

Preparing for and Understanding your 2017 Uniform Data System (UDS) Submission

Bureau of Primary Health Care (BPHC)
October 24, 2017, from 1:00–2:30 p.m. (ET)

Objectives of this Webinar

- ▶ Understand the importance of the UDS and critical dates in the process
- ▶ Implement processes and systems for accurate submission of the UDS report
- ▶ Understand table-specific considerations

Agenda

- ▶ Importance of the UDS
- ▶ Key definitions used in the UDS
- ▶ Introduction to the UDS tables and appendices
- ▶ Report preparation considerations
- ▶ Strategies for successful reporting, training, and technical assistance (TA) resources
- ▶ Questions

Importance of the UDS



What is the Uniform Data System?

- ▶ A standardized set of data reported by the Health Resources and Services Administration (HRSA)-designated health center programs:
 - Section 330-funded grantees — Community Health Center (CHC), Health Care for the Homeless (HCH), Migrant Health Center (MHC), and Public Housing Primary Care Program (PHPC)
 - Health Center Program look-alikes
 - Bureau of Health Workforce (BHW) primary care clinics
- ▶ Reports on the approved scope of project for the period **January 1, 2017–December 31, 2017**

What is Reported?

- ▶ A detailed picture of your health center using:
 - Twelve tables, which provide demographic, clinical, operational, and financial data
 - Two forms (appendices), which provide health information technology (HIT), telehealth, and other data elements

What is Reported	Table(s)
Patients served and their demographic characteristics	ZIP Code, 3A, 3B, 4
Types and quantities of services provided	5, 6A
Staffing mix and tenure	5, 5A
Quality of care, health outcomes, and disparities	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D, 9E
HIT capabilities, electronic health record (EHR) interoperability, Meaningful Use leveraging	HIT Form
Telehealth, medication-assisted treatment (MAT), and outreach and enrollment assists	Other Form

Components of the UDS Report

- ▶ Universal report — completed by all reporting health centers
- ▶ Grant report(s) — completed only by grantees that receive 330 grants under multiple funding streams

Table	Report a UNIVERSAL REPORT if you are a 330-funded program, look-alike, or BHW primary care clinic	Also report GRANT REPORT(S) if you receive 330 grants under multiple program authorities: CHC (330 (e)) HCH (330 (h)) MHC (330 (g)) PHPC (330 (i))
ZIP Code	Yes	No
3A, 3B, 4	Yes	Yes
5	Yes	Yes, but patients and visits only
5A	Yes	No
6A	Yes	Yes
6B, 7, 8A, 9D, 9E	Yes	No

Why do we report the UDS?

- ▶ Comply with legislative and regulatory requirements
- ▶ Inform HRSA, Congress, and the public about health center performance and operations
- ▶ Identify and measure trends over time
- ▶ Reward effective programs and services
- ▶ Support quality improvement at the health center
- ▶ Target and prioritize opportunities for quality improvement
- ▶ Permit performance comparison with national benchmarks

National Impact/Community Focus

Nearly **26 million** people – **1 in 12** people across the United States – rely on a HRSA-funded health center for care, including:

1 IN 3
LIVING IN POVERTY



1 IN 6
RURAL RESIDENTS



1 IN 10
CHILDREN IN THE US



330,000+
VETERANS



ABOUT 2.7 MILLION
PUBLICLY HOUSED



NEARLY 1.3 MILLION
HOMELESS



NEARLY 1 MILLION
AGRICULTURAL WORKERS



MORE THAN 750,000
SERVED AT SCHOOL-BASED HEALTH CENTERS

Key Definitions Used in UDS



Patients Defined — Unduplicated

- ▶ People who have at least one reportable visit during the calendar year
 - On the demographic tables: ZIP Code Table, Table 3A, and in each section of Tables 3B and 4, count each patient once and only once
 - Even if the patient received more than one type of service or had more than one visit
 - Patients are “unduplicated” on these tables — do not report the same patient twice

Count Once and Only Once

- ▶ Table 3A, total on Line 39, must equal the totals from the ZIP Code Table and each section from Tables 3B and 4 to provide an unduplicated count of patients



