considerations:*

  - 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.
  - None of the time of a nurse providing comprehensive nursing support including making an appointment for a patient with another provider is counted here.
  - Case managers often contact third parties in the provision of their services. These contacts or interactions, though recognized as important, are not counted as visits for purposes of UDS reporting.
  - When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility) only one visit is generated, generally for an adult member of the family, regardless of documentation in other charts.
  - Case management is rarely the only type of service provided to a patient.

- **Patient and Community Education Specialists (Line 25)**: Health educators, with or without specific degrees in this area.

  *Patient and community education visit considerations:*

  - 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.
  - Only services provided one-on-one with the patient can be reported. Group education classes or visits are not reported.
  - Health education is provided to support the delivery of other health care services as described above and is rarely the only type of service provided to a patient.

- **Outreach Workers (Line 26)**: Individuals conducting case finding, education, or other services to identify potential patients or clients and/or facilitate access or referral of potential health center patients to available health center services; no visits are recorded for these workers.

- **Transportation Workers (Line 27)**: Individuals who provide transportation for patients (van drivers) or arrange for transportation, including persons who provide for long distance transportation to major cities in some extremely remote clinic locations; no visits are recorded for these workers.
- **Eligibility Assistance Workers (Line 27a)**: Staff providing assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, Medicare, WIC, supplemental security income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Pharmacy Assistance Programs (PAPs), and related assistance programs, as well as staff hired under the HRSA Outreach and Enrollment grants; no visits are recorded for these workers.
- **Interpretation Staff (Line 27b)**: Staff whose *full-time or dedicated time* is devoted to translation and/or interpretation services; no visits are recorded for these workers. *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 his/her other activities.
- **Community Health Workers (Line 27c)**: Lay members of communities who work in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve; no visits are recorded for these workers. Staff may be called community health workers, community health advisors, lay health advocates, promotoras, community health representatives, peer health promoters, or peer health educators.

  *Community health worker considerations:*

  - They may be performing some or all of the tasks of other enabling services workers.
  - Care should be taken not to include individuals better classified under other categories, including Other Medical Personnel (Line 12) or Other Dental Personnel (Line 18).

- **Personnel Performing Other Enabling Service Activities (Line 28)**: All other staff performing enabling services not described above; no visits are recorded for these workers.

  *Other enabling services considerations:*

  - Enabling services, and especially "Other Enabling Services" (Line 28), are not to be used as a catch-all, all-inclusive category for services that are not included on other lines. Often, such services belong on Line 29a (Other Programs and Related Services) or are services that are not counted anywhere on the UDS.
  - If a service does not fit the strict descriptions for Lines 24 through 27b, its inclusion on Line 28 must include a clear detailed statement of what is being reported; there is a "specify" field that must be used to describe what these staff are doing.
  - Health centers are encouraged to check such services with the UDS Support Center or their UDS Reviewer prior to submission.

**Other Programs and Related Services Staff (Line 29a)**

Some health centers, especially "umbrella agencies," operate programs that, although 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 health care programs, fitness or exercise programs, public/retail pharmacies, etc.; no visits are recorded for these workers. There is a "specify" field that must be used to describe what these staff members are doing.

**Quality Improvement Staff (Line 29b)**

Although quality improvement (QI) is a part of virtually all clinical and administrative roles, some individuals have specific responsibility for the design and oversight of quality improvement systems. All or a substantial portion of their time is dedicated to these activities. They may have clinical, IT, or research backgrounds, and may include QI nurses, data specialists, statisticians, and health information technologies (HIT), including electronic health records (EHR) and electronic medical records (EMR), designers; no visits are recorded for these workers.

*Quality improvement staff considerations:*

- *Do not include on this line* the time of clinicians such as physicians or dentists who are involved in the QI process. Their time is to remain on the service delivery lines.
- Staff who support HIT to the extent that they are working with the QI system are to be reported here.
- Staff who document services in the HIT should continue to be reported in the appropriate service category, not here.

**Non-Clinical Support Services (Line 30a-32)**

- **Management and Support Staff (Line 30a)**: Management team including the Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Medical Officer, Chief Operations Officer, and Human Resources Director, as well as other non-clinical support staff and office support (secretaries, administrative assistants, file clerks, etc.); no visits are recorded for these workers. 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 FTE corresponding to the corporate management function. (See limits on non-clinical time above.)
- **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 program, *excluding the Chief Financial Officer* (who is reported on Line 30a); no visits are recorded for these workers.
- **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 program; no visits are recorded for these workers.

  *Information technology (IT) staff considerations:*

  - IT staff managing the hardware and software of an HIT (including EHR/EMR) system are reported on Line 30c.
  - IT staff designing medical forms and conducting analysis of HIT data are included as part of the QI functions reported on Line 29b.

- IT staff performing data entry as well as providing help-desk, training, and technical assistance functions are included as part of the other medical personnel or appropriate service category for which they perform these functions.

- **Facility Staff (Line 31)**: Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff; no visits are recorded for these workers. Note: 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 14 on Table 8A.

- **Patient Services Support Staff (Line 32)**: Intake staff, front desk staff, and medical/patient records; no visits are recorded for these workers.

*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 health center, 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 health center's federally approved indirect cost rate should be reported here.*

## Clinic Visits, Column B

A **visit** is a documented, face-to-face contact between a patient and a licensed or credentialed provider who exercises his/her independent, professional judgment in the provision of services to the patient. Health centers report visits (including fee-for-service visits) that occurred during the reporting year rendered by salaried, contracted, or volunteer staff. Most visits reported in Column B will be provided by staff identified in Column A. (See the Definitions of Visits, Providers, and Patients section, page 18, for further details on the definition of visits).

**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 health center by a provider who is not part of the health center's staff (neither salaried nor contracted on the basis of time worked but meeting the center's credentialing policies),

- The service was paid for in full by the health center, 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 the health center's staff are similarly not counted if provided under some other arrangement.

Some interactions are not to be reported as visits. Please review the **When a Visit is Not a Visit and a Person Served is Not a Patient** section above for these specifics.

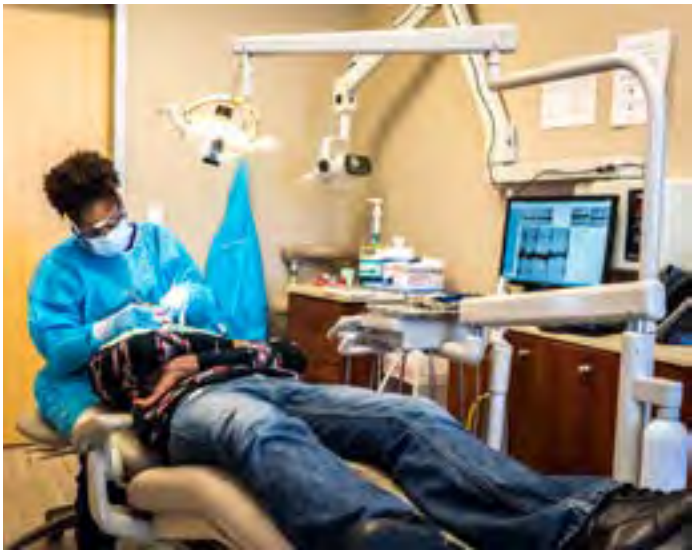
## Patients, Column C

A patient is an individual who has at least one reportable visit during the reporting year. (See the Definitions of Visits, Providers, and Patients section, page 18, for further details.) This will be an unduplicated patient count reported in Column C

for any of the seven categories of services shown below at which the patient had visits reported in Column B during the reporting year.

Report the total number of patients served 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) within each service category.*

- Medical services (Line 15)
- Dental services (Line 19)



- Mental health services (Line 20)
- Substance abuse services (Line 21)
- Vision services (Line 22d)
- Other professional services (Line 22)
- Enabling services (Line 29)

Because patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Please note that individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, outreach) are not included in the patient count reported in Column C (or anywhere in the UDS).

## Relationship between Table 5 and Table 8A

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 and analysis 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 on Table 5) 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 8, 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, dental therapists) | 5: Dental |
| 20a–20c: Mental Health | 6: Mental Health |
| 21: Substance Abuse | 7: Substance Abuse |
| 22: Other Professional (e.g., nutritionists, podiatrists) | 9: Other Professional |
| 22a–22c: Vision (ophthalmologists, optometrists, optometric assistants, other vision care) | 9a: Vision |
| 23: Pharmacy | 8a: Pharmacy |
| 24–28: Enabling (e.g., case management, outreach, eligibility)—relationship of the detail follows. *Note that the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.* | 11a–11g: Enabling |
| 24: Case Managers | 11a: Case Management |
| 25: Patient/Community Education Specialists | 11d: Patient and Community Education |
| 26: Outreach Workers | 11c: Outreach |
| 27: Transportation Staff | 11b: Transportation |
| 27a: Eligibility Assistance Workers | 11e: Eligibility Assistance |
| 27b: Interpretation Staff | 11f: Interpretation Services |
| 27c: Community Health Workers | 11h: Community Health Workers |
| 28: Other Enabling Services | 11g: Other Enabling Services |
| 29a: Other programs and services (non-health related services including WIC, job training, housing, child care, etc.) | 12: Other Related Services |
| 29b: Quality Improvement staff | 12a: Quality Improvement |
| 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) | 14: Facility |

## Questions and Answers for Table 5

1. **Are there changes to this table?**
   Yes. Three new lines have been added to account for dental therapists (and their visits), community health workers, and quality improvement staff.

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 and the service must be paid for consistent with health center policy either by the patient, their insurance, or another contract maintained by the health center. If some patients/visits are billed and others are not billed, only those that 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 for the remaining 25 percent of his/her salary?**
   An individual who is hired as a full-time clinician must be counted as a 1.0 FTE clinician 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 activities 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, is not to be adjusted off – it is to be considered part of his/her time as a physician. The exception to this rule is when a Medical Director or Chief Medical Officer 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, or approving specialty referrals. Note that loan-repayment recipients must be counted as full-time. Note also 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 percent (35 ÷ 40) FTEs?**
   No; they are each counted as 1.0 FTE. Health centers are not required by BPHC to have a 40-hour work week, but whatever work week 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 services you provide are medical services. On Table 5, the health center reports *patients for each type of service with the patient counted once for each 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 in 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?**
Usually. There should be a logical consistency between Table 5 and Table 8A. If a health center reports the costs for case management services, one would expect to see case managers reported on Table 5, unless the service was contracted with no staff time specifically identified. Similarly, if there are staff members on Table 5, we would expect costs on Table 8A unless all staff are volunteers. Some services do not, in fact, involve staff. Spending funds on bus tokens, for example, would involve transportation costs on Table 8a, but no staff on Table 5.

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. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) 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. Note that this is likely to trigger an edit in the EHB data entry system that must be explained, but it is not an error.

8. **Where does Behavioral Health get reported?**
Behavioral Health in some systems is another name for mental health, and the staff and visits are reported on Lines 20a through 20c. However, some health centers have merged the roles of mental health provider and substance abuse provider into a single role which they call a behavioral health provider. In this instance, the health center has two choices. The first is to assert that substance abuse problems are, indeed, mental health problems and classify its behavioral health staff as mental health staff on Lines 20a, 20a1, 20a2, 20b, or 20c. Another method would be to carefully record the time and activities of these dual function providers. In this case, the health center will need to identify each and every visit as either a mental health visit or a substance abuse visit so the patients and visits can be correctly classified. It must also keep track of providers' time so that its FTEs on Table 5 (and associated costs on Table 8A) can be accurately allocated and 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 under 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 the cost of the provider on Table 8A. This does not apply to physicians—the visit, would count as a medical visit in that case.

10. **Do I count the time of volunteer clinicians, interns, or residents?**
Yes. Volunteers, (some) interns, and residents are generally licensed practitioners and their

time is counted just like any other practitioner. Note, however, that some may work shorter days because they are in educational sessions, may 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, interns, and residents in Appendix B.

11. **We contract with a number of individuals who are licensed as physicians to over-read our tests; an ophthalmologist reads the retinal photos that our medical assistant takes for our diabetic patients, a radiologist over-reads the X-rays that our X-ray tech takes, the outside laboratory's pathologist officially provides the test results that come off their machines, and a consulting cardiologist receives our electrocardiograms (EKGs) and confirms our findings. Should we report them as our staff? Do we count what they do as visits?**

    Tests are not counted as visits anywhere in the UDS. Do not count the time (FTE) of any individual who is working on a contract basis where the payment is not for their time worked but rather, is for the activity that they performed. So these activities, *all of which are important to the provision of comprehensive care to your patients,* are not counted or reported separately. Because the costs will be counted on Table 8A, the EHB is likely to identify an exception that you will need to explain.

12. **We employ community health workers at our health center. Where are they reported?**
    Staff with responsibility as a community health worker are to be reported on Line 27c.

## Table 5: Staffing and Utilization

Reporting Period: January 1, 2016, through December 31, 2016

| Line | 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 | | | |
| 7 | Other Specialty Physicians | | | |
| 8 | **Total Physicians** (Lines 1–7) | | | |
| 9a | Nurse Practitioners | | | |
| 9b | Physician Assistants | | | |
| 10 | Certified Nurse Midwives | | | |
| 10a | **Total NPs, PAs, 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 | | | |
| 17a | Dental Therapists | | | |
| 18 | Other Dental Personnel | | | |
| 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 | Ophthalmologists | | | |
| 22b | Optometrists | | | |
| 22c | Other Vision Care Staff | | | |

| Line | Personnel by Major Service Category | FTEs (a) | Clinic Visits (b) | Patients (c) |
|---|---|---|---|---|
| 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 | | | |
| 27c | Community Health Workers | | | |
| 28 | Other Enabling Services (specify___) | | | |
| 29 | **Total Enabling Services** (Lines 24–28) | | | |
| 29a | **Other Programs/Services (specify___)** | | | |
| 29b | **Quality Improvement Staff** | | | |
| 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+29b+33) | | | |

# Instructions for Table 5A: Tenure for Health Center Staff

Table 5A provides information on the tenure of health center providers and key management staff who are employed or committed on the last day of the year to better assess workforce needs and improve efforts for workforce development and retention. They may be employed for all or a part of the year or by contract or retained as NHSC assignees. Staff is 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 definitions for each line (category) on Table 5A is the same as those used on Table 5, and individuals reported on the selected lines on Table 5A are the same individuals that are reported on the comparable lines on Table 5. Line numbers on Table 5A correspond to those on Table 5. Not all Table 5 lines are reported. There are no lines for non-providers, other than key health center management staff, or for the providers of Other Professional and Enabling services.

## Definitions

## Full- and Part-Time Staff, Column A

Full- and part-time staff are individuals who are considered regular employees of the health center. They may be paid in any number of 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 Column A with months in the current position reported in Column B.

### Full-Time Staff

Full-time staff are employed by the health center, receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the Internal Revenue Service (IRS) on a W2 form. 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 full time employees get eight hours off for a holiday, these staff also receive eight hours off.) They may have assigned work hours that are fewer than 40 per week and may actually end up working more than those assigned hours.

### Part-Time Staff

Part-time staff are employed by the health center, for fewer than 40 hours per week. They receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. 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 percent 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 or contracted for 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 employed by the health center on December 31st or be under an agreement to return to the clinic the following year. An individual who works for part of the year and then leaves prior to the last working day of the year with no concrete plan to return *is not reported on this table*.

### Contract Staff

Contract staff are contracted by and work at the health center. They work regular assigned hours every day, 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 they have their income reported to the IRS on a 1099 form. Do not include hospitalists or contract physicians who are paid by the visit to deliver services in their own offices.

### National Health Service Corps (NHSC) Assignees

NHSC assignees are members of the National Health Service Corps (NHSC) who are assigned by the Corps to the health center. This includes members of the NHSC Loan Repayment Program. 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 some or all of the cost of their assignment.

## Locums, On-Call, and Other Service Providers or Consultants Column 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 Column C, with months in the current position reported in Column 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 (e.g., on a day off or to cover for a vacation, sick leave, or the Family and Medical Leave Act [FMLA]), but they may also be used when the center is unable to hire a full- or part-time staff person for a position and may be retained until the position is filled. 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.

### 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 (e.g., on a day off or to cover for a provider who is on vacation, sick leave, or FMLA), but they 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 Federal Tort Claims Act (FTCA), though they may be covered by the center's gap insurance.

### Volunteers

Health center volunteers may have a regular schedule that 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 participate in training programs that 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 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 (LCSW), in which case they would be considered on the LCSW line.
- An individual who is not licensed is not to be counted. An LCSW trainee who holds no independent license would not be reported on this table at all.

### 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 establish a service (e.g., a dental contract) or because it is serving a wider area than its existing sites can reach (especially in migrant voucher or homeless programs).

- If providers are 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 providers are paid by the visit, they are not to be considered for this table.

### Non-Clinical Consultants

Some health centers—especially smaller and more remote health centers—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 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 employed on the last day of the year or who are current employees/contractors 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 who are not regular staff.) Unlike Table 5, Table 5A is a census of staff as of the last work day of the year (i.e., December 31).

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

- Be employed full time
- Be employed part time on a regular basis with a regular schedule
- Be an NHSC clinician who is assigned to the health center
- Be contracted on a regular basis with a regular schedule

- Be an on-call, locum, resident, or volunteer provider who has worked and/or is scheduled to work a regular schedule 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)

Include the number of months reported for each person being included on Table 5A, Columns A and C. Total months is equal to the number of continuous months (rounded up to the next whole number) that that person has been in his/her current position, such as the following examples:

- For 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*.
- For 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.
- For 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 for which they are being counted*.
- For persons who are currently working 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 nine 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 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, such as the following:

- A full-time physician who was employed on the census date is counted as one 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 two 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 one person.
- A full-time physician who worked for the center for ages, but resigned prior to the census date is not counted.
- A physician on pregnancy leave who has been out for eight weeks but intends to return after the leave is over is counted as one person even though she was not present on the census date.

## Locums, On-call, and Other Service Providers and Consultants, 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 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*, though it is possible that some part time FTEs counted on Table 5 *will not* be

included in the count on Table 5A. Count each staff person working in a given position who qualifies under the definitions above as one 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 January 1, 2013 is credited with 48 months. (4 full years × 12 months)
- Two half time physicians who began working on July 1, 2002 are credited with a total of 348 months. (14.5 years × 2 staff × 12 months)
- A part time physician who has worked every summer during the migrant season since July 1, 2005, is credited with 138 months. (11.5 years × 12 months)
- A cardiologist who has worked the first and third Wednesday of every month since January 18, 2013 is credited with 48 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 January 1, 2013 and medical director since July 1, 2016 is credited with 48 months as a pediatrician and six months as a medical director.

## Questions and Answers for Table 5A

1. **Are there changes to this table?**
   Yes—reporting of tenure for dental therapists, Line 17a, has been added.

2. **Are we to reflect FTE or whole numbers to reporting persons on Table 5A?**
   Unlike Table 5, which reports staff FTEs, Table 5A reports persons in Columns A and C based on their *year-end* employment contract or arrangement. Regardless of whether the person works a full- or part-time schedule or works for the full year or part of the year, report them as one person.

3. **If someone fills two roles at the health center, how do I choose on which line to report them?**
   If an individual serves multiple roles for the health center (at the end of the year), report them as one person on each of the corresponding lines. Also report the months of tenure in each position.

4. **We received our health center funding/designation status in 2016, should we count months of tenure as of the date of funding/designation?**
   Months of tenure are not limited to the start of funding or designation, or even to the calendar year. Months of tenure are to be counted from the start of an individual's employment for the health center in their current (year-end) position. Thus a family physician who was first employed at the health center on January 15, 2012 will be counted as having 60 months' tenure, even though funding or designation occurred in 2016. If there was a gap in employment, you would exclude the time prior to the gap. Months should be rounded up to the nearest whole number for reporting purposes.

5. **If we reported staff on Table 5 for a particular line, should we report this same staff on the corresponding line of Table 5A?**
   Not necessarily. Although all staff included on Table 5A will also be reported on Table 5, the reverse is not always true. In cases where an individual was no longer employed as of the last day of the reporting year, you would not count them on Table 5A. For example, if the chief executive officer left your health center in November, you would not report them on Table 5A because they were not there at the end of the year, but you would report the calculated FTE on Table 5.

## Table 5A: Tenure for Health Center Staff

Reporting Period: January 1, 2016, through December 31, 2016

| | | Full and Part Time | | Locum, On-Call, etc. | |
|---|---|---|---|---|---|
| Line | Health Center Staff | 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 | | | | |
| 17a | Dental Therapists | | | | |
| 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

This table reports 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 and/or in HIT, including EHRs. Table 6A is not expected to reflect the full range of diagnoses and services rendered by a health center. The diagnoses and services selected represent those that are prevalent among Health Center Program patients, or that 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, substance abuse, or vision provider only.* Thus, if a case manager or health educator 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 recorded on both the line for hypertension and the line for diabetes.

**Selected Diagnoses**: Lines 1 through 20d present the name and applicable International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range of ICD-10-CM codes is shown, health centers should report on all visits where the provider assigned *diagnostic code* is included in the range/group. All diagnoses reported for the visit (primary, secondary, tertiary, etc.) are reported on Table 6A if they are included in the range of codes listed.