Patients Defined — by Service

- ▶ Also report these patients on Tables 5 and 6A only once for each type of service or diagnosis received during the year
 - Table 5 — seven service categories: medical, dental, mental health, substance abuse, other professional, vision, and enabling services
 - Table 6A — selected diagnoses and services
- ▶ Patients reported on the demographics tables are also the basis for the patients considered for the clinical measures on Tables 6B and 7

Countable Visits — Defined

- ▶ Documented
- ▶ One-on-one, face-to-face contact between a patient and a licensed or credentialed provider
 - Exception: Only behavioral health can count group visits and telemedicine
- ▶ Provided by provider who exercises independent professional judgment in providing services
- ▶ Include visits provided by paid, volunteer, and contracted providers
- ▶ ***Counted only when the visit meets all these criteria***



Count Only One Visit Per

- ▶ Patient, per visit type, per day
- ▶ Provider, per patient, per day, regardless of the number of services provided
- ▶ Provider type
 - Exception: Two providers of the same type at two different locations on the same day



What visits don't count?

- ▶ Do not count immunization only, lab only, dental varnishing or fluoride treatments, mass screenings, health fairs, outreach, or pharmacy visits
- ▶ Group health education, group diabetes sessions, etc., are not counted
- ▶ Not all staff report visits
- ▶ No services are counted for staff providing ancillary services, outreach and eligibility assistance, non-health-related services, or non-clinical support

Provider — Defined

- ▶ A provider:
 - Assumes primary responsibility for assessing the patient and documenting services in the patient's record
 - Exercises independent judgment regarding the services provided — which must be in their field of training (licensure and credentialing)
- ▶ Staff time is to be allocated by function among major service categories
- ▶ Only those designated as “providers” in Appendix A of the UDS Manual can generate visits for services — Not all staff generate visits
- ▶ Providers may be employees of the health center, contracted (paid), or volunteers

Full-Time Equivalent (FTE) Defined

- ▶ 1.0 FTE is equivalent to one person working full-time for one year; prorate part-time and part-year staff
 - Cannot use staff list as of December 31
- ▶ FTE is to be based on work performed
 - FTEs can be allocated across multiple categories
- ▶ Although most sites use 2,080 hours as full-time, some staff actually work 36- or 35-hour weeks; if that is the case, then adjust hours accordingly (e.g., 1,872 paid hours [36 X 52] might be one FTE)

Tenure Defined

- ▶ **Tenure = months of continuous employment**
- ▶ Based on:
 - A head count of persons (not FTE)
 - Number of consecutive months of service in current position

Prenatal Patients, Defined

- ▶ Patients who **directly received or were referred for prenatal care services**. This includes women who were:
 - Provided all prenatal care by the health center, including delivery
 - Provided all prenatal care by the health center, but referred for delivery
 - Provided some prenatal care, but were later referred for care and delivery
 - Diagnosed and referred with no prenatal care provided by the health center (for referral-only programs)

Introduction to the Tables

What to report and what the data tell us



Patient Profile Tables

Patients by ZIP Code, Tables 3A, 3B, and 4



Patients by ZIP Code

- ▶ Report patients by ZIP code by **primary medical insurance**
 - Report all **ZIP codes** with 11 or more patients

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/ Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
<system allows insertion of rows for more ZIP codes>					
Other ZIP Codes					
Unknown Residence					
Total					

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

- ▶ Report patients according to their **sex at birth** (or on a birth certificate)

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		
*	<i>Excerpt from Table 3A</i>		

Table 3B — Demographic Characteristics

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)				

- ▶ Report all patients by ethnicity and race (Lines 1–8)
- ▶ Count patients served in a language other than English (Line 12)

Line	Patients by Language	Number (a)
12.	Patients best served in a language other than English	

Table 3B — Demographic Characteristics

- ▶ Report patients by sexual orientation (Lines 13–19)
- ▶ Report patients by gender identity (Lines 20–26)
 - Note: Also known as SO/GI

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)	

Table 4: Patients by Income and Insurance

- ▶ Report patients income as defined by Federal Poverty Guidelines (Lines 1–6)

Line	Characteristic Income as Percent of 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)	

- ▶ Report primary medical care insurance for all patients by age range (Lines 7–12)

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 (Lines 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 (Lines 10a + 10b)		
11.	Private Insurance		
12.	TOTAL (sum Lines 7 + 8 + 9 + 10 + 11)		

Table 4: Patients by Managed Care and Target Populations

- ▶ Report monthly enrollment of members in managed care contracts (Lines 13a–13c)
- ▶ Report total number of agricultural workers, patients experiencing homelessness, patients served at school-based health centers, and veterans (Lines 17–25)
- ▶ Report all patients seen at a site located in or immediately accessible to a public housing site (Line 26)

Managed Care Utilization						
Line	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)					
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)					

Counting Total Patients at a Health Center Site Located in or Immediately Accessible to a Public Housing Site

Ask the following questions for each health center site separately:

1. Is health center site ***located in*** public housing?
2. Is health center site ***immediately accessible to*** a public housing site?
 - **Note:** Determination is at the discretion of health center administration
3. **If yes, count ALL patients** at this health center site as public housing patients
 - **Note:** Each health center must clearly define “immediately accessible to” support the definition with data and note logic in comments section of UDS Report
4. **If no, count NO patients** at this health center site as public housing patients
5. Aggregate number at all health center sites and report that number on **line 26** of Table 4 in the UDS report

Strategies for Counting Total Patients at a Health Center Site Located in or Immediately Accessible to a Public Housing Site

- ▶ Work with national cooperative agreements to map health center site locations against most up-to-date public housing site information
- ▶ Visualize distance and identify immediate accessibility
- ▶ Discuss findings with health center or primary care association staff to identify geographic, transportation, and cultural aspects that influence ‘immediate accessibility’
 - like long-standing history of serving public housing residents, and/or transportation access (subway, bus, car, bike, foot)

Coming Soon...

UDS Mapper: Health center site locations overlaid with most up-to-date public housing site information to visualize distance and identify immediate accessibility

Patient Profile Tables

ZIP Code Table, Tables 3A, 3B, and 4

- ▶ What the data tell us
 - Describe the patients you serve and demonstrate if you served the target populations proposed in your application
 - Permit mapping of your service area and is available in UDS Mapper to consider how your service area aligns with your proposed service area (Form 5B vs. ZIP Code Table)
 - Quantify the special populations; patient's gender identity and sexual orientation; and individuals served with financial, cultural, racial/ethnic, and linguistic barriers to care
 - Used to calculate some of the performance measures used by BPHC (such as total cost per total patient)

Staffing, Tenure, and Utilization Profile

Tables 5 and 5A



Table 5 — Staffing and Utilization

▶ Report

- Staff FTEs
- Visits by provider type
- Patients by service categories
 - Medical
 - Dental
 - Mental health
 - Substance abuse
 - Other professional
 - Vision
 - Enabling

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 (sum Lines 1–7)			
9a	Nurse practitioners			
9b	Physician assistants			
10	Certified nurse midwives			
10a	Total NPs, PAs, and CNMs (sum Lines 9a–10)			
11	Nurses			
12	Other medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	Total medical (sum Lines 8+10a through 14)			
16	Dentists			
17	Dental hygienists			
17a	Dental therapists			
18	Other dental personnel			
19	Total dental services (sum Lines 16–18)			
20a	Psychiatrists			
20a1	Licensed clinical psychologists			
20a2	Licensed clinical social workers			
*	<i>Excerpt from Table 5</i>			

Table 5A — Tenure for Health Center Staff

- ▶ Report a head count of persons in their current positions as of December 31
 - Report months of service for selected staff categories and positions
 - From personnel records

Line	Health Center Staff	Full- and Part-Time		Locum, On-Call, etc.	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1	Family physicians	blank	blank	blank	blank
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				

Staffing, Tenure, and Utilization Profile

Tables 5 and 5A

- ▶ What the data tell us:
 - Describe what staffing resources you have to provide services to your patients
 - Demonstrate retention of staff