**Selected Tests/Screenings/Preventive Services**: Lines 21 through 26d present the name and applicable ICD-10-CM diagnostic and/or Current Procedural Terminology (CPT) procedure codes for selected tests, screenings, and preventive services that are particularly important to the populations served or of particular interest to HRSA and are services performed by the health center or by contracted paid referral. On several lines, both CPT codes and ICD-10-CM codes are provided. Health centers may use ***either*** the CPT codes ***or*** the ICD-10-CM codes for any specific visit, ***but not both***. *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: ICD-10-CM codes for mammography and Pap tests are listed to ensure capture of procedures that are done by the health center but coded with a different CPT code for state reimbursement under Title X or BCCCP. In some instances, payers (especially governmental payers) ask health centers to use different codes for services that are included in the UDS. In these instances, health centers should add these codes to the published list for reporting purposes.*

In the event a test is paid for by a third party, the health center must actually perform the test in their lab or collect the sample and transfer it to a reference lab for the test to be counted. Do not report referrals or orders for tests or procedures,

such as mammograms, X-rays, or tomography, that are not performed by or paid for by the health center. (For example, referral of a woman to the County Health Department for a mammogram would not be counted.) Mammograms performed by a health center but read by an outside radiologist who then bills a third party would be counted.

**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 16–17a on Table 5 or by an in-scope contractor paid by the health center*. 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: Fluoride treatments or varnishes that 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 or an individual working under their direct supervision. Only services that 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 return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit. Another person who is not a clinic patient and who comes in just for a flu shot during a health center-run flu clinic and without a specific referral from a prior visit would not have the interaction reported on Table 6A.

Care must be taken when **multiple entities are involved with a service**. The following are general examples:

- If the health center provider orders and performs the service, the service is counted. For example, a rapid HbA1c test ordered by a physician and performed in the clinic lab is counted.
- If children are routinely referred to the County Health Department for vaccinations, the vaccinations performed by the Health Department are not reported.
- If the health center provider orders a test (e.g., HIV tests) and the sample is collected at the health center and then sent to a reference lab for processing, the test is counted regardless of whether the test is paid for by the patient, the patient's insurance company[2], a government entity, or the health center.
- If a provider asks the patient to get a test not performed by the health center from a third party provider that sends the results back to the provider to be acted on and bills the health center that pays for it, that test is counted. Thus, a health center with a contract to pay for mammograms performed by a third-party provider is counted.
- If a provider asks the patient to get a test not performed by the health center from a third-party provider that may or may not send the results back to the provider to be acted on *but that does not bill the health center,* that test is *not* counted. Thus, a health center that sends a patient to the County Health Department for a mammogram for which the County will follow up with the patient directly *is not counted or reported*.
- If a provider sends a patient to a third party for a service not provided by the health center, such as sending a patient for an HIV test to a Ryan White Program where the receiving entity performs the service and follows up with the patient, the health center does not count that service.

2 Billing rules require that the charge for a lab test ordered by a provider be sent directly to a third party (including Medicaid and Medicare) and not to the provider or their health center.

## Number of Visits, Column A

### Lines 1–20d: Visits by Selected Diagnoses

Report the total number of visits during the reporting period where the indicated diagnosis is listed in the HIT/EHR or visit/billing record. If a visit has a diagnosis that is among the many diagnoses not listed on Table 6A, it is not reported. All visits are entered into an HIT/EHR or a 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.

### Lines 21–34: Visits by Selected Tests/Screenings/ Preventive and Dental Services

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-10-CM) codes or procedure (ADA or CPT) codes. *During one visit, more than one test, screening, or preventive service may be provided*. If these procedures or tests are on different lines on Table 6A, each would be counted. If they are on the same line, only one would be counted.

Some examples may illustrate these rules:

- 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 Line 21 (HIV Test) and Line 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 Line 11 (hypertension) and once on Line 21 (HIV test).
- Services are also reported where no diagnosis is reported. A patient who comes in for intense headaches who also gets a flu shot would be counted on Line 24a (flu shot), 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: Patients by Diagnosis

For Column B, report each individual who had one or more visits during the year that 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 or family of diagnoses. Any patient may have visits with multiple diagnoses, for example, hypertension and diabetes. In this case, the patient would be reported in Column B once (and only once) for ***each*** diagnosis used during the year. Thus, 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* Lines 9 and 11, regardless of how many times they were seen.

### Lines 21–26d: Patients by Selected Diagnostic Tests/Screening/Preventive Services

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 were provided. Patients may be counted for more than one service during a single visit. Thus, 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, s/he is 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: Patients by Selected Dental Services

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. Health centers can no longer use ICD-9-CM codes and must use only ICD-10-CM codes for diagnosis codes.

2. **If a case manager or health educator serves a patient who, for example, has diabetes, 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, substance abuse, and vision providers on Table 6A. Note that diagnoses are generally limited to those professionals in the specific area of expertise.

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, **then the service is counted***. For example, if a provider asks 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 table 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 a state BCCCP 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 or HITs." 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*. Although health centers are only required to report data derived from billing systems or HITs, the reported data may understate services in the circumstances described below. In today's Electronic Health Records, virtually all of these diagnoses and/or services should be captured in one of the templates available. To more accurately reflect your level of service, health centers may also use other codes in their system to enable the tracking. For example, if a child is given a vaccination for which the clinic does not charge 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. |
| Multiple | Tests (such as HIV tests, Pap tests, etc.) are ordered and collected by us, and we send it to a reference lab for processing, but the lab bills Medicaid or Medicare directly. | Preferred: Use the correct code, but show a zero charge. |
| 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. |
| 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. |
| 25 | Contraceptive management is funded under Title X or a state family planning program and does not have a Z30- diagnosis attached to it. | Preferred: Add a "dummy code" you can map to the Z30- code. Alternative: Code with both the Z30- and the state-mandated code, but suppress printing of the Z30- code. Take care not to count the same visit twice. |

**6. Are health centers required to report all diagnoses and services rendered during a visit?**

Yes. Health centers are required to document and report all diagnoses (not just primary diagnosis) and services rendered during all UDS-countable visits. It is important that health centers appropriately document the breadth of comprehensive services delivered during each visit, including documentation of behavioral health services provided during a medical visit (e.g., screening, brief intervention, and referral to treatment [SBIRT] and/or treatment and counseling for mental health and/or substance use disorders).

# Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2016, through December 31, 2016

## Table 6A: Selected Diagnoses

| | Diagnostic Category | Applicable ICD-10-CM Code | Number of Visits by Diagnosis Regardless of Primacy (a) | Number of Patients with Diagnosis (b) |
|---|---|---|---|---|
| | **Selected Infectious and Parasitic Diseases** | | | |
| 1-2. | Symptomatic / Asymptomatic HIV | B20, B97.35, O98.7-, Z21 | | |
| 3. | Tuberculosis | A15- through A19- | | |
| 4. | Sexually transmitted infections | A50- through A64- (exclude A63.0), M02.3- | | |
| 4a. | Hepatitis B | B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51 | | |
| 4b. | Hepatitis C | B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52 | | |
| | **Selected Diseases of the Respiratory System** | | | |
| 5. | Asthma | J45- | | |
| 6. | Chronic obstructive pulmonary diseases | J40- through J44-, J47- | | |
| | **Selected Other Medical Conditions** | | | |
| 7. | Abnormal breast findings, female | C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, R92- | | |
| 8. | Abnormal cervical findings | C53-, C79.82, D06-, R87.61-, R87.810, R87.820 | | |
| 9. | Diabetes mellitus | E08- through E13-, O24- (exclude O24.41-) | | |
| 10. | Heart disease (selected) | I01-, I02- (exclude I02.9), I20- through I25-, I26- through I28-, I30- through I52- | | |
| 11. | Hypertension | I10- through I15- | | |

## Table 6A: Selected Diagnoses (cont'd.)

| | Diagnostic Category | Applicable ICD-10-CM Code | Number of Visits by Diagnosis Regardless of Primacy (a) | Number of Patients with Diagnosis (b) |
|---|---|---|---|---|
| 12. | Contact dermatitis and other eczema | L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4) | | |
| 13. | Dehydration | E86- | | |
| 14. | Exposure to heat or cold | T33.XXXX, T34.XXXX, T67. XXXX, T68.XXXX, T69.XXXX | | |
| 14a. | Overweight and obesity | E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52) | | |
| | **Selected Childhood Conditions (limited to ages 0 through 17)** | | | |
| 15. | Otitis media and Eustachian tube disorders | H65- through H69- | | |
| 16. | Selected perinatal medical conditions | A33-, P22- through P29- (exclude P22.0, P29.3), P35- through P96- (exclude P50-, P51-, P52-, P54-, P91.6-, P92-, P96.81), R78.81, R78.89 | | |
| 17. | Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only. Does not include sexual or mental development. | E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3 | | |

## Table 6A: Selected Diagnoses (cont'd.)

| | Diagnostic Category | Applicable ICD-10-CM Code | Number of Visits by Diagnosis Regardless of Primacy (a) | Number of Patients with Diagnosis (b) |
|---|---|---|---|---|
| | **Selected Mental Health and Substance Abuse Conditions** | | | |
| 18. | Alcohol related disorders | F10-, G62.1 | | |
| 19. | Other substance related disorders (excluding tobacco use disorders) | F11- through F19- (exclude F17-), G62.0, O99.32- | | |
| 19a. | Tobacco use disorder | F17- | | |
| 20a. | Depression and other mood disorders | F30- through F39- | | |
| 20b. | Anxiety disorders including PTSD | F40- through F42-, F43.0, F43.1- | | |
| 20c. | Attention deficit and disruptive behavior disorders | F90- through F91- | | |
| 20d. | Other mental disorders, excluding drug or alcohol dependence | F01- through F09-, F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0 | | |

## Table 6A: Selected Services Rendered

| | Service Category | Applicable ICD-10-CM Code or CPT-4/II Code | Number of Visits (a) | Number of Patients (b) |
|---|---|---|---|---|
| | **Selected Diagnostic Tests/ Screening/Preventive Services** | | | |
| 21. | HIV test | **CPT-4**: 86689; 86701 through 86703; 87390 through 87391 | | |
| 21a. | Hepatitis B test | **CPT-4**: 86704, 86706, 87515 through 87517 | | |

## Table 6A: Selected Services Rendered (cont'd.)

| | Service Category | Applicable ICD-10-CM Code or CPT-4/II Code | Number of Visits (a) | Number of Patients (b) |
|---|---|---|---|---|
| 21b. | Hepatitis C test | **CPT-4**: 86803, 86804, 87520 through 87522 | | |
| 22. | Mammogram | **CPT-4**: 77052, 77057 OR **ICD-10**: Z12.31 | | |
| 23. | Pap test | **CPT-4**: 88141 through 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 | | |
| 24. | Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child) | **CPT-4**: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748 | | |
| 24a. | Seasonal Flu vaccine | **CPT-4**: 90654 through 90662, 90672, 90673, 90685 through 90688 | | |
| 25. | Contraceptive management | **ICD-10**: Z30- | | |
| 26. | Health supervision of infant or child (ages 0 through 11) | **CPT-4**: 99381 through 99383, 99391 through 99393 | | |
| 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, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F | | |
| 26d. | Comprehensive and intermediate eye exams | **CPT-4**: 92002, 92004, 92012, 92014 | | |

## Table 6A: Selected Services Rendered (cont'd.)

| | 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, D0171, D0180 | | |
| 29. | Prophylaxis – adult or child | **ADA:** D1110, D1120 | | |
| 30. | Sealants | **ADA:** D1351 | | |
| 31. | Fluoride treatment – adult or child | **ADA:** D1206, D1208 | | |
| 32. | III. Restorative Services | **ADA:** D21xx through D29xx | | |
| 33. | IV. Oral Surgery (extractions and other surgical procedures) | **ADA:** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294 | | |
| 34. | V. Rehabilitative services (Endo, Perio, Prostho, Ortho) | **ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx | | |

## Sources of Codes:

- International Classification of Diseases, 2016, The Complete Draft Code Set (ICD-10-CM). American Medical Association (AMA).
- Current Procedural Terminology (CPT), 2014. American Medical Association (AMA).
- Current Dental Terminology (CDT), 2016 – Dental Procedure Codes. American Dental Association (ADA).

*NOTE: "X" in a code denotes any number including the absence of a number in that place. "–" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four-digits.*

# Instructions for Table 6B: Quality of Care Measures

This table reports data on selected quality of care measures. BPHC first implemented these measures in 2008 and has been updating and adding to them since then. BPHC will continue to revise and expand these measures consistent with the National Quality Strategy and other national quality initiatives.

The quality of care measures reported are "process measures," which means that they document services that have been shown 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 an 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 an 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 immunization status**: *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.
- **Cervical cancer screening**: *If* women receive Pap tests as recommended, *then* early detection and treatment of abnormalities can occur and they will be less likely to suffer adverse outcomes from human papillomavirus (HPV) infection and cervical cancer.
- **Weight assessment and counseling for nutrition and physical activity for children and adolescents**: *If* clinicians ensure their patients' body mass index (BMI) percentile is recorded, and *if* 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.
- **Preventive care and screening: Body mass index (BMI) 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 develop a follow-up plan for overweight and underweight patients, *then* the likelihood of the debilitating sequela of serious weight problems can be reduced.
- **Preventive care and screening: Tobacco use: Screening and cessation intervention**: *If* patients are routinely queried about their tobacco use and are provided with effective cessation counseling and pharmacologic intervention if they are tobacco users, *then* patients will be more likely to quit using tobacco and will therefore have a lower risk of cancer, asthma, emphysema, and other tobacco related illnesses.
- **Use of appropriate medications for asthma**: *If* patients identified with persistent asthma are provided with appropriate pharmacological intervention, *then* they will be less likely to have asthma attacks, will require fewer emergency room visits, and be less likely to develop complications related to asthma, including death.

- **Coronary artery disease (CAD): Lipid therapy**: *If* clinicians ensure patients with established coronary artery disease and high lipid levels receive lipid lowering therapy, *then* the likelihood of CAD-related clinical events will be reduced.

- **Ischemic vascular disease (IVD): Use of Aspirin or another antithrombotic**: *If* clinicians ensure patients with established IVD use aspirin or another antithrombotic drug, *then* the likelihood of myocardial infarctions and other vascular events can be reduced.
- **Colorectal cancer screening**: *If* patients receive appropriate colorectal screening, *then* early intervention is possible and premature death can be averted.
- **HIV linkage to care**: *If* patients found to be HIV positive are seen for follow-up care within 90 days of the initial HIV diagnosis, *then* the probability of HIV-related complications and transmission of disease are reduced.
- **Preventive care and screening: screening for clinical depression and follow-up plan**: *If* patients are routinely screened for depression and are provided with a follow-up plan if they are screened as positive, *then* they will be more likely to receive needed treatment and less likely to suffer from the sequela of depression.
- **Dental sealants for children between 6-9 years:** If patients with moderate to high risk for caries are provided sealants on first permanent molars, then they will be less likely to experience dental decay.

The clinical quality measures described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. Many of the UDS quality of care measures are now aligned with CMS e-CQMs for Eligible Professionals. The June 2015 eReporting update is used for the 2016 reporting period. (Although there are other updates available from CMS, they are not to be used for 2016 reporting.) The eReporting specifications can be found at the CMS' eCQI Resource Center at https://ecqi.healthit.gov/ep. E-CQM measure numbers and links are provided to assist you, where applicable. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/ is encouraged for health centers capable of appropriately using this resource as defined below to support the data reporting of these quality of care measures.

## Column Logic Instructions

### Column A: Number of Patients in the Universe (Denominator)

The total number of health center patients who fit the detailed criteria described for the specified measure. *Patients meeting the criteria in the health center's total patient population, including all sites, all programs, and by all providers, are to be considered.*

Because the initial patient population for each measure is defined in terms of age (or age and sex assigned at birth), comparisons to the numbers on

Table 3A and Table 6B will be made when evaluating your submission. The numbers in Column A of Table 6B *will not be equal to* those which might be calculated on Table 3A for the following reasons: (1) all patients seen for all reportable services are counted on Table 3A, but the clinical measures reported on Table 6B relate to medical patients or dental patients (specific to one measure only) or to patients with specific conditions; and (2) Table 3A measures age as of June 30 of the calendar year, but Table 6B defines specific time periods (i.e., by December 31) to measure age.

## Column B: Number of Charts/Records Sampled or EHR Total

The total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will essentially become the denominator in evaluating the measurement standard and will be as follows:

- *all patients* who fit the criteria (and hence the same number as the universe reported in Column A), *or*
- a number equal to or greater than 80 percent* of all patients who fit the criteria (and hence a value no less than 80 percent of the universe reported in Column A), *or*
- a scientifically drawn *sample of 70 patients* selected from all patients who fit the criteria.

  * Note: To streamline the process for reporting on the clinical quality measures, and to encourage the use of HITs to report on the full universe of patients, health centers must use an HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient records are included in the HIT/EHR for any given measure and the HIT/EHR does not exclude patients based on a variable related to any given measure.

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. Health centers *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 because this will result in over-sampling some group of patients.

A review of a sample of charts must be used in lieu of full universe reporting from an HIT/EHR if:

- The HIT/EHR does *not include* a minimum of 80 percent of health center patients who meet the criteria described below for inclusion in the specific measure's universe,
- The HIT/EHR does *not exclude* every health center patient who meets one or more exclusion criteria described below for exclusion from the universe, or
- The look-back period data necessary for many of the UDS clinical quality measures (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations) has not been in place in the HIT/EHR long enough to be able to find the data required in prior year's activities or this documented data was not collected from the patient as part of the visit. It is recommended that records for new patients be obtained from their former providers to document prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR consistent with internal medical records policies, at which point they could be used in the calculated performance rate for the applicable measure.

If the HIT/EHR is used, the number in Column B (records reviewed) must be no less than 80 percent of the number in Column A when the total universe is greater than 70. The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure.

### Column C: Number of Charts/Records Meeting the Measurement Standard (Numerator)

The total number of records that meet the measurement standard for the specified measure. The number in Column C (patients meeting the measurement standard) may never exceed the number in Column B (patient records reviewed).

*Note: The percentage of patient records meeting the measurement standard can be calculated by dividing Column C by Column B.*

## Criteria vs. Exclusions in HITs/EHRs vs. Chart Reviews

Because the UDS follows the structure developed for Meaningful Use and other quality reporting programs, conditions may sometimes be listed as criteria and sometimes as exclusions. They should be treated as described here to either constrain the universe of an HIT/EHR report or identify charts to be replaced in a chart review process.

In the discussion that 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 HIT/EHR (or practice management system [PMS]) based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be able to be found in the HIT/EHR and must be in the HIT/EHR for each and every patient at the health center. To the extent that they cannot be found, they will distort the findings, and means that the HIT/EHR must not be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the immunization of 2-year olds because you cannot limit the universe to medical patients.

In a sample chart review process, items listed as "criteria" below may be used as "exclusions." Thus, for example, you can ask that all 2-year old patients be listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. (In a computer search, you would include as a criterion that they must be medical patients for the child immunization measure.)

**And vs. Or**

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 conditions are met, the services for that patient are considered to have failed to meet the measurement standard. Where conditions are linked with "***or,***" it means that if either of the conditions is met the measure is satisfied.

## Detailed Instructions for Clinical Measures

What follows is a detailed discussion of each of the clinical measures.

*Note: To assist health centers with identifying patients who meet the measurement criteria (numerators and/or denominators), ICD-10-CM or CPT codes may be provided. The codes provided may not be inclusive of all codes listed in the eReporting specifications, and health centers are responsible for proper alignment with the eCQMs. Some of the newer measures do not correspond directly with traditional ICD-10-CM,or CPT codes. As a result, some CPT Category II codes (shown as CPT-II) that are specific to performance measures are included. These may be found in an appendix to most CPT manuals titled Category II Codes.*

## Sections A and B: Demographic Characteristics of Prenatal Care Patients

All health centers must report on all prenatal care patients who are either provided direct care or referred for care.

All health centers must report on the age and trimester of entry into prenatal care for all prenatal care patients regardless of whether they receive all or some of their prenatal services in the health center or are referred elsewhere.

### Prenatal Care by Referral Only (check box)

Check the "Prenatal Care by Referral Only" flag if you only provide prenatal care to patients through direct referral to another provider. Do not select this flag if your health center providers provide some or all prenatal care to patients.

### Section A: Age of Prenatal Care Patients (Lines 1–6)

Report the total number of patients who received or were referred for 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 or were referred for prenatal care during the previous reporting period and continued into this reporting period,
- Began or were referred for care and delivered during the reporting year, or
- Began or were referred for their care in this reporting period, but will not/did not deliver until the next year.