Clinical Profile Tables

Tables 6A, 6B, and 7



Table 6A: Selected Diagnoses and Services Rendered

- ▶ Report **number of visits** with the selected service or diagnosis in Column A
- ▶ Report number of **unduplicated patients** receiving the service or with the diagnosis in Column B

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			
* Excerpt from Table 6A			

Table 6B: Measures to Report

Line	Description	eCQM
7–9	Early Entry into Prenatal Care	No eCQM
10	Childhood Immunization Status	CMS117v5
11	Cervical Cancer Screening	CMS124v5
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v5
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v5
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v5
16	Use of Appropriate Medications for Asthma	CMS126v5

Line	Description	eCQM
17	Coronary Artery Disease (CAD): Lipid Therapy	No eCQM
18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v5
19	Colorectal Cancer Screening	CMS130v5
20	HIV Linkage to Care	No eCQM
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v6
22	Dental Sealants for Children between 6–9 Years	CMS277v0

Note: CQM = electronic clinical quality measure

Table 7: Measures to Report

Section	Description	eCQM
A	Low Birth Weight	No eCQM
B	Controlling High Blood Pressure	CMS165v5
C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v5

- ▶ Note: Report Table 7 by patient's race and ethnicity

Table 6B and 7 Reporting Column Logic

- ▶ **Universe (Denominator) (Column A):** Identify all patients in the initial patient population (universe) and report this total
- ▶ **Number in Review (Column B):** Report one of the following:
 - Universe
 - Reduced universe — number greater than or equal to 80% of universe
 - A random sample of 70 patient charts
- ▶ **Performance (Numerator) (Column C or F):** Report the number of records (from Column B) that meet the measurement standard

Example: Table/Line	Childhood Immunization Status	Total Number of Patients with 2nd Birthday (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
6B/10	MEASURE: Percentage of children 2 years of age who have received age-appropriate vaccines by their 2nd birthday	Universe or denominator	Sample or universe	Records meeting the measurement standard

Tables 6B and 7

- ▶ Most measures aligned with the electronic CQMs used by the Centers for Medicare & Medicaid Services (CMS)
 - Exceptions: Early entry into prenatal care, CAD, HIV linkage to care, and low birth weight
- ▶ Be sure to use the [January 2017 eReporting](#) update even though later versions are available
- ▶ Details on the measure criteria and major differences between 2016 and 2017 reporting will be presented in detail in the all day Primary Care Association-sponsored trainings and a crosswalk will be provided
- ▶ Inquiries about the CMS CQM logic can be vetted to the Office of Information Technology and Communications through <https://oncprojecttracking.healthit.gov/support/login.jsp>

Clinical Profile Tables

6A, 6B, and 7

- ▶ What the data tell us:
 - Demonstrate achievements in national benchmarks for routine and preventive care, chronic care, prenatal care, and healthy behaviors
 - Identify opportunities for monitoring and improving quality improvement activities
 - Promote ongoing quality improvement at the health center

Financial Profile Tables

Tables 8A, 9D, and 9E



Table 8A — Financial Costs

- ▶ Report total accrued costs (by cost center) in Column A
- ▶ Report allocation of total facility and non-clinical support (from Line 16, Column A) to each cost center in Column B
- ▶ Totals of Columns A + B = Column C

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 of 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 of 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			
*	<i>Excerpt from Table 8A</i>			

Table 9D — Patient-Related Revenue

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

- ▶ Report **charges** for patient services during 2017 by payer type — Column A
- ▶ Report **income** received during the year on a cash basis — Column B
- ▶ Report **retroactive settlements, receipts, and paybacks** — Columns c1–c4
- ▶ Report **allowances** granted as part of an agreement with a third-party payer — Column D
- ▶ Report **sliding discount** reductions to patient charges based on the patient’s ability to pay — Column E
- ▶ Report **bad debt** amounts billed and defaulted on by patients — Column F

Table 9D — Patient-Related Revenue

- ▶ Report by payer
 - Medicaid
 - Medicare
 - Other public
 - Private
 - Self-pay
- ▶ Report each payer by sub-category
 - Non-managed care
 - Capitated managed care
 - Fee-for-service managed care

Line	Payer Category
1	Medicaid non-managed care
2a.	Medicaid managed care (capitated)
2b.	Medicaid managed care (fee-for-service)
3	Total Medicaid (sum Lines 1+2a+2b)
4	Medicare non-managed care
5a.	Medicare managed care (capitated)
5b.	Medicare managed care (fee-for-service)
6	Total Medicare (sum Lines 4+5a+5b)
7	Other public, including non-Medicaid CHIP (non-managed care)
8a.	Other public, including non-Medicaid CHIP (managed care capitated)
8b.	Other public, including non-Medicaid CHIP (managed care fee-for-service)
9	Total other public (sum Lines 7+8a+8b)
10	Private non-managed care
11a.	Private managed care (capitated)
11b.	Private managed care (fee-for-service)
12	Total private (sum Lines 10+11a+11b)
13	Self-pay
14	Total (Lines 3+6+9+12+13)

Table 9E — Other Revenues

- ▶ Report **income** received in 2017 (on a cash basis) from grants, contracts, and other non-patient service-related sources
- ▶ Report on the line of the **last party** to have the money before the health center received funds
- ▶ **Do not report:**
 - Money reported on Table 9D
 - Donations reported on Table 8A (e.g., in-kind facilities, services, or supplies)
 - Capital received as a loan

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 (excluding ARRA)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1	Total BHPC 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		
*	<i>Excerpt from Table 9E</i>	

Financial Profile Tables

8A, 9D, and 9E

- ▶ What the data tell us
 - Describe expenses that are related to services
 - Can be used to calculate profitability
 - Describe diversification of funding sources
 - Used to calculate some financial BPHC performance measures (such as medical cost per medical visit and per patient)

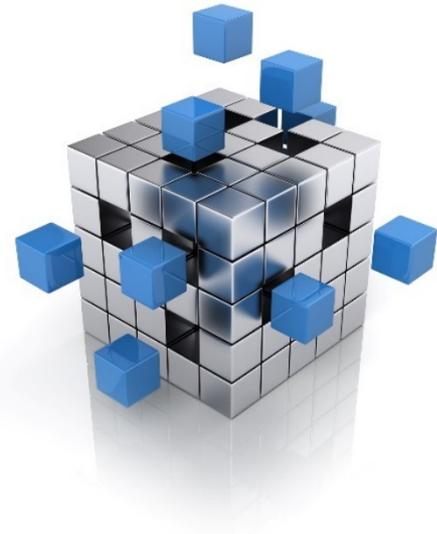
Health Information Technology Capabilities Form

- ▶ Report on a series of questions on **health information technology (HIT) capabilities, including electronic health record (EHR) and Meaningful Use**
 - Includes the implementation of EHR, certification of systems, how widely adopted the system is throughout the health center and its providers, and national and/or state quality recognition (accreditation or primary care medical home [PCMH])
- ▶ What the data tell us
 - Demonstrate HIT and EHR capabilities and quality recognition achievements

Other Data Elements Form (*New*)

- ▶ Report on a series of questions about telehealth, medication-assisted treatment (MAT), and outreach and enrollment assists
 - (*New*) health centers are to report the number of assists for the year by a trained assister (e.g., certified application counselor or equivalent)
 - The definition of assists is unchanged and assists do not count as visits on the UDS tables
- ▶ What the data tell us
 - Demonstrate MAT and telehealth capabilities
 - Inform us of enrollment-related activities through the health insurance marketplace or in Medicaid or the Children's Health Insurance Program (CHIP)

Report Preparation Considerations



Patient Profile Considerations

Ensure data are collected and entered into your EHR or practice management systems during initial patient registration and are updated regularly. Query patients about:

- Residence address (for ZIP code)*
- Date of birth
- Sex at birth
- Race and ethnicity
- Language
- Gender identity
- Sexual orientation
- Income (based on federal poverty guidelines) *
- Primary medical insurance*
- Demographic status (agricultural worker, homeless, veteran) *



Train your front desk staff on collecting and entering this information and updating it regularly