Total prenatal care patients include women who:

- Receive all their prenatal care from the health center,
- Were referred to another provider for all their prenatal care by the health center,
- Began prenatal care with another provider but transferred to the health center at some point during their prenatal care,
- Began prenatal care with the health center but were transferred to another provider at some point during their prenatal care, or
- Were provided with all their prenatal care by a health center provider, but 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: Early Entry into Prenatal Care (Lines 7–9), No e-CQM

**Performance Measure**: Percentage of prenatal care patients who entered prenatal care during their first trimester.

The measure itself, which is not dependent on which category of performance measurement achievement a woman might fall into, is calculated as follows:

**Universe (Denominator)**: Total number of women seen for prenatal care during the year (Line 7 + Line 8 + Line 9, Columns A + B)

**Numerator**: Number of women beginning prenatal care at the health center, including a referral provider (Column A) or with another health center (Column B), during their first trimester (Line 7, Columns A + B)

All women who received prenatal care, either directly or through a referral, including but not limited to the delivery of a baby during the reporting period, are reported on Lines 7–9. A number of criteria are used to identify how women are reported:

- The trimester is determined by the trimester of pregnancy that the woman was in *when she began prenatal care* either at one of the health center's service delivery locations or with another provider, including a referral provider.
- A woman who begins her prenatal care with the health center or is referred by the health center to another provider is reported once and only once in Column A.
- A woman who begins her prenatal care on her own at another provider and then transfers to the health center 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 prenatal exam. This visit is considered the first visit for UDS purposes. (Most women will have one or more interactions with the health center prior to that for their pregnancy test, other lab tests, dispensing vitamins, and/or taking a health history. These interactions do not count as the start of prenatal care.)
- In the event a woman is referred to another provider for care by a health center that does not have its own prenatal care program, the first visit is the visit at which they receive a complete prenatal exam from the referral provider. It is not when she first contacts the prenatal referral provider, when they do lab tests, or when she has psycho-social or nutritional assessments done.
- A woman is counted only once, regardless of the number of trimesters during which she receives care.
- In those rare instances where a woman receives prenatal care services for two separate pregnancies in the same calendar 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)**: Women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after their last menstrual period. If the woman began prenatal care during the first trimester at the health center's service delivery location or from a provider she was referred to by the health center, 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 health center's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with the health center.

**Second Trimester (Line 8)**: Women who were prenatal patients during the reporting period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period. If the woman began prenatal care during the second trimester at the health center's service delivery location or from a provider she was referred to by the health center, she is reported on Line 8 in Column A; if she received prenatal care starting the second trimester from another provider before coming to the health center's service delivery location, she is reported on line 8 in Column B, regardless of when she begins care with the health center.

**Third Trimester (Line 9)**: Women who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after their last menstrual period. If the woman began

prenatal care during the third trimester at the health center's service delivery location or from a provider she was referred to by the health center, 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 health center's service delivery location, she is reported on Line 9 in Column B, regardless of when she begins care with the health center. (Note that it is highly unusual for the number in Column B to be very large or larger than that in Column A because 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 prenatal care from the health center 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), whether they were seen by the health center or a referral provider, or when they deliver (this year or next year).

## Sections C through N: Other Quality of Care Measures

In these sections, health centers will report on the findings of their reviews of services provided to targeted populations. Sections C through M specifically assess the health center's current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Patients whose only visits were for dental, mental health, or something other than medical care are *not* included in the universe for these measures. Section N assesses the health center's current dental patients (i.e., patients who had a dental visit at least once during the reporting period). Patients whose only visits were for medical, mental health, or something other than dental care are *not* included in the universe for this measure. Age criteria are based on the patient's age during the reporting year.

Note: In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2016 data.

### Childhood Immunization Status (Line 10), **CMS117v4**

**Performance Measure**: Percentage of children age 2 years who were fully immunized by their second birthday. This is calculated as follows:

**Universe (Denominator):** Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period (Columns A and B)

Enter the number of children who:

- Were born between January 1, 2014, and December 31, 2014, ***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**.**

Include all children meeting this criterion regardless of whether they came to the health center for well child[3] services or other medical services, which include vaccinations or if 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 services are not to be counted as patients on any of the demographic tables and are not included in the universe for this table.*

There will no doubt be a number of children for whom no vaccination information is available

3 Health centers 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.

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 still must be included in the universe, and thus in the denominator.

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 that permit allowable vaccination exclusions:

- Any particular vaccine: Anaphylactic/Allergic reaction to the vaccine or its components: ICD-9: 999.4; ICD-10-CM: T80.52-.
- Diphtheria, Tetanus, and Pertussis (DTaP): Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine) or 323.6x; ICD-10-CM: G04.01, G04.02, G04.32 (use T50.A-, T50.B-, T50.Z- to identify vaccine) or G04.00, G04.01, G04.30, G04.31, G04.39, G05.4.
- Varicella zoster virus (VZV), Measles, Mumps, Rubella (MMR):
    - Immunodeficiency, including genetic (congenital) immunodeficiency syndromes ICD-9: 279; ICD-10-CM: D80-, D81- (exclude D81.3, D81.5, D81.81-), D82-, D83-, D84-, D89- (exclude D89.0, D89.1, D89.2)
    - HIV-infected or household contact with HIV infection ICD-9: Infection V08, symptomatic 042; ICD-10-CM: B20, Z21
    - Cancer of lymphoreticular or histiocytic tissue ICD-9: 200-202; ICD-10-CM: C81-, C83-, C82-, C84.0-, C84.1-, C84.4-, C84.6-, C84.7-, C84.9-, C84.A-, C84.Z-, C85-, C86-, C88.4, C91.4-, C96- (exclude C96.5, C96.6)
    - Multiple myeloma ICD-9: 203; ICD-10-CM: C90-, C88- (exclude C88.0), Leukemia ICD-9: 204-208; ICD-10-CM: C91- (exclude C91.4-), C92-, C93.0-, C93.1-, C93.3-, C93.Z-, C93.9-, C94- (exclude C94.4-), C95-, D45
    - Allergic reaction to neomycin
- Inactivated polio vaccine (IPV): Allergic reaction to streptomycin, polymyxin B, or neomycin
- Haemophilus influenzae type b (Hib): None
- Hepatitis B: Allergic reaction to common baker's yeast
- Pneumococcal conjugate: None
- Hepatitis A: None
- Rotavirus (RV): None
- Influenza (flu) vaccines: Cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, or have had an anaphylactic reaction to neomycin

**Exclusions**: None

**Numerator**: Number of children among those included in the denominator who were fully immunized before their second birthday (Column C)

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]

- 4 diphtheria, tetanus, and acellular pertussis (DTP/DTaP),
- 3 polio (IPV),

4 This measure is aligned with the Healthy People 2020 IID-8 measure.

- 1 measles, mumps, rubella (MMR),
- 3 H influenza type b (Hib),
- 3 Hepatitis B (Hep B),
- 1 chicken pox VZV (Varicella),
- 4 pneumococcal conjugate (PCV),
- 1 Hepatitis A (Hep A),
- 2 or 3 rotavirus (RV), and
- 2 influenza (flu) vaccines.

In addition to those who have documentation of receiving the vaccine, count any of the following as documenting meeting the measurement standard 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**: At least four DTaP before the child's second birthday; any vaccination administered prior to 42 days after birth cannot be counted. DT vaccine does not contain pertussis and can be used as a substitute for children who cannot tolerate the pertussis vaccine.
- **IPV**: At least three polio vaccinations (IPV) with different dates of service 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 before the child's second birthday.
- **HIB**: Three H influenza type B (HiB) vaccinations with different dates of service before the child's second birthday; HiB administered prior to 42 days after birth cannot be counted.
- **Hepatitis B**: Three hepatitis B vaccinations with different dates of service 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 before the child's second birthday.
- **Pneumococcal conjugate**: At least four pneumococcal conjugate vaccinations before the child's second birthday.
- **Hepatitis A**: One hepatitis A vaccination before the child's second birthday.
- **Rotavirus**: At least two rotavirus vaccinations with different dates of service before the child's second birthday. RV administered prior to 42 days after birth cannot be counted.
- **Influenza**: Two influenza (flu) vaccinations with different dates of service before the child's second birthday. Flu shots administered prior to 180 days after birth cannot be counted.

The following ICD-9, ICD-10-CM, and/or CPT codes are evidence of meeting the measurement standard either by providing the vaccine *or* by having an exempting condition. *Note: Additional vaccines for these diseases—especially combination vaccines—may have been approved, and their CPT codes may be added by health centers to demonstrate meeting the measurement standard. Others listed here, especially those for single diseases covered by the MMR or MMRV vaccines may no longer be manufactured. Also note: 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); ICD-10-CM (Z22.2, A36-)
- **Tetanus**: CPT (90703); ICD-9 (037*, 99.38); ICD-10-CM (A35)
- **Pertussis**: ICD-9 (033*, 99.37); ICD-10-CM (A37-)
- **IPV**: CPT (90698, 90713, 90723); ICD-9 (V12.02*, 045*, 99.41); ICD-10-CM (Z86.12, A80-)
- **MMR**: CPT (90707, 90710)
- **Measles and Rubella**: CPT (90708)
- **Measles**: CPT (90705); ICD-9 (055*, 99.45); ICD-10-CM (B05-)
- **Mumps**: CPT (90704); ICD-9 (072*, 99.46); ICD-10-CM (B26-)
- **Rubella**: CPT (90706); ICD-9 (056*, 99.47); ICD-10-CM (B06-)
- **Hib**: CPT (90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748); ICD-9 (041.5*, 038.41*, 320.0*, 482.2*); ICD-10-CM: (B96.3, A41.3, G00.0, J14)
- **Hepatitis B**: CPT (90723, 90731, 90740, 90744, 90745, 90747, 90748); ICD-9 (VO2.61*, 070.2*, 070.3*); ICD-10-CM (B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51)
- **VZV**: CPT (90396, 90710, 90716); ICD-9 (052*, 053*); ICD-10-CM (B01-, B02-)
- **Pneumococcal conjugate**: CPT (90669, 90670)
- **Hepatitis A**: CPT (90633); ICD-10-CM (B15.0, B15.9)
- **Rotavirus**: CPT (90680, 90681); ICD-10-CM (A08.0*)
- **Influenza (flu)**: CPT (90655, 90657, 90661, 90662, 90673, 90685)

*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 meeting the measurement standard 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 that includes 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 generally do not update the HIT/EHR data set automatically and may require several queries to use. Registries can be used to fill in any voids in the immunization record at the health center, especially when a sample is used.

For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred prior to the patient's third birthday and been confirmed by a clinical provider.

Notes in the newborn discharge record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward meeting the measurement standard 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 that fail do not meet the measurement standard, including the following:

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

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

### Cervical Cancer Screening (Line 11), **CMS124v4**

**Performance Measure**: Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer. (Note: This measure review is of women age 23 through 64 years of age. No women aged 21 or 22 should be included in the calculation of this measure.) This is calculated as follows:

**Universe (Denominator)**: Women 23-64 years of age with a medical visit during the measurement period (Columns A and B)

Enter the number of female patients who:

- Were born between January 1, 1952, and December 31, 1992, ***and***
- Were first seen by the health center prior to their 65th birthday, ***and***
- Had at least one medical visit in a clinical setting[5] during the measurement year.

**Exclusions**: Women who have had a hysterectomy and who have no residual cervix. 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, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135); ICD-9-CM (68.4-68.8, 618.5); and ICD-10-CM (N99.3). NOTE, however that 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.

**Numerator**: Women with one or more Pap tests during the measurement year or during the ***two*** calendar years prior to the measurement year (2014, 2015, or 2016) (Column C)

Documentation in the medical record of a test performed outside of the health center must include the date the test was performed, who performed it, 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 that documents the name, date, and results from a test performed by another provider that is based on communications between the clinic and the provider is also acceptable.

The following ICD-9, ICD-10-CM, and/or CPT codes are evidence of meeting the measurement standard:

- CPT: 88141 through 88155, 88164, 88165, 88166, 88167, 88174, 88175
- ICD-9-CM: 91.46, V72.32; ICD-10-CM: Z01.42
- CPT-II: 3015F = Pap test

5 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 health center as approved "sites" are considered to be clinical settings and women seen in these clinics are included in the universe. This should not be construed to imply that these women do not need the test.

Do not count as meeting the measurement standard charts that note a referral to a third party but 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 meeting the measurement standard unsubstantiated statements from patients that cannot be backed up with third-party documentation. Do not count as compliant charts that note the refusal of the patient to have the test.

### Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Line 12), **CMS155v4**

**Performance Measure**: Percentage of patients 3 -17 years of age who had a medical visit and who had evidence of height, weight, and body mass index (BMI) *percentile* documentation ***and*** who had documentation of counseling for nutrition ***and*** who had documentation of counseling for physical activity during the measurement year. This is calculated as follows:

**Universe (Denominator)**: Patients 3 through 17 years of age with at least one medical visit during the measurement period (Columns A and B)

Enter the number of patients who:

- Were born between January 1, 1999, and December 31, 2012, ***and***
- Were first seen ever by the health center prior to their 18th birthday, ***and***
- Had at least one medical visit in a clinical setting[6] during the measurement year.

6 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 that cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the health center as approved sites are considered to be clinical settings, and children and adolescents seen in these clinics are included in the universe.

**Exclusions**: Patients who have a diagnosis of pregnancy during the measurement period

**Numerator**: Patients who had their BMI percentile (not just BMI or height and weight) documented during the measurement period ***and*** who had documentation of counseling for nutrition ***and*** who had documentation of counseling for physical activity during the measurement period (Column C)

The following ICD-10-CM, and/or CPT codes are evidence of meeting the measurement standard:

- ICD-10-CM code Z68.5- is for recording BMI percentile. Presence is sufficient, but not necessary.
- Codes 97802, 97803, 97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary.
- ICD-10-CM code Z71.89 is sufficient, but not necessary for physical activity counseling.

Do not count as meeting the performance measure, 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.

### Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (Line 13), **CMS69v4**

**Performance Measure**: Percentage of patients aged 18 years and older with a visit during the reporting period with a documented BMI during the most recent visit or within the six months prior to that visit ***and*** when the BMI is outside of normal parameters a follow-up plan is documented during the visit or during the previous six months of the visit with the BMI outside of normal parameters. This is calculated as follows:

**Universe (Denominator)**: Patients who were 18 years of age or older with a medical visit during the measurement year (Columns A and B)

Enter the number of patients who:

- Were born on or before December 31, 1997, ***and***
- Were last seen by the health center after their 18th birthday, ***and***
- Had at least one medical visit during the measurement year.

**Exclusions:**

- Patients who are pregnant (18-64 only),
- Visits where the patient is receiving palliative care, refuses measurement of height and/or weight, is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or
- There is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

**Numerator**: Patients with a documented BMI (not just height and weight) during their most recent visit ***or*** during the previous six months of the most recent visit, ***and*** when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the current visit (Column C)

Normal parameters:

- Age 18-64 years ***and*** BMI was greater than or equal to 18.5 and less than 25
- Age 65 years and older ***and*** BMI was greater than or equal to 23 and less than 30

The following codes are evidence of meeting the measurement standard:

- CPT-II: 3008F = BMI documented sufficient, but not necessary
- ICD-9: V65.3 and ICD-10-CM: Z71.3 = dietary surveillance and counseling sufficient, but not necessary for follow-up plan

Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must normally display BMI. Do not count as meeting the measurement standard, charts or templates which display only height and weight. The fact that an HIT/EHR is capable of calculating BMI does not replace the presence of the BMI itself.

### Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), **CMS138v4**

**Performance Measure**: Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months ***and*** who received cessation counseling intervention if defined as a tobacco user. This is calculated as follows:

**Universe (Denominator)**: Patients aged 18 years and older seen for at least two visits in the measurement year or at least one preventive visit during the measurement period (Columns A and B)

Enter the number of patients who:

- Were born on or before December 31, 1997, ***and***
- Were last seen by health center after their 18th birthday, ***and***
- Had at least one preventive medical visit during the measurement year, ***or***
- Had at least two medical visits during the measurement year.

**Exclusions**: Patient records with documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

**Numerator**: Patients who were screened for tobacco use at least once within 24 months of the most recent visit ***and*** who received tobacco cessation intervention if identified as a tobacco user (Column C)

Include records that demonstrate:

1) that the patient 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 ***and***

2) if the patient is found to be a tobacco user and they:

- Received tobacco use cessation services, ***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***
- Were found to be on (using) a smoking cessation agent.

The following codes may be useful to evidence meeting the measurement standard:

- CPT-II: 1000F = Tobacco use assessed
- CPT-II: 1034F = Current tobacco smoker
- CPT-II: 1035F = Current smokeless tobacco user (e.g., chew, snuff)
- CPT-II: 1036F = Current tobacco non-user
- CPT-II: 4000F = Tobacco use treatment, counseling
- CPT-II: 4001F = Tobacco use treatment, pharmacologic treatment
- CPT: 99406, 99407 = Smoking and tobacco use cessation counseling—sufficient but not necessary

The following codes may be useful in identifying evidence of tobacco use:

- ICD-9: 305.1, 649.00-649.04 = Tobacco use disorder—sufficient but not necessary
- ICD-10: F17-, O99.33- = Tobacco use (smoking) during pregnancy, childbirth, and the puerperium; Z72.0 = Tobacco use

## Use of Appropriate Medications for Asthma (Line 16), **CMS126v4**

**Performance Measure**: Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and who were appropriately prescribed medication during the measurement period. This is calculated as follows:

**Universe (Denominator)**: Patients age 5 through 64 years with a diagnosis of persistent asthma and who had at least one medical visit during the measurement period (Columns A and B)

Enter the number of patients who:

- Were born on or after January 1, 1952, and on or before December 31, 2010, ***and***
- Were diagnosed with ***persistent***[7] asthma ***or*** have persistent asthma as a current diagnosis on a chronic illness form or template, ***and***
- Were last seen by health center while they were age 5 through 64 years, ***and***
- Had at least one medical visit during the measurement year.

**Exclusions**: Patients with emphysema, chronic obstructive pulmonary disease, cystic fibrosis, or acute respiratory failure during or prior to the measurement period

7 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.

The following ICD-10 codes will be useful in identifying the universe:

- CPT-II (1038F or 4015F) and ICD-10 (J45.3x, J45.4x, J45.5x) = persistent asthma, including appropriate pharmacologic treatment prescribed (mild, moderate, or severe)

The following patients are to be excluded from the universe:

- Those with intermittent asthma (CPT-II (1039F) and ICD-10-CM (J45.2x))
- Patients whose only pharmacologic treatment is using a short-acting bronchodilator for symptomatic relief

**Numerator**: Patients who were dispensed at least one prescription for a preferred therapy during the measurement period (Column C)

Include records that demonstrate 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 inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

The following codes are evidence of meeting the measurement standard:

- CPT-II (1038F or 4015F) = persistent asthma, including appropriate pharmacologic treatment prescribed (mild, moderate, or severe)

## Coronary Artery Disease (CAD): Lipid Therapy (Line 17), No e-CQM

**Performance Measure**: 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:

**Universe (Denominator)**: Patients 18 years of age and older who had an active diagnosis of CAD or diagnosed as having had a myocardial infarction (MI) or had cardiac surgery in the past, with at least one medical visit during the measurement period and had at least two medical visits ever (Columns A and B)

Enter the number of patients who:

- Were born on or before December 31, 1997, ***and***
- Have an active diagnosis of CAD ***or*** were diagnosed as having had a myocardial infarction (MI) ***or*** had cardiac surgery[8], ***and***
- Were last seen by health center after their 18th birthday, ***and***
- Had at least one medical visit during ***the*** measurement year, ***and***
- Had at least two medical visits ever.

**Exclusions**:

- Individuals whose last low-density lipoprotein(LDL) lab test during the measurement year was less than 130 mg/dL
- Individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL lowering medications

Note: Patients who have no record of an LDL lab test must be included in the universe and evaluated for this measure

**Numerator**: Patients who received a prescription for or were provided or were taking lipid lowering medications during the measurement period (Column C)

8 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 utilize HIT reporting capabilities to identify patients with a history of pertinent cardiac surgeries.

The following CPT and ICD-9 and ICD-10-CM codes will be useful in identifying the universe:

- CAD and MI = ICD-10-CM (I20-, I21-, I22-, I23-, I24-, I25- (exclude I20.0, I25.3, I25.4-, I25.82, I25.83, I25.84))
- History of surgeries = ICD-9 (V45.81, V45.82); ICD-10-CM (Z95.1, Z98.61); CPT (33140, 33510-33514, 33516-33519, 33521-33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92981, 92982, 92984, 92995, 92996)

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 have not met the measurement standard.

## Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (Line 18), **CMS164v4**

**Performance Measure**: Percentage of patients aged 18 years of age and older who were discharged alive for acute myocardial infarction (AMI) a coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period *or* who had an active diagnosis of IVD during the measurement period and who had documentation of use of aspirin or another antithrombotic during the measurement period. This is calculated as follows:

**Universe (Denominator)**: Patients 18 years of age and older with a medical visit during the measurement period and who had an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for AMI, CABG, or PCI in the 12 months prior to the measurement period (Columns A and B)

Enter the number of patients who:

- Were born on or before December 31, 1997, ***and***
- Had an active diagnosis of ischemic vascular disease (IVD) or who had been discharged alive after AMI, CABG, PCI during the 12 months prior to the measurement period, ***and***
- Were last seen by the health center while they were 18 years of age or older, ***and***
- Had at least one medical visit during the measurement year**.**

**Exclusions**: None

The following CPT and ICD-10-CM codes will be useful in identifying the universe:

- IVD, AMI = 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); ICD-10-CM: I20-, I21-, I24-, I25-, I63-, I65-, I66-, I70.1, I70.20-, I70.21-, I70.22-, I70.23-, I70.24-, I70.25, I70.26-, I70.29-, I70.92, I74-, I75-, Z95.1, Z98.61 (exclude I25.2-, I25.4-, I25.82, I25.83, I25.84)
- History of surgeries = CPT (33510 through 33514, 33516 through 33519, 33521, 33522, 33523, 33533 through 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943)

**Numerator**: Patients who had documentation of use of aspirin or another antithrombotic during the measurement period (Column C)

Include patients who received a prescription for, were given, or were using aspirin or another antithrombotic drug.

## Colorectal Cancer Screening (Line 19), CMS130v4

**Performance Measure**: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. This is calculated as follows:

**Universe (Denominator)**: Patients who were aged 50 through 75 with a medical visit during the measurement period (Columns A and B)

Enter the number of patients who:

- Were born between January 1, 1941, ***and*** December 31, 1965, ***and***
- Had at least one medical visit during the measurement year.

**Exclusions**: Patients with a diagnosis or past history of colorectal cancer or colectomy

**Numerator**: Patients with one or more screenings for colorectal cancer (Column C)

Appropriate screenings are defined by any one of the following:

- a colonoscopy during the measurement period or the nine years prior to the measurement period (January 1, 2007, or later), ***or***
- a flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period (January 1, 2012, or later), ***or***
- a fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test *during* the measurement period.

The following CPT/CPT-II/ICD-9/ICD-10-CM codes will be useful in identifying meeting the measurement standard:

- ICD-9 = 45.22 - 45.25, 45.42 - 45.43, V76.51
- ICD-10-CM = Z12.11
- CPT = 44150 through 44158, 44210, 44211, 44212, 44388 through 44397, 45330 through 45345, 45355, 45378 through 45392, 82270, 82274
- CPT – II = 3017F

Though codes are shown for colonoscopy and flexible sigmoidoscopy, it is possible that these CPT codes may not be found in the health center's HIT/EHR or other computerized systems. 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 tests (FOBTs), including the fecal immunochemical test (FIT), can be used to document meeting the measurement standard. Because the FOBT is to be conducted annually, evidence of a test is required during the measurement year. Thus, a patient who had an FOBT in November 2015, for example, would still need one in 2016 even if the patient did not present in the clinic after June 2016. Stool specimens for FOBT, including FIT, should be collected as recommended by the manufacturer. An in-office stool specimen obtained via digital rectal examination does not meet the measurement standard nor does it comply with manufacturers' recommendations or national screening guidelines. However, stool specimen collection from a spontaneously passed stool during an office visit using an FIT demonstrated to have high sensitivity when analyzing a single stool sample is evidence-based and meets the measurement standard. FOBT/FIT test kits can be mailed to patients during the year, but receipt, processing, and documentation of the test sample is required. Evidence of mailing is not, in and of itself, sufficient.

## HIV Linkage to Care (Line 20), No e-CQM

**Performance Measure**: Percentage of patients newly diagnosed with HIV who were seen for follow-

up treatment within 90 days of diagnosis.[9] This is calculated as follows:

**Universe (Denominator)**: Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year (Columns A and B)

Enter the number of patients who:

- Were diagnosed with HIV for the first time ever[10] by the health center between October 1, 2015, and September 30, 2016[11], ***and***
- Had at least one medical visit during 2016 or 2015.

Note that the identification of patients for this measure crosses years and may include prior year patients.

**Exclusions**: None

The following codes will be useful in identifying the universe:

- ICD-10 = B20, B97.35, Z21

*Note, however, that these codes will identify all patients with HIV. There is no code for newly diagnosed HIV patients. Health centers that expect to see a very small number of such patients should develop alternative methods for tracking within the HIT/EHR or medical record.*

**Numerator**: Newly diagnosed HIV patients that received treatment within 90 days of diagnosis (Column C)

Include patients who:

- Were newly diagnosed by your health center providers, ***and***
- Had a medical visit with your health center provider who initiates treatment for HIV, ***or***
- Had a visit with a referral resource who initiates treatment for HIV.

Note: The numerator criteria are only fulfilled when the patient attended the medical visit for HIV care within 90 days of the HIV diagnosis. If the treatment is by referral to another clinician/organization (such as a Ryan White provider), the medical treatment at the referral source must begin and the referral loop must be closed during the 90-day period. That is, the referring provider receives confirmation from the provider to whom the patient was referred that the visit was completed.

Also note: *Actual treatment must be initiated* within 90 days of the HIV diagnosis, not just a referral made or education provided or retesting at the referral site.


9 Note that this measure does not conform to the calendar year reporting requirement.
10 "Patients first diagnosed with HIV" is defined as patients who received a reactive initial HIV test confirmed by a positive supplemental HIV test.
11 Because the measure gives up to 90 days to complete the follow-up, you look back 90 days to find the entire universe of patients who should have had a follow-up during the measurement year.

## Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Line 21), **CMS2v5.0**

**Performance Measure:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the visit using an age-appropriate standardized depression screening tool, ***and***, if screening is positive, for whom a follow-up plan is documented on the date of the positive screen. This is calculated as follows:

**Universe (Denominator)**: Patients aged 12 years and older with at least one medical visit during the measurement period (Columns A and B)

Enter the number of patients who:

- Were born on or before December 31, 2003, ***and***
- Had at least one medical visit during the measurement year.

**Exclusions**:

- Patients who refuse to participate, who are in urgent or emergent situations
- Patients whose functional capacity or motivation to improve affects the accuracy of results
- Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Note: Patients who are already participating in on-going treatment for depression will not be included in the universe count.

**Numerator**: Patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool ***and***, if screened positive for depression, for whom a follow-up plan is documented on the date of the positive screen (Column C)

Include patients who received a standardized depression screening test during the measurement year:

- That was negative, ***or***
- That was positive ***and*** had a follow-up plan documented.

The following codes are evidence of meeting the measurement standard:

- CPT–II = 3725F (screening for depression performed)

## Dental Sealants for Children between 6-9 Years (Line 22), **CMS277v0**

**Performance Measure**: Percentage of children, age 6-9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period. This is calculated as follows:

**Universe (Denominator)**: Children 6 through 9 years of age who had a dental visit in the measurement period who had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the measurement period (Columns A and B)

Enter the number of patients who:

- Were born between January 1, 2007, and December 31, 2009, ***and***
- Had a dental visit with the health center or with another dental provider through a paid referral, ***and***
- Had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement period, ***and***
- Were at moderate to high risk for caries.

**Exclusions**: Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/ missing)

The following CDT codes will be useful in identifying the universe:

- CDT = D0602 and D0603 for caries risk assessment of moderate or high risk
- CDT = D0191 for oral assessment performed
- CDT = D0120, D0145, D0150, D0180 for comprehensive or periodic oral evaluation

**Numerator**: Children who received a sealant on a permanent first molar tooth during the measurement period (Column C)

## Questions and Answers for Table 6B

1. **Are there any changes to the table this year?**
   Yes, the specifications for the clinical measures reported have been revised to align with the Centers for Medicare and Medicaid Services' electronic-specified Clinical Quality Measures (e-CQMs). The quality of care measures are aligned with the e-CQMs for Eligible Professionals June 2015 eReporting update for the 2016 reporting period. (Although there are other updates available, they should not to be used for the 2016 reporting.)

   ICD-9-CM has been replaced with ICD-10-CM codes. Health centers are required to use ICD-10 codes, where applicable.

2. **A child came in only once during the year 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 not have met the measurement standard?**
   Yes. After 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 s/he has received it.

3. **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?**
   After 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 coordinate care and document Pap test results by contacting providers of Pap tests directly to obtain appropriate documentation. The woman would be considered to be a part of your universe if she received *any* medical visit(s) in the measurement year. If there is no copy of the results of her Pap test included in her chart, she would be considered as not having met the measurement standard.

4. **If we pull a record during our sampling process 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 record as having met the measurement standard?**
   The health center should obtain a copy of her test result to include in the patient's record for future care. However, the record still has not met the measurement standard for the reporting year (although the record may now be valid for successive years depending on when the test was performed).

5. **If we inform parents of the importance of immunizations but they refuse to have their child immunized, may we count the record as having met the measurement standard 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.

6. **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 to obtain documentation by fax, 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.

7. **Some of the immunization details are different than those used by CDC in the Clinic Assessment Software Application (CASA) or Comprehensive-CASA (CO-CASA) reviews of our clinic. May we use these CDC standards to report on the UDS?**
No. HRSA is now using the Centers for Medicare and Medicaid Services' electronic-specified Clinical Quality Measures (e-CQMs) standards to evaluate provision of vaccines to children. 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 health centers will be asked to resample their data. A center *may* use a different set of standards for its own internal quality improvement/quality assurance program, but these may not be substituted for the BPHC measure definitions for the UDS reporting on Table 6B.

8. **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 health centers 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 health center *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 over-sample specific sites or providers to facilitate internal QI activities.

9. **What happens if the CPT or ICD-10-CM codes change again?**
The codes are reviewed annually by the UDS Support Center staff. Health centers are responsible for aligning specifications with e-CQMs outlined by CMS to ensure no codes are missing. If you think that there is a CPT or ICD code for a measure that is not being reflected in the list, contact the UDS Support Center. Staff will review the code(s) with BPHC and incorporate approved changes to codes in the manual for future reporting.

10. **Is the Pap test review for women starting at age 21 or at age 23?**
For this measure, you will look only at women who were 23 years or older (through age 64) at some point in the measurement year. You will not look at any women who were 21 or 22 years old at the end of that measurement year. Because the measure asks about Pap tests *administered* in 2016, 2015, or in 2014, it is possible that a 23 year-old woman would have been 21 in 2014. If she received a Pap test in that year, she would be considered to have met the measurement standard. You are looking only at women who are 23 through 64, but their qualifying test may have been received when they were 21 through 64. Health centers should take care to review charts only for women who were 23 through 64 in the measurement year and should not select any charts for women who were younger.

**11. When the listing of CPT codes says "sufficient but not necessary," what does this mean?**
The codes are generally for activities that, if undertaken, make it obvious that the criteria were 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.

**12. 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 has no specific required content. It is tailored by the clinician given the patient's BMI percentile. But, yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for *all* children and adolescents. Starting children and adolescents off right is important in efforts to improve long-term health outcomes and quality of life.

**13. 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.

**14. The measure says that there must be effective intervention for tobacco users. Are there specific interventions that must be used to consider them effective?**
No. This is at the discretion of the clinicians and should be consistent with their assessment of the patient's level of tobacco use. As long as the clinicians document that they intervened and this intervention is consistent with the health center's own protocols, the treatment has met the measurement standard for this measure.

**15. 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 patient's treatment to have met the measurement standard?**
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.

**16. Who are we to consider as having been first diagnosed with HIV?**
Line 20, HIV Linkage to Care, asks for a count of health center patients who (any provider in) your practice diagnosed with HIV where this was the first time the patient had ever been told they had HIV. The following might clear some of the ambiguity.

Do not include patients who:

- Were diagnosed elsewhere and can provide documentation of the positive test result;
- Were diagnosed elsewhere, referred to you for treatment, and can provide documentation of the positive test result;
- Had a (positive) reactive initial screening test but not a positive supplemental test;

- Were positive on an initial screening test provided by you but were then sent to another provider for definitive testing and treatment.

Do include patients who:

- Were referred to you after a (positive) reactive initial HIV test but did not have a supplemental test;
- Self-identify as being HIV positive, but cannot provide documentation of an HIV positive test result.

Note that there are no ICD-10-CM or CPT codes to identify this condition (newly diagnosed). Health centers should either modify their HIT/EHR to record this information or keep track of the patients who are identified in a separate system.

17. **How should we collect data for measures that require a look-back period?**
Many of the UDS clinical quality measures require a look-back period (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations, and others). It is important that this information is noted in patient records. It is recommended records for new patients be obtained from their former providers to document their prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR consistent with internal medical records policies, at which point they could be used in the calculated performance rate.

18. **Can we use National Quality Forum (NQF) or Healthcare Effectiveness Data and Information Set (HEDIS) directly to report on the clinical measures?**
No. Not directly. Health centers must report on the clinical measures outlined according to the UDS definitions outlined in this manual, many of which have been aligned with Meaningful Use's e-CQMs.

19. **Which dental patients are we required to report in the universe for the dental sealants measure?**
Health centers providing dental services directly on site or through paid referral under contract must report dental patients age 6 through 9 who are at elevated risk for caries in the universe count. Note that caries risk assessment must be based on patient-level factors and not population-based factors such as low socio-economic status.

20. **Do DNA colorectal cancer screening tests meet the measurement standard for the colorectal cancer screening measure?**
No. DNA colorectal cancer screening tests, Cologuard, for example, do not meet the colorectal cancer screening measure standard.

21. **What should we do if we do not have adequate documentation about the tooth on which a sealant was placed?**
In these situations, the health center should pull 70 patient charts using a random sample and have the reviewer evaluate the chart records to find evidence for the sealant being applied to a permanent first molar. If the tooth descriptor (tooth number) is undocumented and there is insufficient documentation to determine whether at least one of the sealant(s) was placed on a permanent first molar, the record will not be included in the numerator of the dental sealants measure calculation and may lower the overall measure score (percentage).

## Table 6B: Quality of Care Measures

Reporting Period: January 1, 2016, through December 31, 2016

| | | |
|---|---|---|
| 0 | **Prenatal Care Provided by Referral Only (Yes or No)** | |

**Section A - Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients**

| Line | 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 - Early Entry into Prenatal Care**

| Line | Early Entry into Prenatal Care | Women Having First Visit with Health Center (a) | Women Having First Visit with Another Provider (b) |
|---|---|---|---|
| 7 | First Trimester | | |
| 8 | Second Trimester | | |
| 9 | Third Trimester | | |

**Section C - Childhood Immunization Status**

| Line | Childhood Immunization Status | Total Patients with 2nd Birthday (a) | Number Charts Sampled or EHR total (b) | Number of Patients Immunized (c) |
|---|---|---|---|---|
| 10 | MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday | | | |

**Section D - Cervical Cancer Screening**

| Line | Cervical Cancer Screening | Total Female Patients Aged 23 through 64 (a) | Number Charts Sampled or EHR total (b) | Number of Patients Tested (c) |
|---|---|---|---|---|
| 11 | MEASURE: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer | | | |

### Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

| Line | Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | Total Patients Aged 3 through 17 (a) | Number Charts Sampled or EHR Total (b) | Number of Patients with Counseling and BMI Documented (c) |
|---|---|---|---|---|
| 12 | MEASURE: Percentage of patients 3-17 years of age with a BMI percentile, and counseling on nutrition and physical activity documented | | | |

### Section F – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

| Line | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up | Total Patients Aged 18 and Older (a) | Number Charts Sampled or EHR Total (b) | Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c) |
|---|---|---|---|---|
| 13 | MEASURE: Percentage of patients aged 18 and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters | | | |

### Section G – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

| Line | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Total Patients Aged 18 and Older (a) | Number Charts sampled or EHR total (b) | Number of patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c) |
|---|---|---|---|---|
| 14a | MEASURE: Percentage of patients aged 18 years and older who (1) were screened for tobacco use one or more times within 24 months *and* if identified to be a tobacco user (2) received cessation counseling intervention | | | |

### Section H – Use of Appropriate Medications for Asthma

| Line | Use of Appropriate Medications for Asthma | Total Patients Aged 5 through 64 with Persistent Asthma (a) | Number Charts Sampled or EHR Total (b) | Number of Patients with Acceptable Plan (c) |
|---|---|---|---|---|
| 16 | MEASURE: Percentage of patients aged 5 through 64 years of age identified as having persistent asthma and were appropriately prescribed medication during the measurement period | | | |

### Section I - Coronary Artery Disease (CAD): Lipid Therapy

| Line | Coronary Artery Disease (CAD): Lipid Therapy | Total Patients Aged 18 And Older With CAD Diagnosis (a) | Number Charts Sampled or EHR Total (b) | Number of Patients Prescribed A Lipid Lowering Therapy (c) |
|---|---|---|---|---|
| 17 | MEASURE: Percentage of patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy | | | |

### Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

| Line | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic | Total Patients Aged 18 And Older With IVD Diagnosis or AMI, CABG, or PCI Procedure (a) | Charts Sampled or EHR Total (b) | Number of Patients With Documentation of Aspirin or Other Antithrombotic Therapy (c) |
|---|---|---|---|---|
| 18 | MEASURE: Percentage of patients aged 18 and older with a diagnosis of IVD or AMI,CABG, or PCI procedure with aspirin or another antithrombotic therapy | | | |

### Section K - Colorectal Cancer Screening

| Line | Colorectal Cancer Screening | Total Patients Aged 50 through 75 (a) | Charts Sampled or EHR Total (b) | Number of Patients With Appropriate Screening For Colorectal Cancer (c) |
|---|---|---|---|---|
| 19 | MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer | | | |

### Section L - HIV Linkage to Care

| Line | HIV Linkage to Care | Total Patients First Diagnosed with HIV (a) | Charts Sampled or EHR Total (b) | Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c) |
|---|---|---|---|---|
| 20 | MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis | | | |

### Section M – Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

| Line | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan | Total Patients Aged 12 and Older (a) | Charts Sampled or EHR Total (b) | Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c) |
|---|---|---|---|---|
| 21 | MEASURE: Percentage of patients aged 12 and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented | | | |

### Section N – Dental Sealants for Children between 6-9 Years

| Line | Dental Sealants for Children between 6-9 Years | Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a) | Charts Sampled or EHR Total (b) | Number of Patients with Sealants to First Molars (c) |
|---|---|---|---|---|
| 22 | MEASURE: Percentage of children aged 6 through 9 years, at moderate to high risk of caries who received a sealant on a first permanent molar | | | |

# Instructions for Table 7: Health Outcomes and Disparities

This table reports data on health status measures by race and Hispanic or Latino ethnicity. The health outcome and disparity measures reported are "intermediate outcome measures," which means that they document measurable outcomes of clinical intervention as a surrogate for good long term health outcomes. Use and analysis of clinical quality measures by health centers in their Plan, Do, Study, Act (PDSA) cycles is one tool that can lead to improved health care for patients. Thus, by increasing the proportion of health center patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. Specifically:

- **Low Birth Weight**: *If* there are fewer low birth weight children born, *then* there will be fewer children who suffer the multiple negative sequela of low birth weight, such as delayed or diminished intellectual and/or physical development.
- **Controlling High Blood Pressure**: *If* there is less uncontrolled hypertension, *then* there will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life.
- **Diabetes: Hemoglobin A1c Poor Control**: *If* there is less poorly controlled diabetes, *then* there will be fewer long-term complications such as amputations, blindness, and end-organ damage.

The clinical health outcome and disparity measures described in this manual must be reported by all health centers using specifications detailed in the measure definitions below. Many of the UDS health outcome and disparity measures are now aligned with CMS e-CQMs for Eligible Professionals. The June 2015 eReporting update is used for the 2016 reporting period. (Although there are other updates available from CMS, they are not to be used for the 2016 reporting.) The eReporting specifications can be found at the CMS' eCQI Resource Center at https://ecqi.healthit.gov/ep. E-CQM measure numbers and links are provided to assist you, where applicable. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/ is encouraged for health centers capable of appropriately using this resource as defined below to support the data reporting of these health outcome and disparity measures.

## Column Logic Instructions

The column logic reflected here specifically applies to the High Blood Pressure and Diabetes measures.

### Column A (2a and 3a): Number of Patients in the Universe (Denominator)

The total number of health center patients who fit the detailed criteria described for the specified measure. *Patients meeting the criteria in the health center's total patient population, including all sites, all programs, and by all providers are to be considered.*

Because the initial patient population for each measure is defined in terms of age, comparisons to the numbers on Table 3A and Table 7 will be made when evaluating your submission. The numbers in column A of Table 7 *will not be equal to* those that might be calculated on Table 3A for

the following reasons: (1) All patients seen for all reportable services are counted on Table 3A, but the clinical measures reported on Table 7 relate to medical patients with specific conditions. (2) Table 3A measures age as of June 30 of the calendar year, but Table 7 defines specific time periods (i.e., by December 31) to measure age.

### Column B (2b and 3b): Number of Charts/ Records Sampled or EHR Total

The total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will essentially become the denominator in evaluating the measurement standard and will be:

- *all patients* who fit the criteria (and hence the same number as the universe reported in Column A) *or*
- a number equal to or greater than 80 percent* of all patients who fit the criteria (and hence a value no less than 80 percent of the universe reported in Column A).
- a scientifically drawn *sample of 70* patients selected from all patients who fit the criteria *or*

  * Note: To streamline the process for reporting on the clinical quality measures and encourage the use of HITs to report on the full universe of patients, health centers must use an HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient records are included in the HIT/EHR for any given measure and the HIT/EHR does not exclude patients based on a variable related to any given measure.

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. Health centers *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 because this will result in over-sampling some groups of patients.

A review of a sample of charts must be used in lieu of full universe reporting from an HIT/EHR if:

- The HIT/EHR does *not include* a minimum of 80 percent of health center patients who meet the criteria described below for inclusion in the specific measure's universe.
- The HIT/EHR does *not exclude* every single health center patient who meets one or more exclusion criteria described below for exclusion from the universe.

If the HIT/EHR is used, the number in Column B (records reviewed) must be no less than 80 percent of the number in Column A when the total universe is greater than 70. The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure.

### Column 2C: Number of Charts/Records Meeting the Measurement Standard (Numerator)

The total number of records that meet the measurement standard as discussed for the specified measure. The number in Column 2C (patients meeting the measurement standard) may never exceed the number in Column 2B (patient records reviewed).

*Note: The percentage of patient records meeting the measurement standard can be calculated by dividing Column 2C by Column 2B.*

### Column 3F: Number of Charts/Records that Do Not Meet the Measurement Standard (Numerator)

The total number of records that do not meet the measurement standard as discussed for the specified measure. The number in Column 3F (patients not meeting the measurement standard)

may never exceed the number in Column 3B (patient records reviewed).