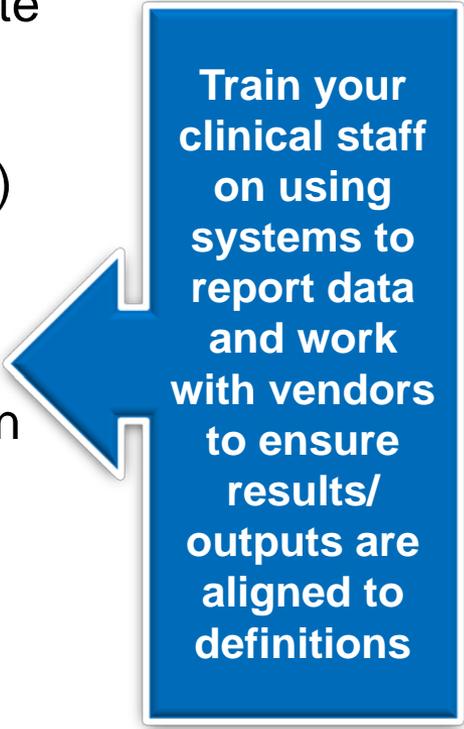
* To be updated regularly

Staffing and Utilization Profile Considerations

- ▶ Ensure tenure calculations follow UDS definitions
 - Staffing data are typically pulled from payroll and/or human resources systems for tenure
- ▶ Calculate full-time equivalents (FTEs) based on hours paid and the health center's base for that position
- ▶ Refer to the Appendix A personnel list for staff titles
- ▶ Ensure data entered on Table 5 align with Table 8A costs

Clinical Profile Considerations

- ▶ Understand data sources — typically billing, practice management systems, and EHRs are used to generate data for these tables
- ▶ Ensure patient demographics in clinical system (EHR) align with patient registration data
- ▶ Develop methods to collect clinical data from outside providers (e.g., prenatal care, deliveries, immunization records)
- ▶ Ensure data fields required for performance measurements are included in EHR
- ▶ Ensure measures align with CMS electronic CQMs



Train your clinical staff on using systems to report data and work with vendors to ensure results/ outputs are aligned to definitions

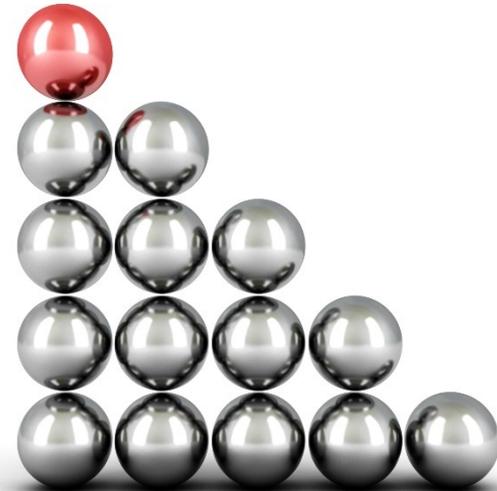
Financial Profile Considerations

- ▶ Ensure payer revenue aligns with data reported by insurance and managed care enrollment
- ▶ Report charges that correspond with billable visit data
- ▶ Maintain process to reclassify charges to appropriate payers
- ▶ Ensure that costs align with staff and services



Financial staff must ensure systems are in place to properly record accrued costs, charges, and cash collections by payer, including reclassifications

Strategies for Successful Reporting, Training & TA Available, and Other Considerations



Strategies for Successful Reporting

- ▶ Work as a team
 - Tables are interrelated
- ▶ Adhere to definitions and instructions
 - Refer to manual, fact sheets, and other resources
- ▶ Before submitting:
 - Check data trends and relationships across tables
 - Review last year's report and reviewer's letter
 - Compare key metrics between current and prior year
 - Address edits in EHB by correcting or providing explanations that demonstrate your understanding of the data reported
 - Note: Edit validation rules will be published and available at <https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html>
 - Noting that “number is correct” is not sufficient
 - Report on time, but do not submit incomplete reports
 - Utilize the UDS Submission Checklist — provided at in-person trainings