*Note: The percentage of patient records not meeting the measurement standard can be calculated by dividing Column 3F by Column 3B. Health centers will also report records with HbA1c levels <8% in column 3d1.*

## Criteria vs. Exclusions in HITs/EHRs vs. Chart Reviews

Because the UDS follows the structure developed for Meaningful Use and other quality reporting programs, conditions may sometimes be listed as criteria and sometimes as exclusions. They should be treated as described here to either constrain the universe of an HIT/EHR report or identify charts to be replaced in a chart review process.

In the discussion that 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 HIT/EHR (or practice management system [PMS]) based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be able to be found in the HIT/EHR and must be in the HIT/EHR for each and every patient at the health center. To the extent that they cannot be found, they will distort the findings, and means that the HIT/EHR must not be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the diabetes measure because you cannot limit the universe to medical patients.

In a sample chart review process, items listed as "criteria" below may be used as "exclusions." Thus, for example, you can ask that all patients with diabetes be listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. (In a computer search, you would include as criterion that they must be medical patients for the diabetes measure.)

**And vs. Or**

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 conditions are met, the services for that patient are considered to have failed to meet the measurement standard. Where conditions are linked with "***or***" it means that if either of the conditions is met the measure is satisfied.

**Race and Ethnicity Reporting**

Table 7 reports health outcome data by race and Hispanic or Latino ethnicity to provide information on health centers' efforts to help to reduce health disparities. Race and Hispanic or Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. *Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to ensure race and ethnicity data across the systems are aligned*. Thus, under no circumstances may a health center report more Hispanic or Latino patients with hypertension or more patients with hypertension of any given race on Table 7 than are reported for that race or for the Hispanic or Latino ethnicity on Table 3B.

Because the initial patient population for each measure is defined in terms of race and ethnicity, comparisons to the numbers on Table 3B and Table 7 will be made when evaluating your submission. The numbers in Column A of Table 7 *will not be equal to* those that might be calculated on Table 3B because all patients seen for all reportable services are counted on Table 3B by race and ethnicity, but the clinical measures reported on Table 7 relate to medical patients of that race and ethnicity with specific conditions. The following table illustrates the cross-walk between the comparable fields across the two tables.

| Race | Ethnicity | Table 3B Reference | Table 7 Reference |
|---|---|---|---|
| Asian | Hispanic | Line 1, Column A | Line 1a |
| | Non-Hispanic | Line 1, Column B | Line 2a |
| Native Hawaiian | Hispanic | Line 2a, Column A | Line 1b1 |
| | Non-Hispanic | Line 2a, Column B | Line 2b1 |
| Other Pacific Islander | Hispanic | Line 2b, Column A | Line 1b2 |
| | Non-Hispanic | Line 2b, Column B | Line 2b2 |
| Black/African American | Hispanic | Line 3, Column A | Line 1c |
| | Non-Hispanic | Line 3, Column B | Line 2c |
| American Indian/Alaska Native | Hispanic | Line 4, Column A | Line 1d |
| | Non-Hispanic | Line 4, Column B | Line 2d |
| White | Hispanic | Line 5, Column A | Line 1e |
| | Non-Hispanic | Line 5, Column B | Line 2e |
| More than One Race | Hispanic | Line 6, Column A | Line 1f |
| | Non-Hispanic | Line 6, Column B | Line 2f |
| Unreported/Refused to Report Race | Hispanic | Line 7, Column A | Line 1g |
| | Non-Hispanic | Line 7, Column B | Line 2g |
| Unreported/Refused to Report Race AND Ethnicity | Unreported/Refused to Report Race AND Ethnicity | Line 7, Column C | Line h |

Health centers that 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 in their own systems given small sample sizes. On a national level, however, reported data permits HRSA to evaluate the impact on disparities for all BPHC-funded programs.

## Detailed Instructions for Clinical Measures

What follows is a detailed discussion of each of the clinical measures.

*Note: To assist health centers with identifying patients who meet the measurement criteria (numerators and/or denominators), ICD-10-CM or CPT codes may be provided. The codes provided may not be inclusive of all codes listed in the eReporting specifications, and health centers are responsible for proper alignment with the eCQMs.*

## HIV-Positive Pregnant Women, Top Line (Line 0)

All health centers 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 or HIV treatment for these women.*

## Deliveries Performed by Health Center Provider (Line 2)

Report the total number of deliveries *performed by health center clinicians* during the reporting period on Line 2. On this line ONLY, the health center is to include deliveries of women who were not part of the health center's prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor's patients when the health center provider participates in a call group and is on-call at the

time of delivery; emergency deliveries when the health center provider is on-call for the emergency room; and deliveries of "undoctored" patients who are assigned to the provider as a requirement for privileging at a hospital. Include as "health center providers" any clinician who is paid by the health center while doing the delivery, regardless of the method of compensation. Do not include deliveries where a clinic provider bills separately, receives, and retains payment for the delivery.

## Section A: Deliveries and Birth Weight Measure by Race and Hispanic and Latino Ethnicity, Columns 1a-1d

All health centers must report on *all* prenatal care patients who are either provided direct care or referred for care. No sampling is permitted on this measure. All health centers must report all their patients who delivered during the reporting period, and all babies born to them, in Columns 1a–1d. Included in this population will be any woman who is a patient of the health center and is referred to another provider for some or all of her prenatal care.

Women (Column 1a) and babies (Columns 1b, 1c and 1d) are separately reported by their race and ethnicity. Race and ethnicity of mothers should be obtained from and be consistent with the information on their patient registration forms. Race and ethnicity of children will be obtained from their registration forms, their birth certificates, or from their parent.

### Prenatal Care Patients and Referred Prenatal Care Patients Who Delivered During the Year (Column 1a)

Report all health center prenatal care patients who delivered during the reporting period including those who health center staff cared for and delivered and those who had some or all care provided by a referral provider. 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 otherwise lost to follow-up). This column collects data on "patients who delivered." Even if the delivery is of twins or triplets, or is a still-birth, the health center is still to report only one woman as having delivered.

*Note: The percentage of prenatal care patients who delivered can be calculated by dividing Table 7, Line i, Column 1a by Table 6B, Line 6, Column A.*

### Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year (Columns 1b-1d)

### Low Birth Weight (Columns 1b and 1c), No e-CQM

**Performance Measure**: Percentage of babies of health center prenatal care patients born whose birth weight was *below* normal (less than 2,500 grams). This is calculated as follows:

**Universe (Denominator)**: Babies born during the measurement period to prenatal care patients (Columns 1b + 1c + 1d)

Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period, according to the appropriate birth weight group. These columns collect data on "infants born." If the delivery is of twins or triplets, the health center will report the birth weight of the two or three children separately.

*NOTE: Data are reported regardless of whether the health center did the delivery themselves, referred the delivery to another provider, or the woman transferred to another provider on her own. Follow-up on all patients is required.*

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.

**Exclusions**: Still-births or miscarriages

**Numerator**: Babies born with a birth weight below normal (under 2,500 grams) (Columns 1b + 1c)

**Health centers must report birth outcomes as follows:**

- **Very Low Birth Weight (Column 1b)**

  Report the total number of live children whose weight at birth was less than 1,500 grams.

- **Low Birth Weight (Column 1c)**

  Report the total number of live children whose weight at birth was 1,500 grams through 2,499 grams.

- **Normal Birth Weight (Column 1d)**

  Report the total number of live children whose weight at birth was equal to or greater than 2,500 grams.

  Note: Be careful not to confuse pounds and ounces for grams when reporting these numbers.

Note that this is a "negative" measure. -- For this measure the higher the number of infants born below normal birth weight, the worse the performance on the measure. Although data are provided for each racial and ethnicity category, the performance measure looks only at the totals[12].

## Sections B and C: Other Health Outcome and Disparity Measures

In these sections, health centers will report the findings of their reviews of services provided to targeted populations. Sections B and C specifically assess the health centers current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Patients whose only visits were for dental, mental health, or something other than medical care are *not* included in the universe for these measures. Age criteria are based on the patient's age during the reporting year.

Note: In this section, the term "measurement period" is the same as the term "reporting period," and is intended to capture calendar year 2016 data.

### Controlling High Blood Pressure (Columns 2a-2c), CMS165v4

**Performance Measure**: Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the measurement period. This is calculated as follows:

**Universe (Denominator)**: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period and had a medical visit during the measurement period (Columns 2a and 2b)

Enter the number of patients who:

- Were born between January 1, 1931, and December 31, 1997, ***and***
- Have been diagnosed with hypertension before June 30th of the measurement year (the diagnosis and notation of hypertension may appear during or prior to the measurement year), ***and***
- Had at least one medical visit during the measurement year.

**Exclusions**: Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

12 However, during the review of the UDS report, reviewers will question unusually high or low birth weights for individual race or ethnicity categories.

The following ICD-10-CM codes will help to identify the universe:

- ICD-9: 401.xx through 405.xx and ICD-10-CM: I10- through I15-

Note: Health centers that 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 (i.e., it includes data for the required time frame for all patients with hypertension from all service sites).

**Numerator**: Patients whose blood pressure at the most recent visit is adequately controlled during the measurement period (Column 2c)

Adequate control is defined as systolic blood pressure lower than 140 mm Hg and diastolic blood pressure lower than 90 mm Hg.

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 2a and 2b, but not in Column 2c.

Many health centers use a different measure for their quality assurance process for their dialysis patients or for older patients. This may well be appropriate, but for the purposes of UDS reporting, BP lower than 140/90 measure must be used.

Blood pressure readings 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.

## Diabetes: Hemoglobin A1c Poor Control (Columns 3a-3f), CMS122v4

**Performance Measure**: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period. This is calculated as follows:

**Universe (Denominator)**: Patients 18-75 years of age with a medical visit during the measurement period (Columns 3a and 3b)

Enter the number of patients who:

- Were born between January 1, 1941, and December 31,1997, ***and***
- Have a diagnosis of Type 1 or Type 2 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 2016 measurement year.
- Had at least one medical visit during the measurement year.

Note that unlike the hypertension measure, the diabetes measure calls for reporting on patients with diabetes regardless of when they were first diagnosed. It specifically *does not make use* of the June 30 date used to identify patients with hypertension.

**Exclusions**: Gestational diabetes (ICD-10-CM: O24.4-, O99.81X) or steroid-induced diabetes (ICD-10-CM: E16.4, E16.8). (Note: Patients with a diagnosis of secondary diabetes due to another condition should not be included.)

The following ICD-9 and ICD-10-CM codes will help to identify the universe:

- ICD9: 250.xx or 648.0x
- ICD-10-CM: E10-, E11-, O24-

- Patients with diabetes may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics)

**Numerator**: Patients whose most recent hemoglobin A1c level during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period (Column 3f)

Health centers must report hemoglobin A1c levels, as follows:

- **HbA1c <8% (Column 3d1)**

  Report the total number of patients whose most recent HbA1c level was less than 8 percent.

- **HbA1c >9% or No Test During the Year (Column 3f)**

  Report the total number of patients whose most recent HbA1c level was greater than 9 percent or who did not receive an HbA1c test during the reporting year or whose test result is missing.

Even if the treatment of the patient's diabetes has been referred to a non-health center provider, the health center is expected to have the current lab test results in its records.

Note that this is a "negative" measure. For this measure, the lower the number of adult diabetics with poor diabetes control, the better the performance on the measure. Although data are provided for each race and ethnicity category, the performance measure looks only at the totals.

## Questions and Answers for Table 7

1. **Are there any changes to the table this year?**
   Yes. The specifications for the clinical measures reported have been revised to align with the Centers for Medicare and Medicaid Services' electronic-specified Clinical Quality Measures (e-CQMs). The quality of care measures are aligned with the e-CQMs for Eligible Professionals June 2015 eReporting update for the 2016 reporting period. (Although there are other updates available, they are not to be used for the 2016 reporting.)

   ICD-9-CM has been replaced with ICD-10-CM codes. Health centers are required to use ICD-10 codes, where applicable.

2. **When would we use Row h—"Unreported/Refused to Report" race and ethnicity?**
   Row h will be used only in those instances where patients refuse to provide their race *and* refuse to state whether or not they are Hispanic or Latino. Patients who provide a race but do not answer affirmatively to a question about Hispanic or Latino ethnicity are to be classified as Non-Hispanic or Latino and reported on the appropriate race line, Lines 2a–2g. Patients who indicate they are Hispanic or Latino but do not provide a race are reported on Line 1g.

3. **Data are requested by race and Hispanic or Latino ethnicity. How are these to be coded?**
   Race and Hispanic or 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. Note that if the race and/or ethnicity in the patient's medical chart is different than that reported in the registration process, it will result in errors. Care should be taken to ensure the same information is recorded in both data sources.

4. **Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**
   Health centers should document all HbA1c tests by contacting providers of tests directly to obtain documentation by fax, by requesting that health center patients 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 not meeting the measurement standard.

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 this permitted?**
   *No*. First, all health centers 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 health center 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 over-sample specific sites or providers to facilitate internal QI activities.

6. **In Section A, Deliveries and Birth Outcomes, should the race and ethnicity reported for the mother be the same for the baby?**
   *Not necessarily*. Report the race and ethnicity of the mother (Column 1a) separately from the child (Column 1b, 1c, or 1d). The baby's race and ethnicity may be different from the mother and would be reported as such.

7. **How do we report miscarriages and pregnancy terminations?**
   All pregnant women in your (direct or referral) prenatal care program are reported on Table 6B, but only those women who deliver are reported on Table 7. We do, however, consider a still-birth to be a delivery for purposes of counting women in column 1a, but no baby is reported in columns 1b, 1c, or 1d.

## Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2016, through December 31, 2016

**Section A: Deliveries and Birth Weight**

| Line | Description | Patients |
|---|---|---|
| 0 | HIV Positive Pregnant Women | |
| 2 | Deliveries Performed by Health Center'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 | Other 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 | Other 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** | | | | |

## Section B: Controlling High Blood Pressure

| Line # | Race and Ethnicity | Total Patients 18 through 85 Years of Age with Hypertension (2a) | Charts Sampled or EHR Total (2b) | Patients with HTN Controlled (2c) |
|---|---|---|---|---|
| | **Hispanic/Latino** | | | |
| 1a | Asian | | | |
| 1b1 | Native Hawaiian | | | |
| 1b2 | Other 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 | Other 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** | | | |

## Section C: Diabetes: Hemoglobin A1c Poor Control

| Line # | Race and Ethnicity | Total Patients 18 through 75 Years of Age with Diabetes (3a) | Charts Sampled or EHR Total (3b) | Patients with HbA1c <8% (3d1) | Patients with HbA1c >9% Or No Test During Year (3f) |
|---|---|---|---|---|---|
| | **Hispanic/Latino** | | | | |
| 1a | Asian | | | | |
| 1b1 | Native Hawaiian | | | | |
| 1b2 | Other 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 | Other 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 reports the total cost of all activities that are within the scope of the project supported, in whole or in part, by (1) the scope of the Health Center Program grant covered by the UDS, ***or*** (2) the look-alike designation, ***or*** (3) the scope of the BHW primary care clinics. The same costs may be included in both a BHW clinic *and* a BPHC grantee or look-alike if they are included in the scope of both grants. The same costs cannot be reported under both a BPHC grant-and a look-alike.

All costs on Table 8A are reported on an accrual basis. These are the costs attributable to the reporting period, including depreciation, regardless of when actual payments were made. (Note: Only depreciation is reported for capital investments, including BPHC capital grants.) Under UDS rules, health centers do not report bad debts or the repayment of the principal of a loan on Table 8A, though they do show interest on any such loans 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 facility cost and the total cost of non-clinical support services separately on Lines 14 and 15.

### Column B - Allocation of Facility Costs and Non-Clinical Support Service Costs

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.
- Facility and non-clinical support services attributable to pharmacy are to be allocated to the non-supply line (Line 8a) and reported in Column B. No facility and non-clinical support services costs are reported on the pharmaceutical supplies line (Line 8b) which is blacked out in the EHB. This is true even if the health center does not report any direct pharmacy costs on Line 8a, Column A.

A more detailed description of what is included in the facility and non-clinical support category is provided below. The allocation of facility and non-clinical support services costs should be done as follows, unless your center has a more accurate method:

**Facility Costs** should be allocated based on the amount of usable 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, Quality Improvement, and Non-Clinical Support Services. Square Footage refers to the portion of the health center's facility space used in the operation of the organization, not including common spaces such as hallways, restrooms, and utility closets. Note that hallways and similar shared space *within a dedicated* area are assigned to that area. For example, the hallways inside 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 cost of the square footage associated with space owned by the health center and leased or rented to other parties as a rule will not be reported on Line 14, or anywhere, if it is considered to be outside the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Program Related Services (Line12) and the rent received should be included on Table 9E under Other Revenue (Line 10).

Health centers that employ an alternative allocation method that effectively distributes facility costs may continue to use it, but should save back-up paperwork for review and explain the methods 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 vary dramatically—and recognizes substantial remodeling or renovation costs that affect only a portion of the program. Thus, the depreciation of a major remodeling of the medical exam rooms would best be attributed to medical costs only rather than allocated to all cost centers.

**Non-Clinical Support Services Costs** should be allocated *after* its share of facility costs have been allocated to it. The non-clinical support services cost is generally allocated based on a straight-line allocation method. The means allocating non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category. For example, if medical staff account for 50 percent of net cost (excluding facility and non-clinical support services costs) then 50 percent of the non-clinical support services cost is allocated to medical staff. Health centers that use an alternative method that provides more accurate allocations may use it but should be sure to save back-up paperwork for review and explain the methods used in the table note. For example, it would be appropriate to allocate the cost of billing and collection activities exclusively to those cost centers that actually generate bills. Where a very substantial cost is for pharmacy supplies, which requires only minimal administrative costs, the share of non-clinical support services allocated to pharmaceuticals should be reduced or eliminated.

### 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 is

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 that 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, laboratory and X-ray, and other direct costs wholly attributable to medical care (e.g., staff recruitment, equipment depreciation, medical supplies, professional dues and subscriptions, continuing medical education and travel associated with continuing medical education [CME]). It does not include costs associated with pharmacy, dedicated quality improvement staff, or other non-medical service categories. Note that for the purposes of the UDS, psychiatry and ophthalmology costs are not counted in the medical cost centers. They are to be reported on mental health (Line 6) and vision (Line 9a), respectively.

**Medical Staff Costs (Line 1)**

Report all staff costs, including salaries and fringe benefits for personnel supported directly or under contract for all medical care staff, including nurses, medical assistants, etc., *but specifically excluding* lab and x-ray staff. Dedicated QI, including HIT/EHR informatics staff costs, are excluded from medical but reported on Line 12a. The accrued cost (if any) of medical interns and residents who were paid or paid for, either directly or through a contract with their teaching institution, are reported on Line 1. Include the cost for vouchered or contracted medical services here. Also include the cost of any medical visit paid for directly by the center, such as at-risk specialty care from a health maintenance organization (HMO) contract or other specialty care. The costs of intake, medical records, and billing and collections are considered non-clinical support costs that are reported on Line 15 and then allocated in Column B.

In the event a health center opts to permit one or more providers to retain Meaningful Use EHR incentive payments, or transfers some or all of these payments to providers, the amounts should be shown on this line as well. The Meaningful Use EHR incentive payments received from Medicare or Medicaid are reported on Table 9E on Line 3a.

**Medical Lab and X-Ray Costs (Line 2)**

Include all costs for medical lab and x-ray (including sonography, mammography, and any advanced forms of tomography). Include salaries and fringe benefits for lab and X-ray personnel supported directly or under contract, and all other direct costs, including but not limited to supplies, equipment depreciation, related travel, contracted or vouchered lab, and X-ray services.

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 under dental, Line 5. If there are costs for retinography (most commonly for diabetic patients), these would be reflected in vision services on Line 9a.

**Other Direct Medical Costs (Line 3)**

Include all other direct costs for medical

care, including but not limited to supplies, equipment depreciation, related travel, continuing medical education (CME) registration and travel, laundering of uniforms, recruitment, membership in professional societies, books, and journal subscriptions. The cost of an HIT/EHR system is reported on Line 3, including but not limited to the depreciation on the software and hardware, training costs, and licensing fees.

**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, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, and podiatrists). Unlike Medical, all costs are included on a single line.

**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 they must be consistent with Table 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 62)

**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 they 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 62.)

**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, *but excluding the cost of pharmaceuticals*. The cost of all pharmacists is reported on this line, including clinical pharmacists. 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 the total cost of clinical pharmacists on this line. Note that the cost of personnel engaged in assisting patients to become eligible for and/or receive free pharmaceuticals from manufacturers (often called Pharmacy Assistance Programs) is reported on Line 11e – Eligibility Assistance, not here. If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, the *full* dispensing fee and any other service fees (such as share of profit, pharmacy benefit manager costs, inventory fees, ordering fees, or a charge of pharmacy computer services) *must* also be shown on this line, regardless of whether the grantee pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

**Pharmaceuticals (Line 8b)**

Report all direct costs for the purchase of pharmaceuticals, including the cost of vaccines and other drugs that may be used (or directly dispensed) in the health center. These include but are not limited to Depo-Provera and buprenorphine. Do not include other supplies. Do not include the value of donated pharmaceutical supplies. (These are recorded on Line 18, Column C.) The cell for the allocation of facility and non-clinical support services costs associated with the purchase of pharmaceuticals is closed. To the extent that there are such costs (they would generally be limited to costs for purchasing and paying for the drugs), they are combined with the allocation for pharmacy costs and reported on Line 8a, Column B. If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, these full costs must also be shown on this line, regardless of whether the grantee pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

**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 and hearing pathology, or occupational and physical therapy. (A more complete list appears at Appendix A.) Provider and support staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services are included in direct costs. 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. Staff, fringe benefits, supplies (including frames and lenses), equipment depreciation, related travel, and contracted services are included in direct costs. If there are costs for retinography (for example, for diabetic patients), these would be reflected here, as would any contract reading costs. 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 + 9a

## Enabling and Other Services (Lines 11-13)

This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, community health workers, eligibility assistance—including pharmacy assistance program eligibility, environmental risk reduction, and other services that support and assist in the delivery of primary care 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. Finally, it includes costs associated with HIT/EHR informatics and quality improvement.

**Enabling (Line 11)**

Enabling services include a wide range of services that support and assist primary care and facilitate patient access to care. Line 11 is calculated automatically as the total of the detail lines. It reports all direct costs for the provision of enabling services, including but not limited to 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–11h are used to detail seven specific types of enabling services, as well as an "other" category for all other forms of enabling services. Note: Descriptions of the services and staff that belong in each of these categories is included in the Table 5 instructions on page 56.

- Case management (11a)
- Transportation (11b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (including pharmacy program eligibility and the HRSA-ACA Outreach and Enrollment program) (11e)
- Translation/Interpretation services (11f)
- Other (11g)

If the "other" category is used, the health center must "specify" the other forms of enabling services included on this line.

- Community health workers (11h)

The allocated costs detailed on each of these Enabling categories should be consistent with the staff and visits reported on Table 5. If they are not, perhaps because of donated services, staff, or supplies, an explanation should be provided in the EHB.

**Other Program Related (Line 12)**

Report all direct costs for the provision of services not included in any other category here. These are most frequently other programs that support the health of the center's patients and mission but are not traditionally considered health care programs. This includes services such as WIC, child care centers, adult day health care centers, fitness centers, Head Start and Early Head Start, and employment training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. (Staffs 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. It may also include the estimated cost of something where part is program related and part is not. Examples might include renting out space in the health center or providing retail pharmacy services to non-patient members of the community. Health centers are asked to describe the program costs in the "specify" field provided.

*Note that the cost of space leased to others is to be reported as Other Program Related on Line 12, not Facility on Line 14. There is no need to associate overhead to this cost. If the rent income approximates the cost of the space, it is acceptable to move an amount equal to that income.*

**Quality Improvement (Line 12a)**

Report all direct costs for the quality improvement program, including all personnel who are dedicated in whole or in part to quality improvement (QI). Although most of these staff tend to work in the medical area, they are accounted for separately here. QI is part of every aspect of the health center. No attempt should be made to carve out portions of the time of clinical or non-clinical support staff who attend meetings, participate in peer review, etc. Included in the direct costs are staff dedicated to the QI program and/or HIT/EHR system development and analysis, their 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 QI in Column B.

**Total Enabling, Other Program Related, and Quality Improvement Services (Line 13)**

The sum of Lines 11 + 12 +12a

## 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 all staff dedicated to facility services, including their salaries, fringe benefits, and related travel, as well as rent and/or depreciation, facility (mortgage) interest payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs. Do not report space leased to others on this line. Instead, report it as Other Program Related costs on Line 12. Report the depreciation of major renovations or capital equipment (e.g., building air conditioners), not the gross cost.

**Non-Clinical Support Services Costs (Line 15)**

Non-Clinical Support Services costs (sometimes referred to as administrative 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 salaries, fringe benefits, supplies, equipment depreciation, and travel. The senior administrative staff (CEO, CFO, COO, HR director, etc.) and their staff and supportive services are included in this category. In addition, include other *corporate* costs (e.g., purchase of facility and liability insurance not including malpractice insurance, audits, legal fees, interest

payments on non-facility loans, Board of Directors' costs). The cost of all patient support services (e.g., medical records and intake) should be included in non-clinical support services costs and should not be reported as medical. Note that the "cost" of bad debts is ***not*** to be included or shown on this table in any way. Instead, the UDS reports bad debt as one of a number of adjustments to patient self-pay charges 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 are not to be considered when completing Lines 14 and 15.** The "non-clinical support services" and facility categories for this report include *all* such personnel working at the health center, 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)[13]

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 health center 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. 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 (including vaccines), for example, would be shown at the price that would be paid under the Federal Section 340(b) 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 health center's operation.

If the health center is not paying NHSC for assignees, the full market value of NHSC Federal assignee(s), including "ready responders," should also be included in this category. NHSC-furnished equipment, including a dental operatory, 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.

Health centers are asked to describe the donated items in detail using the "specify" field provided.

## Total with Donations (Line 19)

The sum of Lines 17 and 18, Column C

NOTE: As staff makes up 70 percent plus 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:

13 This is the amount that is used in any BPHC calculation that is based on total cost.

| 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, dental therapists) | 5: Dental |
| 20a–20c: Mental Health | 6: Mental Health |
| 21: Substance Abuse | 7: Substance Abuse |
| 22: Other Professional (e.g., nutritionists, podiatrists) | 9: Other Professional |
| 22a–22c: Vision Services (ophthalmologists, optometrists, optometric assistants, other vision care) | 9a: Vision |
| 23: Pharmacy | 8a: Pharmacy |
| 24–28: Enabling (e.g., case management, outreach, eligibility)—relationship of the detail follows. | 11a–11g: Enabling<br>*Note that the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.* |
| 24: Case Managers | 11a: Case Management |
| 25: Patient/Community Education Specialists | 11d: Patient and Community Education |
| 26: Outreach Workers | 11c: Outreach |
| 27: Transportation Staff | 11b: Transportation |
| 27a: Eligibility Assistance Workers | 11e: Eligibility Assistance |
| 27b: Interpretation Staff | 11f: Interpretation Services |
| 27c: Community Health Workers | 11h: Community Health |
| 28: Other Enabling Services | 11g: Other Enabling Services |
| 29a: Other programs/services (e.g., non-health related services including WIC, job training, housing, child care) | 12: Other Related Services |
| 29b: Quality Improvement | 12a: Quality Improvement |
| 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) | 14: Facility |

## Questions and Answers for Table 8A

1. **Are there any changes to this table?**
   Yes. Line 11h, Community Health Workers, and Line 12a, Quality Improvement, have been added. See also Table 5 for definitions of these cost center staff. Also, the cost of dental therapists, previously reported in "other services" is now reported in dental.

2. **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 that 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 or an office visit to a dermatologist.

3. **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 payer would pay for them* and is reported on Table 8A on Line 18. This is NOT the retail cost of the drug; it is the 340(b) price of the drug—an amount that is generally 40 percent – 60 percent 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. However, since we are interested in knowing the total value of supplies provided to the health center *directly or indirectly*, health centers are encouraged to include the value of such drugs on Line 18 as well.

4. **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.

5. **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 whereby their providers inform the health center of payments received and to account for all 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 on Line 3a.

6. **What method of overhead (facility and non-clinical support services) allocation should we use for this table?**
   It is preferable that health centers allocate facility cost to all cost centers, including administration based on square footage and then apply administrative cost based on the percent distribution of direct costs.

7. **Do we need to allocate overhead for contracted services?**
   Contracted services do not warrant a full overhead charge given that they do not involve the management of personnel. However, the procurement and supervision of those arrangements does consume overhead, which is often charged at the rate the accounting and contract management operation is of total cost.

8. **Why don't our financial statements tie to the UDS financials?**
   The health center financials (Tables 8A, 9D, and 9E) will not tie to your financial statements for the following reasons: (1) If the fiscal year is not January 1 – December 31, (2) out-of-scope activities will be in your financial statements but must not be included in the UDS, (3) Tables 9D and 9E are on a cash basis, not accrual, and (4) contributed services are not to be shown as income or as an expenditure as they would be in an audit.

## Table 8A: Financial Costs

Reporting Period: January 1, 2016, through December 31, 2016

| Line | Cost Center | 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- 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 Services** | | | |
| 11a. | Case Management | | | |
| 11b. | Transportation | | | |
| 11c. | Outreach | | | |
| 11d. | Patient and Community Education | | | |
| 11e. | Eligibility Assistance | | | |
| 11f. | Interpretation Services | | | |
| 11g. | Other Enabling Services (Specify: _____) | | | |
| 11h. | Community Health Workers | | | |

| Line | Cost Center | Accrued Cost (a) | Allocation of Facility and Non-Clinical Support Services (b) | Total Cost After Allocation of Facility and Non-Clinical Support Services (c) |
|---|---|---|---|---|
| 11. | Total Enabling Services Cost (Sum Lines 11a through 11h) | | | |
| 12. | Other Related Services (Specify:_____) | | | |
| 12a. | Quality Improvement | | | |
| 13. | **Total Enabling and Other Services** (Sum Lines 11, 12, and 12a) | | | |
| | **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

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 payers. This does not preclude the center from discounting these fees (see discussion regarding sliding discounts below, page 142) but there must be charges. Note that, unlike Table 8A, Table 9D is reported on a ***cash basis***.

## Rows: Payer Categories and Form of Payment

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

### Form of Payment

**Fee-for-Service**

Charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes and the charge associated with each of these charges; third-party payers pay some or all of the bill, generally based on agreed upon maximums or discounts.

**Managed Care – Capitated**

Charges are billed to a managed care payer listing each of the services provided and the associated fee; the HMO pays the health center a monthly capitation fee *regardless of whether or not any services were rendered during the month*. If the billed services are on a list of covered services in the agreement between the health center and the HMO, no further payment is provided by the HMO (though an FQHC wrap-around payment may be paid for Medicaid, Medicare, or CHIP services). If the service is "carved out" of the listed services, an additional amount is reflected as a fee-for-service managed care service. The capitation (monthly payment) is not reported as an additional charge, but it *is* reported as a collection.

**Managed Care – Fee-for-Service**

Patients are assigned to the health center and must receive their primary care from the health center – hence the managed care inclusion—but no monthly fee is paid. Instead, the HMO pays some or all of the bill, generally based on agreed upon maximums or discounts. A supplemental wrap-around payment may also be paid. In addition to basic services to fee-for-service managed care patients, some carved out charges and collections for capitated patients are reflected on these lines.

### Payer Categories

**Medicaid (Lines 1–3)**

Health centers 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 health center has a contract with a private plan like Blue Cross, the payer 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. The EPSDT program includes some children who are eligible for the screening services *only* and are not included in the rest of the Medicaid program. Their charges are reported here as well – always on Line 1.

CHIP (or CHIP-RA), the Children's Health Insurance Program (Title XXI), 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. Note that some states are experimenting with the Medicaid expansion program by providing funds for eligible individuals to purchase their own insurance. *These payers must be classified as Medicaid, not as private*. Also included here will be a portion of the charges for dually eligible patients 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. Charges and collections for patients enrolled in Adult Day Health Care or Program of All-Inclusive Care for the Elderly (PACE) programs should be treated as discussed in Appendix B, page 169.

**Medicare (Lines 4–6)**

Health centers 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 health center has a contract with a private plan like Blue Cross, the payer is considered to be 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 payer, some portion of the charge will be reclassified to these other payment sources and patient co-payments will be reclassified to "self-pay" after the initial Medicare payment is received. Charges and collections for patients enrolled in Adult Day Health Care or PACE programs should be treated as discussed in Appendix B, page 169.

**Other Public (Lines 7–9)**

Health centers 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 the Children's Health Insurance Program (CHIP), 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. Also included here are state-run insurance plans, such as Washington's Basic Health Plan or Massachusetts'

Commonwealth Plan. ***Other Public does not include state or local indigent care programs***. Patients whose only payment source is one of these state or local indigent care programs are reported as "uninsured" on Table 4 and their charges, and any associated self-pay collections, etc., are reported on the self-pay line, Line 13. Third party coverage purchased through state or federal exchanges, which may be subsidized, are *not* reported here. They are reported as Private unless they can be identified as being enrolled through purchased subsidies from a Medicaid Expansion program, which are reported as Medicaid.

NOTE: Report on state or local indigent care programs that subsidize services rendered to the uninsured as follows:

- Report *all charges* for these services and collections from patients on the "self-pay" line (Line 13, Columns A and B of this table);
- Report *all amounts not collected or due from the patients as sliding discounts* or *bad debt write-off*, as appropriate, on Line 13, Columns E and F of this table; and
- Report *collections* from the associated state and local indigent care programs on *Table 9E* on 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 with the UDS Support Center.

**Private (Lines 10-12)**

Health centers should report as "Private" all services billed to and paid for by commercial insurance companies or by other third-party payers. Do not include any services that fall into one of the other categories. As noted above, charges, etc., for Medicaid, Medicare, and CHIP programs that use commercial programs as intermediaries are classified elsewhere. Private insurance *includes* insurance purchased for public employees or retirees such as Tricare, Trigon, and the Federal Employees Insurance Program, as well as Workers' Compensation. Charges and collections associated with insurance purchased through state exchanges are reported here unless they can be identified as being enrolled through purchased subsidies from a Medicaid Expansion program. 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)**

Health centers should report as "Self-pay" all charges and collections where the responsible party is the patient, *including charges for indigent care programs* 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)

### Column A – Full Charges this Period

Record in Column A the total charges for each payer source. This will initially reflect the total full charges (per the fee schedule) for services rendered to patients in that payer category during the calendar year. Charges should only be recorded for services that are billed to ***and*** covered in whole or in part by a payer, or the patient, even if some or all of them are written off as contractual allowances, sliding discounts, or bad debts. Full gross charges should always be reported. The difference between these charges and contracted payments from third parties is adjusted off 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 of charges will then be moved to the secondary payer and to a tertiary payer if one exists and, eventually, to the patient as a self-pay charge.

Charges that are generally not billable to or covered by traditional third-party payers 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 payer (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, that are donated* to the health center or directly to a patient through the health center, however, should not be included, since the clinic may not legally charge for these drugs. Charges for dispensing or injecting these pharmaceuticals should, however, be included if they are actually shown on bills and collected from first and third parties.

Pharmaceuticals dispensed through a (340(b)) contract pharmacy are to be reported at their usual, customary, and reasonable (UCR) gross charge even though they are sold at a discount to clinic patients.

Charges which are not accepted by a payer and which need to be reclassified (including deductibles and co-insurance) should be reversed as negative charges if your management information system (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 payer be used as the actual charges. Charges must come from the health center's CPT-based fee schedule.*

### Column B – Amount Collected This Period

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, pay for performance (P4P) payments, quality bonuses, court settlements, and other payments. These additional payments are reported in Column B and are also reported in Columns c1, c2, c3, and/or c4.* When a pharmacy is dispensing 340(b) drugs on behalf of the health center, *the payments to the pharmacies* by patients and third parties are also reported in Column B.. Note: Charges and collections for deductibles and co-payments that are charged to, paid by, and/or due from patients are recorded as "self-pay" on Line 13.

## Columns C1-C4 – Retroactive Settlements, Receipts, or Paybacks

*In addition to including them in Column B*, details on some payments by third parties that may have their origin in prior periods, which are included in Column B and reduced from Column D, are *also* broken out and reported in Columns c1 – c4. Most common are Medicaid, Medicare, and CHIP FQHC PPS reconciliations and wrap-around payments. Also included are managed care pool distributions, pay for performance (P4P) payments, quality bonuses, and paybacks to FQHC payers or HMOs.

**Column C1 – Collection of Reconciliation/Wrap-Around, Current Year**

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) from Medicare, Medicaid, or Other Public payers that are for *services provided during the* ***current reporting period***. *Include the current-year component, if any, of multi-year settlements here.*

**Column C2 – Collection of Reconciliation/Wrap-Around, Previous Years**

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) from Medicare, Medicaid, or Other Public payers that are for *services provided during* ***previous reporting periods***. *Include the prior-year component of multi-year settlements here.*

*Note: Settlement data reported in Columns c1 and c2 should be apportioned between the fee-for-service lines and the managed care lines, when both payment reimbursement methods are used. Health centers may use the percent distribution of visits, charges, or net charges as the basis for the allocation.*

**Column C3 – Collection of Other Retroactive Payments Including Risk Pools, Incentives**

Enter other cash payments including managed care risk pool redistribution, incentives including "pay for performance" incentives, and quality bonuses from any payer. CMS patient-centered 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 that may result from a court decision which requires a payer to make a settlement, including a multi-year settlement.* These payments may apply to either a managed care or non-managed care payer.

Note: Do *not* include eligible provider payments from CMS for implementing electronic health records. These payments are recorded separately on Table 9E, on Line 3a.

**Column C4 – Penalty/Payback**

Enter payments made by health centers to FQHC payers 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.) Do *not* include as paybacks bonuses that were not earned because P4P goals were not met.

Note: If a center arranges to have its "repayment" deducted from its monthly payment checks, the amount deducted

should be shown in Column c4 *as if it had actually been paid to the third party in cash during the year*. The same amount should be added to the amount received in Column B as if it had actually been paid by the third party. In addition, the repayment should be added to Column D as an allowance. Such paybacks may stretch across multiple reporting periods. Show only the amount paid back in the current reporting period.

## Column D – Allowances

Allowances are granted as part of an agreement with a third-party payer. 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 that contracted amount. These amounts are reported in Column D. In some states Medicaid pays the contracted amount and then later pays a wrap-around and/or reconciliation. In these instances, the initial *allowance must be reduced by the amount of retroactive settlements and receipts* (reported in Columns c1, c2, and c3), including current and prior year FQHC reconciliations, managed care pool distributions, quality or pay-for-performance awards, 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 payers reimburse less than the health center's full charge, and the health center cannot bill the patient for the remainder, the remainder or reduction on the appropriate payer line is entered in Column D at the time the explanation of benefits (EOB) or advice of allowance (AOA) is received and the amount is written off.

For 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 health center 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.)

For example, the state Title XIX agency has paid the health center'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" payers for co-payments) are not considered allowances. They should be reduced from the initial charges to the primary payer and 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, and make this payment in the current month of enrollment, these plans typically do not carry any receivables. For capitated plans (reported on 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) *which span the beginning or end of the calendar year.*

*Also note that self-pay, Line 13, Column D is blanked out because 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. Patients may be provided with other discounts, most commonly a discount for prompt payment or prepayment, but this is not recorded anywhere in the UDS Report.*

## Column E - Sliding Discounts

In this column, enter reductions to patient charges based on the patient's ability to pay. These discounts are determined by processes detailed in the health center's sliding discount policies and procedures. This would include discounts to required co-payments and deductibles, as applicable.

Note: Only the patient may be granted a sliding discount based on their ability to pay. Column E is blanked out on all other lines. When a sliding discount is used to write off part of a charge originally made to a third party, such as Medicare or a private insurance company's co-payment or deductible, *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. No other types of discounts should be wrapped into or included in the sliding discount column.

## Column F - Bad Debt Write-Off

Any payer 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, though most health centers do so monthly or quarterly.) 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 recorded the patient's income and family size and eligibility level, it must not write off the amount as a sliding discount. No automatic discounting of charges for specific categories of patients (i.e., students, homeless persons, or agricultural farmworkers) may be granted or reported, though a health center's board-approved policies may permit them to self-declare their income with no presentation of documentation. If there are no sliding discounts, charges must either be collected or written off as a bad debt. Bad debt write-off (Line 13, Column F) may occur due to the health center's inability to locate persons, a patient's refusal to pay, a patient's inability to pay with an income greater than 200 percent of the Federal Poverty Guideline, or a patient's inability to pay even after the sliding discount is granted. Health centers are free to set up such arrangements (see PIN 2014-02) but may not consider the discounts or forgiveness to be sliding discounts.

*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 debt 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 s/he 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 percent of poverty (for example, the Title X Family planning program which mandates discounts up to 250 percent of the Federal Poverty Guidelines). By law, the discount may not be granted using grant-related resources or shown as a sliding discount on the UDS, but this does not preclude the health center from writing off or waiving the charges under some other policy.

**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 on Line 6a. See Table 9E for specific instructions. Health centers 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 on Line 6a*.

3. **Are the data on this table cash- or accrual-based?**
   Table 9D is 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. We would not normally expect charges (Column A) minus collections (Column B) minus adjustments (Columns D+E+F) to equal zero. 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 defined in the UDS to be the difference between charges and collections, 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 for the reporting period, enter zero (0) in Column c1.

6. **We regularly use 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/HIT/EHR, the UDS report must reflect this reclassification of all charges that end up being the responsibility of a party other than the initial party. (As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred.)

8. **How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?**
This is discussed at length in Appendix B, page 167. In general, the full charge is reported in Column A by payer. Then the amount received from the patient (on Line 13) or insurance company (on Line 10) is shown in Column B. The amount that is written off for an insurance company is reported in Column D. The amount written off for a patient as a sliding discount is written off in Column E.