Strategies for Successful Reporting

- ▶ After submission:
 - Work with your reviewer
 - Work with your team to resolve data issues
 - Respond in a timely manner to the issues raised by your reviewer

Multiple Systems

- ▶ Extra attention is required to ensure accurate reporting under the following multiple system situations:
 - Transitioning EHR systems (especially if it occurs mid-year)
 - Data from multiple sources
 - Fiscal reporting cycle
 - New sites or new providers or revised scope
 - Data from external contractors
- ▶ In these situations, the health center may need to pull data from these multiple systems, consolidate them into another system, and un-duplicate patient activity
 - Allow sufficient time to complete this process

Electronic Health Record Considerations

- ▶ Ensure EHR has latest specifications in place
- ▶ Work with your vendor
 - Most vendors have UDS packages with varying ranges of support services (e.g., documentation to pull data, webinars, forums, direct consulting)
 - Work closely with your vendor to ensure you understand where data are being extracted to create your report
 - Know who to contact if you have questions or concerns

Electronic Health Record Considerations *(continued)*

- ▶ Test the accuracy and assess the ability to use EHR for performance measurement
 - Understand what UDS reporting capabilities your EHR provides and consider whether it requires any additional configurations
 - Systems should be tested to ensure validity of data and optimize workflow
 - Test data in the performance data collection environment (PDCE)

New Functionality for CY2017 UDS Reporting



Performance Data Collection Environment

A pre-production space where health centers can enter UDS data and test validations before the production module opens in January. The PDCE is an **optional** enhancement.

BENEFITS

- New UDS reporters and Health Center teams have more time with the system
- Access UDS forms earlier
- Test UDS validation rules
- Improve data quality
- Reduce time spent on reporting UDS

KEY DATES/REMINDERS

- September 11th - Performance Data Collection Environment opened
- Fall 2017 - State/Regional UDS trainings
- January 1st - UDS 2017 reporting period begins
- February 15th - UDS 2017 submission deadline

Training on UDS



- ▶ Involve staff in UDS reporting submission and review process
- ▶ Train/orient staff on EHR and UDS reporting
- ▶ Develop clear documented processes for staff
- ▶ Ensure staff attend in-person trainings, listen to modules, and participate in webinars to understand UDS content
- ▶ Provide a forum for addressing questions
- ▶ Read the UDS Manual
- ▶ Contact the UDS Support Line for content questions throughout the year