## Table 9D: Patient Related Revenue (Scope of Project Only)

Reporting Period: January 1, 2016, through December 31, 2016

| | | | | Retroactive Settlements, Receipts, and Paybacks (c) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Line | Payer Category | Full Charges This Period (a) | Amount Collected This Period (b) | Collection of Reconciliation/ Wrap-Around Current Year (c1) | Collection of Reconciliation/ Wrap-Around Previous Years (c2) | Collection of Other Retro Payments: P4P, Risk Pools, Withholds, etc. (c3) | Penalty/ Payback (c4) | Allowances (d) | Sliding Discounts (e) | Bad Debt Write Off (f) |
| 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: Patient Related Revenue (Scope of Project Only) (cont'd.)

| | | | | Retroactive Settlements, Receipts, and Paybacks (c) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Line** | **Payer Category** | **Full Charges This Period (a)** | **Amount Collected This Period (b)** | **Collection of Reconciliation/ Wrap-Around Current Year (c1)** | **Collection of Reconciliation/ Wrap-Around Previous Years (c2)** | **Collection of Other Retro Payments: P4P, Risk Pools, Withholds, etc. (c3)** | **Penalty/ Payback (c4)** | **Allowances (d)** | **Sliding Discounts (e)** | **Bad Debt Write Off (f)** |
| 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

This table collects and reports information on non-patient income received during the reporting period that supported activities described in the scope of project(s) covered by the Health Center Program grant, the look-alike program, or the HRSA BHW primary care program. (Look-alike health centers and BHW Primary care clinics will file this table, but will show no income from the BPHC Health Center Grant program on Line 1.) 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 (earned) 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 "other" revenues. The "last party rule" means that *grant and contract funds should always be reported based on the entity from which the health center 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, are generally passed through the State, and are reported on Line 6 as State funds, not on Line 3 as Federal. A rare exception to the rule is for the Medicare and Medicaid EHR Incentive Grants received for eligible providers (Line 3a). In rare cases these payments may be made directly to the clinic's providers. It is presumed that 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. (See below for further details on Meaningful Use [MU] funds.)

## BPHC Grants

### Lines 1a through 1e

Enter draw-downs made during the reporting period for the Health Center Program (section 330) grant. Migrant Health Center grant draw-downs are reported on Line 1a, Community Health Center grant draw-downs are reported on Line 1b, Health Care for the Homeless draw-downs are reported on Line 1c, and Public Housing Primary Care draw-downs are reported on Line 1e.Amounts should be consistent with the PMS-272 report.

### Total Health Center Program (Line 1g)

The EHB automatically calculates 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.

### Capital Development Grants (Line 1k)

Enter the amount of Affordable Care Act (ACA) Capital Development grant dollars drawn down. This includes funds from the Health Center Program facility program as well as funds from the HRSA

administered School-Based Health Center capital grant program.

### Total BPHC Grants (Line 1)

Enter the total of Lines 1g (Total Health Center Program), 1j (Capital Improvement Program Grants), and1k (Capital Development Grants). Be sure that all BPHC Health Center Program (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 from another BPHC health center nor should they be reduced by money that the health center passed through to other centers including "sub-grantees" or "sub-recipients".

## Other Federal Grants

### Ryan White Part C – HIV Early Intervention Grants (Line 2)

Enter the amount of Ryan White Part C funds the health center has 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, or when the reporting entity *is* a county or city government). 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). Special Projects of Regional and National Significance (SPRANS) grants are generally direct Federal grants, and are reported on Line 3. The one exception to this rule is when the health center is a State, county, or city entity, in which case the health center still reports who it received the grant funds from but it will be "one level higher."

### 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 health 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 health center such as WIC, or Part A or Part B Ryan White funds. These are included below on Lines 6 through 8. Health centers are asked to describe ("Specify") the program(s) 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 Office of Minority Health (OMH), Indian Health Service (IHS), Housing and Urban Development (HUD), and Substance Abuse and Mental Health Services Administration (SAMHSA).)

Dually funded IHS/HRSA-funded health centers will report IHS funds, *not including any PL 93-638 Compact funds* on this line. PL 93-638 Compact funds are reported on line 6A, indigent care.

### Medicare and Medicaid EHR Incentive Grants for Eligible Providers (Line 3a)

Funds from the Medicare and Medicaid Electronic Health Record Incentive Program grants (also known as "Meaningful Use awards") 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. In rare cases these payments are made directly to the clinic's providers but they are most commonly paid to the providers' 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 health center. 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 the amount retained by the provider should be shown on Table 8A on Line 1 as staff compensation*.

### Total Other Federal Grants (Line 5)

The EHB automatically calculates the total of Line 2 + Line 3 + Line 3a.

## 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 from State government grants or contracts. This includes grants of flat sums to support the operation of the health center with no specific tie to a level of service. Do *not* include funds from State indigent care programs or from Medicaid or CHIP. When a State grant or contract program *other than an indigent care program* pays a health center 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. This is most commonly seen in Family Planning and Cancer Detection programs. Health centers are asked to describe ("Specify:") the program 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, New York Public Goods Pool Funding, New Mexico Tobacco Tax program, and the Colorado Indigent Care Program).

Dually funded IHS/Health Centers will report IHS *PL 93-638 Compact funds* allocated to the health center on this line. (Private contracts between a health center and a tribe are to be reported as Private on Table 9D.) Health centers are asked to describe ("Specify:") the program 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 Support Center, 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 the actual payment to the health center 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 unless they have some other form of insurance****, and all 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 Table 9D. The amounts provided by the programs subsidizing these services are reported on Table 9E, Line 6a. Care should be taken to ensure that none of the funds reported on Line 6a of Table 9E are also reported as income in Column B of 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 health center's project(s). This includes grants of flat sums to support the operation of the health center with no specific tie to a level of service. It does *not* include funds from local indigent care programs. When a local grant or *contract other than an indigent care program* pays a health center 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. Health centers are asked to describe ("Specify") the program 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 a Primary Care Association, another health center or another community service provider are considered "private grants and contracts" and included on this line regardless of their origin. Health centers are asked to describe ("Specify") the program so the UDS reviewer can make sure that the classification of the program as a foundation/private grant or contract is appropriate.

### Total Non-Federal Grants and Contracts (Line 9)

The total of Lines 6, 6a, 7, and 8 – this number is calculated automatically by the EHB.

### 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, pharmacy sales to the public (i.e., non-health center patients), etc. Health centers are asked to describe ("Specify") these sources of "other revenue." *Do not* enter the value of in-kind or other donations made to the health center—these are shown only on Table 8A on 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 in kind "community benefit" from a third party is not to be reported here or anywhere else on the UDS unless it is received as a cash donation, and health centers may not recognize community benefit as an amount on the UDS. *Under no circumstances* should payments or net payments from a pharmacy contracted to dispense 340(b) pharmaceuticals be reported on this line. All patient pharmacy income (gross income) must be reported on Table 9D and expenses must be recorded on Table 8A. (Also see Appendix B.)

### Total Other Revenue (Line 11)

Enter the total of Lines 1, 5, 9, and 10 for total other revenues/income—this number is calculated automatically by the EHB.

## Questions and Answers for Table 9E

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

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, the FQHC Look-Alike program, or the BHW Primary Care Clinics program. 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 award amount unless the full award was paid/drawn down 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 or not the actual payment to the health center 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 charges, self-pay patient 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 Table 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D.

## Table 9E: Other Revenues

Reporting Period: January 1, 2016, through December 31, 2016

| Line | 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 | |
| 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 | |
| 5. | **Total Other Federal Grants** (Sum Lines 2–3a) | |
| | **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 that are not counted as visits. Interactions with individuals listed as "non-providers" are never 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 | |
| Obstetricians/Gynecologists (Line 4) | X | |
| Pediatricians (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 | |
| **Physician 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 Nurses (RNs) | X | |
| Licensed Practical Nurses/Licensed Vocational Nurses | X | |
| Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT) | X | |
| **Other Medical Personnel** (Line 12) | | |
| Nurse Aides/Assistants (Certified and Uncertified) | | X |
| Clinic Aides/Medical Assistants (Certified and Uncertified Medical Technologists) | | X |
| Unlicensed Interns and Residents | | X |
| EMS/EMT Staff (not credentialed as a nurse) | | 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 Technicians | | 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 Therapists (Line 17a) | X | |
| Dental Assistants, Advanced Practice Dental Assistants (Line 18) | | X |
| Dental Technicians (Line 18) | | X |
| Dental Aides (Line 18) | | X |
| Dental Students | | X |
| **Mental Health** (Line 20) and **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 Counselors (Line 20b or 21) | X | |
| **All Other Professional Personnel** (Line 22) | | |
| Audiologists | X | |
| Acupuncturists | X | |

| Personnel by Major Service Category | Provider | Non-Provider |
|---|---|---|
| Chiropractors | X | |
| Community Health Aides and Practitioners | X | |
| Herbalists | X | |
| Massage Therapists | X | |
| Naturopaths | X | |
| Nutritionists/Dietitians | X | |
| Registered 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 Assistants (Line 22c) | | X |
| Ophthalmologist/Optometric Aides (Line 22c) | | X |
| Ophthalmologist/Optometric Technicians (Line 22c) | | X |
| **Pharmacy Personnel** (Line 23) | | |
| Pharmacists, Clinical Pharmacists | | X |
| Pharmacy Technicians | | X |
| Pharmacist Assistants | | X |
| Pharmacy Clerks | | 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) | | |

| Personnel by Major Service Category | Provider | Non-Provider |
|---|---|---|
| Family Planning Counselors | X | |
| Health Educators | X | |
| Social Workers | X | |
| Public Health Nurses | X | |
| Home Health Nurses | X | |
| Visiting Nurses | X | |
| Registered Nurses | X | |
| Licensed Practical Nurses | X | |
| **Outreach Workers** (Line 26) | | X |
| **Patient Transportation Workers** (Line 27) | | |
| Patient Transportation Coordinators | | X |
| Drivers | | 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 |
| **Community Health Workers** (Line 27c) | | |
| Community Health Workers | | X |
| Community Health Advisors or Representatives | | X |
| Lay Health Advocates | | X |
| Promotoras | | X |
| **Other Enabling Services Personnel** (Line 28) | | X |
| **Other Program 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 Health Care, Frail Elderly Support staff | | X |
| **Quality Improvement Staff (QI)** (Line 29b) | | |
| QI Nurses | | X |
| QI Technicians | | X |

| Personnel by Major Service Category | Provider | Non-Provider |
|---|---|---|
| QI Data Specialists | | X |
| Statisticians, Analysts | | X |
| Quality Assurance/Quality Improvement and HIT/EHR Design and Operation Staff | | X |
| **Management and Support Staff** (Line 30a) | | |
| Project Directors | | X |
| Chief Executive Officer/Executive Directors | | X |
| Chief Financial Officers/Fiscal Officers | | X |
| Chief Information Officers | | X |
| Chief Medical Officers | | X |
| Secretaries | | X |
| Administrators | | X |
| Directors of Planning And Evaluation | | X |
| Clerk Typists | | X |
| Personnel Directors | | X |
| Receptionists | | X |
| Directors of Marketing | | X |
| Marketing Representatives | | X |
| Enrollment/Service Representatives | | X |
| **Fiscal and Billing Staff** (Line 30b) | | |
| Finance Directors | | X |
| Accountants | | X |
| Bookkeepers | | X |
| Billing Clerks | | X |
| Cashiers | | X |
| Data Entry Clerks | | X |
| **IT Staff** (Line 30c) | | |
| Directors of Data Processing | | X |
| Programmers | | X |
| IT Help Desk Technicians | | X |
| Data Entry Clerks | | X |
| **Facility** (Line 31) | | |
| Janitors/Custodians | | X |
| Security Guards | | X |
| Groundskeepers | | 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 |

| Personnel by Major Service Category | Provider | Non-Provider |
|---|---|---|
| Medical and Dental Appointment Clerks | | X |
| Medical and Dental Patient Records Clerks | | X |
| Patient Records Supervisors | | X |
| Patient Records Technicians | | X |
| Patient Records Clerks | | X |
| Patient Records Transcriptionists | | X |
| Registration Clerks | | X |
| Appointments Clerks | | 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.) that is paid for by the reporting health center
- Services provided by a volunteer provider
- Interns and residents
- WIC

- In-house pharmacy or dispensary services for health center'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)/Program of All-inclusive Care for the Elderly (PACE)
- 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
- New start/New access point

## Contracted Care (Specialty, dental, mental health, etc.)

*Service must be paid for by health center*

| Tables Affected | Treatment |
|---|---|
| 5 | **Providers (Column A)** are counted if the contract is for a portion of an FTE (e.g., one day a week OB/Gyn = 0.20 FTE). Providers are *not* counted if the contract is for a service (e.g., $X per visit or $55 per resource-based relative value unit [RBRVU]). **Visits (Column B)** are *always* counted, regardless of method of provider payment or location of service (health center's site or contract provider's office). |
| 6A | Health center receives encounter form or equivalent from contract provider, reports diagnoses and/or services provided as applicable. |
| 6B / 7 | If contract clinician provides any services that are subject to quality measures, all data are to be collected from contractor (e.g., birth weight of a child from contract obstetrician, last HbA1c from an endocrinologist, sealants placed from a dentist). |
| 8A | **Column A: Total Cost**—Cost of provider/service is reported on applicable line. If the provider receives a "co-payment" or a "nominal fee" from the patient, the sum of that and what the center pays is reported.<br>**Column B: Facility and non-clinical support services**—Health center will generally use a lower facility and non-clinical support services allocation rate for off-site services. If the provider is off-site, all facility and non-clinical support costs are included in the direct charge in Column A. |
| 9D | **Charge (Column A)** is the health center's usual, customary, and reasonable (UCR) charge if on-site; use the contractor's UCR charge if off site.<br>**Collection (Column B)** is the amount received by *either* the health center *or* contractor from first or third parties.<br>**Allowance (Column D)** is the amount disallowed by a third party for the charge (if on Lines 1–12).<br>**Sliding Discount (Column E),** if applicable, is the amount written off for eligible patients per the center's fiscal policies (Line 13). Calculate as UCR charge, minus amount collected from patient, minus amount owed by patient as their share of payment. Note that the payment by the health center is not considered here. |

## Services Provided by a Volunteer Provider

*Services are not paid for by health center, but are provided on site.*

Volunteer staff (including AmeriCorps/HealthCorps, but not National Health Service Corps) who provide services on site on behalf of the health center. Where there is a basis for determining their hours, FTE can be included in the UDS report.

| Tables Affected | Treatment |
|---|---|
| 5 | **Column A: Provider FTE** – FTE is reported if the service is provided on site at health center's clinic. FTE is calculated by using hours volunteered as the numerator. Because volunteers do not receive paid leave 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.<br><br>Providers are not counted if their services are provided at their own offices.<br><br>**Column B: Clinic Visits –** Visits are counted only if the service is provided at a site in the health center's scope of service and under the health center's control. |
| 6A | Health center counts diagnoses and/or services provided on site, as applicable. |
| 8A | **Column C, Line 18 –** Show the value of donated services provided by volunteers on this line only. |
| 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

Health centers often make use of individuals who are in training, referred to variously as students, interns, or residents, depending on their field and their licensing. Medical residents are generally licensed practitioners. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing.

| Tables Affected | Treatment |
|---|---|
| 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 a Family Physician. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the health center) or like a volunteer (if they are *not* being paid). See volunteer providers, immediately above.<br><br>**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. |
| 8A | *If the intern or resident is paid by the health center* ***or*** their cost is being paid through a contract which pays 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 health center* and the health center 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. |

## Women, Infants, and Children (WIC)

| Tables Affected | Treatment |
|---|---|
| 3A, 3B, 4 | Clients whose only contact with the health center 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.<br>**Visits and patients (Columns B and C)** are *never* reported. |
| 8A | **Column A: Net costs**—Total cost of program included on Line 12 in Column A.<br>**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, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center *is* receiving WIC funds from a state government, the grant/contract funds received are reported on Line 6. If the funds are received from another intermediary organization, the funds are reported on Line 8. |

## In-house Pharmacy or Dispensary Services for Health Center's Patients

*Including only that part of the pharmacy that is paid for by the health center and dispensed by in-house staff (see below for other situations)*

| Tables Affected | Treatment |
|---|---|
| 5 | **Column A: Staff**—Pharmacy staff is 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 members (not including pharmacists) who spend a readily identifiable portion of their time with PAP programs should be counted on Line 27a, Eligibility Assistance. Clinical Pharmacists are included on Line 23 even if they are physically located in the clinic.<br>**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. |
| 8A | **Line 8b, Column A: Pharmaceutical Direct Costs**—The actual cost of drugs purchased by the pharmacy is placed on Line 8b. The cost of vaccines, birth control pills, injectable antibiotics, and other drugs dispensed in the clinic and not in a pharmacy are still reported on line 8b. The value of donated drugs is *not* reported here. The value of these donations *is* reported on Line 18 in Column C.<br>**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.<br>**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.<br>**Column B: Facility and Non-clinical Support Services**—All facility and non-clinical support services costs associated with Lines 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.<br>**Column C, Line 18**: Show the value of donated drugs (generally calculated at 340(b) rates) on this line *only*. |
| 9D | **Column A: Charge**— is the health center's full retail charge for the drugs dispensed.<br>**Column B: Collection**— is the amount received from patients or other third parties/insurance companies.<br>**Column D: Allowance**— is the amount disallowed by a third party for the charge (if on Lines 1–12).<br>**Column E: Sliding Discount**— is the amount written off for eligible patients per health center policies (Line 13). Calculate 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)

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center 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:

| 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-access Pharmacy." |

## Contract Pharmacy Dispensing to Clinic Patients, Generally Using 340(b) Purchased Drugs

| Tables Affected | Treatment |
|---|---|
| 5 | No staff, visits, or patients are reported. PAP staff are reported as enabling services on Line 27a: Eligibility Assistance Workers. |
| 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.<br>**The full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy** (340(b) regulations require that the official purchase be made by the CHC) goes on Line 8b and any administrative or dispensing costs charged by the pharmacy go on Line 8a.<br>**If the pharmacy is reporting a flat amount** for services, including both pharmaceuticals and its 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.<br>**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.<br>**Payments to pharmacy benefit managers** are reported on Line 8a.<br>**Share of profits:** Some pharmacies engage in fee splitting and keep a "share of profit." This is to be considered a payment to the pharmacy and reported on Line 8a. |
| 9D | **Charge (Column A)** is the health center/contract pharmacy's full retail charge for the drugs dispensed or the amount charged by the distributer/pre-packager, if retail is not known.<br>**Collection (Column B)** is the amount received from patients or insurance companies. Health centers must identify and report this amount. (NOTE: Most health centers do not have this sort of arrangement for their Medicaid patients.)<br>**Allowance (Column D)** is the amount disallowed by a third party for the charge (if on Lines 1–12).<br>**Sliding Discount (Column E)** is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge (or pharmacy charge), minus amount collected from patient (by pharmacy or health center), 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 the pharmacy*. Actual gross income must be reported on Table 9D. |

## Donated Drugs, Including Vaccines

| Tables Affected | Treatment |
|---|---|
| 8A | *If the drugs are donated to the health center, 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*, the health center 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 generally accepted accounting principles (GAAP) might suggest another treatment for the value. |

## Clinical Dispensing of Drugs

Many pharmaceuticals, ranging from vaccines to allergy shots to family planning shots or pills to drugs used in medication-assisted treatment of opiate use, are dispensed in the clinic area of the health center. 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. Unless they were received as a donation to the clinic it is appropriate to charge for these services, though dispensing them is not considered to be a visit.

| Tables Affected | Treatment |
|---|---|
| 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) and the Program of All-inclusive Care for the Elderly (PACE)

ADHC programs are often recognized by Medicare, Medicaid, and certain other third-party payers. 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 per member per month (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. The PACE program is even more expansive and may include ADHC services, as well as additional services to maintain independence for the elderly.

| Tables Affected | Treatment |
|---|---|
| 5 | When a provider does a formal, separately billable, examination of a patient at the ADHC/ PACE facility, it is treated as any other medical visit. The nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service are *not* counted as a visit for the purposes of reporting on this table. Staff is included on Line 29a. |
| 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. PACE costs over and above medical and pharmacy costs are similarly included 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/Dually Eligible

Some individuals are eligible for both Medicare and Medicaid coverage (commonly referred to as Medi-Medi or Dually Eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC) fee, the remainder is billed to Medicaid, which pays an amount based on policy which varies from State to State.

| Tables Affected | Treatment |
|---|---|
| 4 | Patients are reported on Line 9, Medicare. Do not report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare. |
| 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. It is possible that the reclassification will cross a calendar year. A much smaller portion of the total charge, if any, will transfer to Medicaid (according to Medicare procedures), where it will be reported as a charge on a Medicaid line. The payment received from Medicaid will appear on Line 1 in Column B. The difference between the charge and the collection will be shown as a positive or negative allowance, depending on the amount. |

## Certain Grant-supported Clinical Care Programs: BCCCP, Title X, etc.

*These are fee-for service or fee-per-visit programs only.*

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 grant period – usually the state fiscal 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.

| Tables Affected | Treatment |
|---|---|
| 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" payer 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

These are programs that 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. Most are generally capped at a maximum total amount, and payments are often paid in a different fiscal year.

| 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 health center's usual charges for each service 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 is collected or is written off as a bad-debt in Column F. All the rest of the charge (or all 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

| Tables Affected | Treatment |
|---|---|
| 4 | Workers' Compensation is a form of *liability insurance for employers*, not a *health insurance for employees*. Patients whose bills are being paid by Workers' Compensation will generally 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/workplace-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, Public Employees Insurance, Etc.

| Tables Affected | Treatment |
|---|---|
| 4 | There are many individuals whose insurance premium is paid for, in whole or in part, by a government, including military and dependents, school teachers, congressmen, and HRSA staff. These individuals are all considered to be covered by private insurance. 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.*

Some health centers have **included in their scope of service** a site in a school, a workplace, a jail, or some other location where they are contracted to provide services to 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.

| 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).<br>**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.") *Family insurance must be reported. Except for confidential minor consent services, it is not acceptable to report a student as uninsured*. |
| 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

| Tables Affected | Treatment |
|---|---|
| 4 | **Medicaid**: If CHIP is handled through Medicaid and the enrolled patients are identifiable, they are reported on Line 8b. *If it is not possible to differentiate CHIP from regular Medicaid,* the enrolled patients are reported on Line 8a with all other Medicaid patients.<br>**Non-Medicaid**: CHIP-enrolled patients in states that 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.<br>**Non-Medicaid**: Report on Lines 7–9, as appropriate. *Do not report on Lines 10–12, even if the plan is administered by a commercial insurance company*. |

## Carve-Outs

**Relevant to capitated managed care only**: The health center 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.

| Tables Affected | Treatment |
|---|---|
| 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. Wrap-around payments will be reported on both lines using the health center's allocation process. |

## Incarcerated Patients

Some health centers contract with jails or 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.

| Tables Affected | Treatment |
|---|---|
| 4 | Income for prisoners must be presumed to be below poverty (Line 1).<br>Unless the state has arranged for inmates to be enrolled in Medicaid, incarcerated individuals receiving health services under a contract are generally 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. |

## HIT/EHR Staff and Costs

Health Information Technology (HIT), including 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 aid to clinicians in the management and integration of patient services. As such, they are considered to be part of a quality improvement program, though some aspects are counted in other service categories.

| Tables Affected | Treatment |
|---|---|
| 5 | Staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions, are included as part of the appropriate *service* category they perform these functions for, not as IT staff or quality improvement staff.<br>The staff members dedicating some or all of their time to design, operation, and oversight of quality improvement systems, data specialists, statisticians, and HIT/EHR or medical form designers are reported as quality improvement staff and reported on Line 29b.<br>Staff managing the hardware and software of a practice management billing and collection system is reported as non-clinical support staff, under IT, Line 30c. |
| 8A | Costs for staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions, as noted above, are included as part of the appropriate *service* category they perform these functions for, not as IT staff or quality improvement staff.<br>Costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the HIT/EHR are reported on Line 3: Other Medical.<br>If the HIT/EHR covers dental and/or mental health, then some of costs will logically be allocated to these lines as well.<br>Cost for staff noted above as being included in quality improvement staff are reported on Line 12a.<br>Costs for staff managing the hardware and software of a practice management billing and collection system are reported as non-clinical support, Line 15. |

## Issuance of Vouchers for Payment of Services

Voucher programs have traditionally been a unique delivery of primary and specialty care services to agricultural workers in geographically dispersed areas. Some homeless and other health center programs also make use of the mechanism as a means of outsourcing care that cannot be provided in-house. This system involves the process of contracting with providers outside of the health center. Vouchers are issued to authorize a third-party provider to deliver the services and the voucher is returned to the health center for payment. Payment is generally at less than the provider's full fee, but is consistent with other payers, such as Medicaid.

| Tables Affected | Treatment |
|---|---|
| 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. A vouchered taxi ride or prescription would *not* make the patient "countable" because transportation and pharmacy services are not counted on Table 5, but a vouchered eye exam 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 (FP) 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.<br>**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 that lists the services and diagnoses. These are to be tracked by the center and reported on Table 6A, 6B, and 7. |
| 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 health center.<br>**Discounts**: Virtually all clinical providers are paid less than their full fee. Some health centers like to report the amount of these discounts as "donated services." *While this is not required,* health centers 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.<br>**Column B: Collections –** If the patient paid the voucher program or the voucher provider a nominal or other fee, show this in Column B.<br>**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 or voucher provider and failed to do so.<br>**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. |

## New Start/New Access Point

Health center sites may be added in-scope at any point during the reporting period. Health centers must submit data for the calendar year, so health centers operational prior to the start of the Notice of Award must submit data on all tables with activity covering January 1 to December 31.

| Tables Affected | Treatment |
|---|---|
| ZIP, 3A, 3B, 4 | It is understood that a health center may have never collected some of the data required to be reported in the UDS prior to the start of Notice of Award, such as veteran status, member months in managed care, etc. Provide the best data available, but for this first year only you may have some unusual numbers. Work with your reviewer to explain apparent data inconsistencies. |
| 5A | Report how long key staff have been with the health center going back to your founding, not the start date of award. For example, if you have only been funded for six months, but your CEO has been with the health center for seven years, report the CEO with seven years of tenure. |
| 6B, 7 | When it comes to the clinical measures, you may need to use a sampling process instead of being able to rely on your PMS or HIT/EHR. See Appendix C of the UDS manual for details.<br>If the added site or the health center will transition HIT/EHR during the year, the health center must gather the information for the year across the two systems, and add them to a separate database to remove any duplication in the data. |

# Appendix C: Sampling Methodology 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 health information technology, including an electronic health record, must include a minimum of 80 percent of all medical (or dental for the sealants measure) patients from all service delivery sites and grant-funded programs in the defined universe. In addition, the data source must cover the period of time to be reviewed (e.g., 3 years for Pap tests, 2 years for immunizations) and include information to assess meeting the measurement standard with the clinical measure, as well as to evaluate exclusions.

If all conditions can be met, reporting on the universe is more accurate because it reports on 80 percent or more of patients and can be easier if queries are properly automated. If the health center chooses to do so, it may use less than 100 percent of the patients in the universe as long as the reason for using less than 100 percent of the patients is not related to the variable being reported on (see instructions for Tables 6B and 7) and the result must include 80 percent or more of the total population. This is not considered to be a sample and the methods discussed here are not relevant to these situations.

If the health center cannot report on at least 80 percent of the universe (or if they choose not to use their HIT/EHR), 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 the universe where each member of the universe has had the exact same chance of being selected as every other member of the universe.

A true random sample will, thus, generate outcomes 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 for which a sample is to be used, perform each of the following steps. A new random sample must be created for each measure to be sampled.

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

Define the universe for the measure being reviewed. The universe must:

- Include all active (measurement year) medical patients
- Include all sites in the scope of project

- Include all funding streams
- Include contracted medical services

Identify the number of patients who fit, or who initially appear to fit, the criteria for that measure. (Because you will review each record in the sample, you can remove any that was mistakenly included.) 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 that each record has met the measurement standard with the clinical measure

For each measure, review available data sources to identify any automated sources to simplify data collection. Since the automated data fields (if any) for these data sources will be augmented by the text and scanned documents, they do not need to be available for all patients. Examples of data sources include:

- Electronic health records
- Disease-specific (PCDEMS, PECs, i2i-track, etc.) 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 meeting the measurement standard. If meeting the measurement standard cannot be confirmed from the alternative source, review text and scanned information to retrieve required information. (Thus, if, for example, a woman's chart shows she is an active medical patient, but does not show the CPT or ICD-10-CM code for a Pap test, review scanned documents to see if there is a copy of a Pap test done by another agency in the record.)

### 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 a woman has ever had a hysterectomy, may not be available. When criteria cannot be used to include patients in 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 (record) would be removed. If the review is of a sample of records, then another record is selected to replace the record that was originally selected.

If a record is selected that should be excluded from the sample, the record will be replaced with a substitute. Use the replacement methodology described for the sampling methodology selected. Any criteria which was missed in selecting a record (e.g., not noting that the 2-year old was first seen after his/her second birthday) may be used to exclude a record. 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 records which were excluded during the review process.

## 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 Randomizer website at http://www.randomizer.org/. The website requires no password or subscription to access. To obtain a list of random numbers, complete the questions as documented below.

### Identifying an Initial List

1. Request one list of 70 numbers.
2. Complete the "Number Range" by entering 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 2 in the reporting year in the universe, enter 628 as n.
3. 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. (It is often helpful, but not necessary, to request that the selected random numbers be sorted from lowest to highest.)

### Identifying a Replacement

To create a "sample" of records to substitute for records which 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 record should be excluded from the original random sample of 70, replace that record with one of the records from the replacement sample. Because of the need to replace ineligible charts, more than 70 records may need to be evaluated for meeting the measurement standard for a particular measure, but the final sample will include 70 records which meet all the selection criteria.

Alternatively, you can draw a sample of 80 patients (for example) and use the first 70. If one needs to be replaced, use the 71st, then the 72nd, and so on. In this instance, do not request a sorted list since it will be biased toward lower numbers.

| 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 number in sequence | Last sequence number in list |
| Unique numbers | Yes | Yes |
| Sort numbers | Yes, least to greatest | No |

## Option #2: Interval

### Identifying an Initial List

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

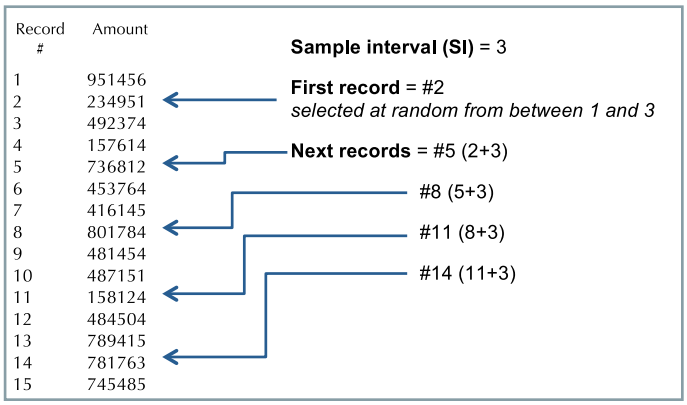
A second method uses the same numbered list of records in the universe created in Step 1, above. To generate the sample:

1. Calculate the "sample interval" by dividing the number of records in the universe by 70.
2. Randomly pick a record from the first sampling interval. For example, if the sampling interval is 10, the first sampling interval includes charts number 1 through number 10. Randomly select one record from this interval to use as your first record.
3. Then, select every nth record where n is 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 numbers 18, 28, 38, etc.

**First sequence # + SI = second #**

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

**Example:**




### Identifying a Replacement

If a selected record needs to be excluded from the sample, return to the original list and substitute the next record on the list after the excluded record. If the replacement record needs to be excluded, select the record after that on the list until an eligible record is selected. Resume selection using the next chart you had pre-selected for the sample. (If you run out of records on the list, continue your count back at the beginning

of the universe.) In this manner, more than 70 records may be evaluated for meeting the measurement standard for a particular measure, but the final sample will include 70 records which meet all the selection criteria.

## Identifying Dental Sealants Universe Where Codes and Caries Risk Level Are Unavailable

Under certain situations, a larger number of records may need to be identified in order to identify the necessary 70 random records. Some health centers may not have used the ADA Dental Risk Assessment codes or may not have tracked caries risk. Under these situations, alternative instructions for determining the size of the universe and measuring the performance standard are provided.

1. Identify all children age 6 through 9 who had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement year.

2. Review these records to find 70 records where the dental records or other documentation demonstrate the level of caries risk. You may need to have providers retrospectively review the records to determine caries risk based on available diagnostic information at that time if the caries risk level is not currently documented in the patient record.

3. Continue to review charts until 70 charts meet the universe criteria (dental patients aged 6 through 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year with moderate to high risk for caries).

   *Estimate* the size of the universe by:

   a. Dividing the 70 charts that were identified to have met the universe criteria by the number of records you had to review to find the 70.

   b. Multiplying this result by the total number of children age 6 through 9 who had an oral health visit (the value from step 1). The resulting value will be your estimated universe.

5. Enter the estimated universe in Column A, 70 in Column B, and the number of the 70 who met the performance standard (received a sealant on a permanent first molar tooth in the measurement year).

# Appendix D: Health Center Health Information Technology (HIT) Capabilities and Quality Recognition

## Instructions

The Health Information Technology (HIT) Capabilities and Quality Recognition Form includes a series of questions on health information technology (HIT) capabilities, including electronic health record (EHR) interoperability and eligibility for Meaningful Use. The HIT and Quality Recognition Form must be completed and submitted as part of the UDS submission. The first part includes questions about the health center's implementation of an EHR, certification of systems, how widely adopted the system is throughout the health center and its providers, national and/or state quality recognition (accreditation or PCMH), telemedicine, and medically-assisted treatment.

## Questions

The following questions will be presented on a screen in the Electronic Handbook to be completed before the UDS Report is submitted. Instructions for the HIT questions can be found in EHB as you are completing the questions.

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

   This question seeks to determine whether or not an EHR has been installed by the health center as of December 31 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 health center purchased an EHR but had not yet placed it into use, answer "No." If it has been installed, indicate if it was being used, as of December 31, by:

   a. **All sites and all providers**: For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although 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. This option may be checked even if a small number of newly hired and as yet not trained individuals are the only ones not using the system.

   b. **At some sites or for some providers**: Select option b if one or more permanent

sites did not have the EHR installed, or in use (even if this is planned), or if one or more medical providers (as defined above) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do 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, even if the system had been installed and staff was training on how to use the system.

If a system is in use (i.e., if a or b has been selected above), indicate if your system has been certified under the Office of the National Coordinator - Authorized Testing and Certification Bodies (ONC-ATCB).

1a. Is your system certified under the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

a. Yes

b. No

Health centers are to indicate in the blanks the vendor, product name, version number, and certified health IT product list number. (More information is available at ONC-ATCB at http://onc-chpl.force.com/ehrcert.) If you have more than one EHR (if, for example, you acquired another practice which has its own EHR), report the EHR that will be the successor system.

Vendor

Product Name

Version Number

Certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

a. Yes

b. No

If "yes, but only at some sites or for some providers" is selected above, a box expands for health centers to 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 login identities at more than one site is still counted as just one provider:

1c. How many sites have the EHR system in use?

1d. How many providers use the EHR system?

1e. When do you plan to install the EHR system?

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 (more information on Meaningful Use). For each capability, indicate:

a. **Yes** if your system has this capability and it is being used by your center;

b. **No** if your system does not have the capability or it is not being used; or

c. **Not sure** if you do not know if the capability is built in and/or do not know if your center is using it.

Select a (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 a.

Select b or c 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 b or c only if none of the providers are making use of the function.

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.)

   a. Yes

   b. No

   c. Not sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?

   a. Yes

   b. No

   c. Not sure

4. Does your center exchange clinical information electronically with other key providers/health care settings, such as hospitals, emergency rooms, or subspecialty clinicians?

   a. Yes

   b. No

   c. Not sure

5. Does your center engage patients through health IT, such as patient portals, kiosks, or secure messaging (i.e., secure email) either through the EHR or through other technologies?

   a. Yes

   b. No

   c. Not sure

6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?

   a. Yes

   b. No

   c. Not sure

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?

   a. We use the EHR to extract automated reports

   b. We use the EHR but only to access individual patient charts

   c. We use the EHR in combination with another data analytic system

   d. We do not use the EHR

8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as "Meaningful Use"?

a. Yes, all eligible providers at all sites are participating

b. Yes, some eligible providers at some sites are participating

c. No, our eligible providers are not yet participating

d. No, because our providers are not eligible

e. Not sure

If yes (a or b), at what stage of Meaningful Use are the majority (more than half) of your participating providers (i.e., what is the stage for which they most recently received incentive payments)?

a. Adoption, Implementation, or Upgrade (AIU)

b. Stage 1

c. Stage 2

d. Stage 3

e. Not sure

If no (c only), are your eligible providers planning to participate?

a. Yes, over the next 3 months

b. Yes, over the next 6 months

c. Yes, over the next 12 months or longer

d. No, they are not planning to participate

9. Does your center use health IT to coordinate or to provide enabling services, such as outreach, language translation, transportation, case management, or other similar services?

a. Yes

b. No

If yes, specify the type(s) of service: _____ _____ _____

10. Has your health center received or retained patient-centered medical home recognition or certification for one or more sites during the measurement year?

a. Yes

b. No

If yes (a), which third-party organization(s) granted recognition or certification status? (Can identify more than one.)

a. National Committee for Quality Assurance (NCQA)

b. The Joint Commission (TJC)

c. Accreditation Association for Ambulatory Health Care (AAAHC)

d. State-based initiative

e. Private payer initiative

f. Other recognition body (Specify __ _____ _____)

11. Has your health center received accreditation?

a. Yes

b. No

If yes (a), which third-party organization granted accreditation?

a. The Joint Commission (TJC)

b. Accreditation Association for Ambulatory Health Care (AAAHC)

12. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

a. How many physicians, on-site or with whom the health center has contracts, had obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?

b. How many patients received medication-assisted treatment for opioid use disorder from a physician with a DATA waiver working on behalf of the health center?

*Note: The following ICD-10-CM code may assist in identifying MATs: ICD-10-CM F11-*

13. Are you using telehealth?
Telehealth is defined as the use of telecommunications and information technologies to share information and provide clinical care, education, public health, and administrative services at a distance.[14]

a. Yes

b. No

If yes (a), how are you using telehealth? (Choose all that apply)

a. Provide primary care services

b. Provide specialty care services

c. Provide mental health services

d. Provide oral health services

e. Manage patients with chronic conditions

f. Other (Please specify: _____)

If no (b), please explain why you are not using telehealth: _____

14 http://www.hrsa.gov/ruralhealth/telehealth/index.html

# Appendix F: Health Center References

Several resources are available to assist health centers with UDS Reporting or EHB system questions:

| Description | Contact | Email | Phone |
|---|---|---|---|
| UDS reporting questions | BPHC UDS Support Center | udshelp330@bphcdata.net | 866-837-4357 (866-UDS-HELP) |
| EHB account and user access questions | HRSA Call Center | HRSA Call Center at http://www.hrsa.gov/about/contact/ehbhelp.aspx | 877-464-4772 |
| EHB electronic reporting issues | BPHC Helpline | Health Center Program Support at http://www.hrsa.gov/about/contact/bphc.aspx | 877-464-4772 |

Other data and resource links, including this manual, notifications of changes to reporting criteria, and training opportunities and other materials can be found on the BPHC website at http://bphc.hrsa.gov/datareporting/index.html or the UDS Training Website at http://www.bphcdata.net/html/bphctraining.html.

Strategic partnerships, including Health Center Controlled Networks, National Cooperative Agreements, Primary Care Associations, and Primary Care Offices can be found on the BPHC Quality Improvement website at http://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/index.html.

Resources are available to assist health centers serving special populations with meeting performance requirements and training needs:

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| National Association of Community Health Centers (NACHC) | http://www.nachc.com | Cindy Thomas; cthomas@nachc.com | 301-347-0400 |

**Public Housing Primary Care (PHPC) Program**

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| Community Health Partners for Sustainability (CHPFS) | http://www.chpfs.org | Alexander Lehr; alex@chpfs.org | 215-821-4004 |
| National Center for Health in Public Housing (NCHPH) | http://www.nchph.org | Jose Leon; jose.leon@namgt.com | 703-812-8822 |

### Migrant Health Center (MHC) Program

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| Migrant Clinicians Network (MCN) | http://www.migrantclinician.org | Theressa Lyons; tlyons@migrantclinician.org | 512-579-4511 |
| National Center for Farmworker Health (NCFH) | http://www.ncfh.org | Bobbi Ryder; ryder@ncfh.org | 512-312-5453 |

### Health Care for the Homeless Program

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| National Health Care for the Homeless Council (NHCHC) | http://www.nhchc.org | Darlene Jenkins; djenkins@nhchc.org | 615-226-2292 |
| Corporation for Supportive Housing (CSH) | http://www.csh.org | Kim Keaton; Kim.keaton@csh.org | 917-297-9033 |

### Other Vulnerable Populations

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| Association of Asian Pacific Community Health Organizations (AAPCHO) | http://www.aapcho.org | Jen Lee; jlee@aapcho.org | 510-272-9536 x118 |
| National LGBT Health Education Center | http://www.lgbthealtheducation.org | Harvey Makadon; HMakadon@fenwayhealth.org | 617-927-6426 |
| National Center for Medical-Legal Partnerships | http://www.medical-legalpartnership.org | Ellen Lawton; ellawton@gwu.edu | 617-549-1733 |
| Health Information and Technology, Evaluation, and Quality (HITEQ) Center | http://hiteqcenter.org/ | Julia Rossen; hiteqinfo@jsi.com | 844-305-7440 |

### Oral Health

| Organization | Website | Contact and Email | Phone |
|---|---|---|---|
| National Network for Oral Health Access | http://www.nnoha.org | Phillip Thompson; executivedirector@nnoha.org | 303-957-0635 x6 |

Health centers can access their current year and prior year UDS reports, as well as several standard reports, through the EHB Web-link at https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx.

### Reports and Their Availability

| UDS Report Level | Timing | Description | Grantee | Look-Alike |
|---|---|---|---|---|
| Health Center Trend Report | July | Compares the Health Center's performance for key performance measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a three-year period. | HC, S, N | HC, N |
| UDS Summary Report | July | Summary and analysis on the Health Center's current UDS data using measures across various tables of the UDS report. | HC, S, N | HC, N |
| UDS Rollup Report | July | Compiles annual data reported by Health Centers. Summary data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. | S, N | N |
| Performance Comparison Report | September | Provides the summary and analysis on the Health Center's latest UDS data giving details at grantee, state, national, urban, and rural levels with trend comparisons and percentiles. | Includes all levels | Includes all levels |

*Abbreviations indicate geographies and detail level for which each report is available. HC=Health Center, S=State, N=National*


HRSA
Health Center Program

2016 UDS Manual – November 4, 2016 V 1.1
OMB Number: 0915-0193, Expiration Date: 02/28/2018