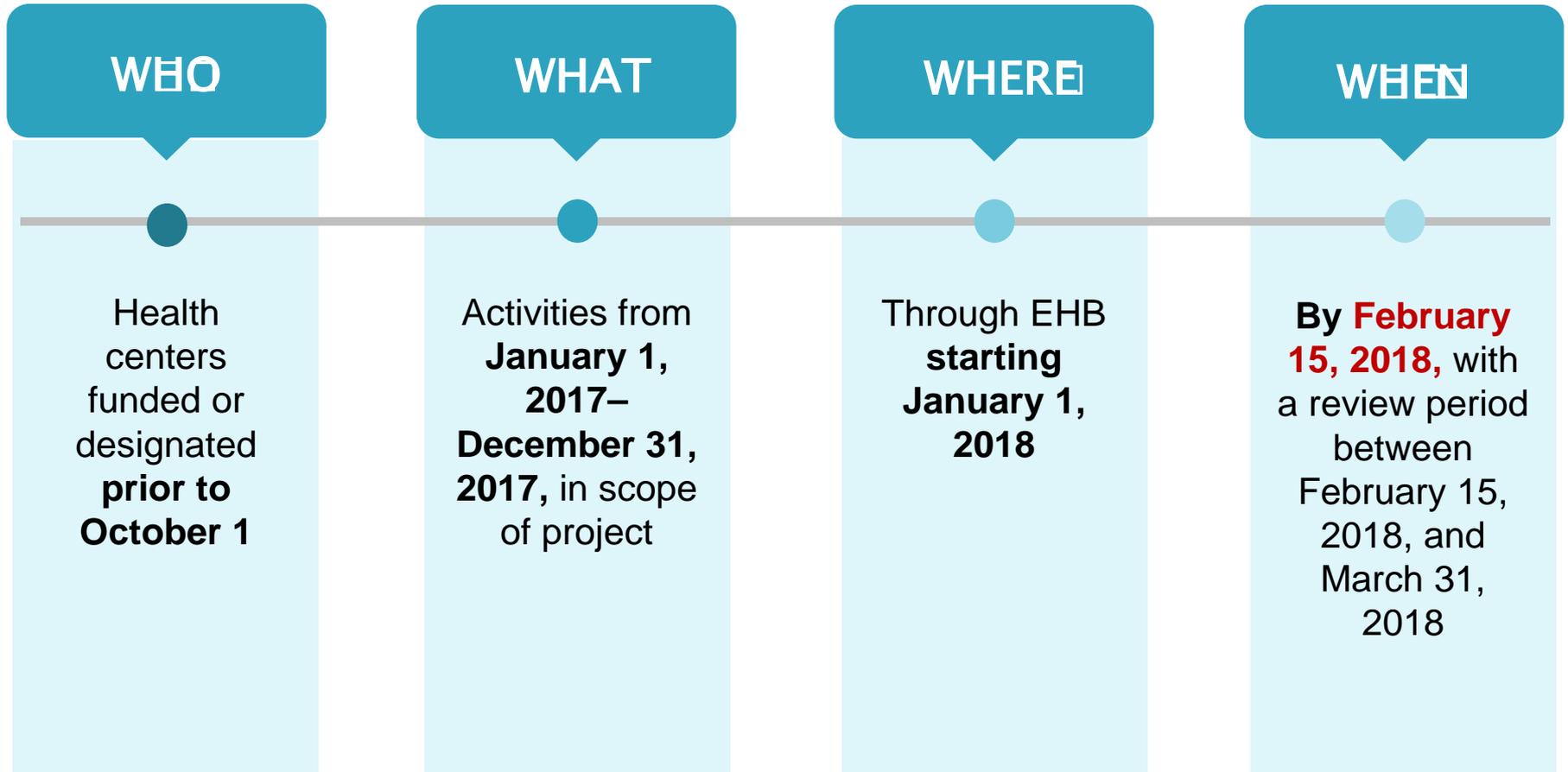
Reporting Assistance

- ▶ Regional in-person UDS trainings
- ▶ **Manual**, tables, fact sheets, webinars, data, modernization efforts, and other technical assistance materials, including program assistance letters (PALs)
 - <http://www.bphcdata.net>
 - <http://bphc.hrsa.gov/datareporting/index.html>
 - <https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html>
- ▶ **Telephone and email support line for reporting questions and use of UDS data:**
 - 866-UDS-HELP (866-837-4357) or email udshelp330@bphcdata.net
- ▶ Technical support from a UDS reviewer during the review period

Additional System Resources

- ▶ EHB Access (UDS submission, PDCE, and reports)
 - <https://grants3.hrsa.gov/2010/WebEPSEExternal/Interface/common/accesscontrol/login.aspx>
- ▶ UDS Mapper
 - <http://www.udsmapper.org/contact-us.cfm>
- ▶ EHB Support
 - HRSA Call Center for EHB access and roles: 877-464-4772 or <http://www.hrsa.gov/about/contact/ehbhelp.aspx>
 - BPHC Help Desk for EHB system issues: 877-974-2742 or <http://www.hrsa.gov/about/contact/bphc.aspx>

Timeline Reminders



Upcoming UDS Webinars

- ▶ ***Introduction to Clinical Measures***
 - November 2, 2017, 1:00 p.m.–2:30 p.m. (ET)
- ▶ ***Using UDS Data and Reports for Program Evaluation and Quality Improvement***
 - November 16, 2017, 1:00 p.m.–2:30 p.m. (ET)
- ▶ ***UDS for BHW Grantees***
 - November 17, 2017, 1:00 p.m.–2:30 p.m. (ET)

Questions From Chat Pod



Thank you!

Thank you for attending this training and for all your hard work to provide comprehensive and accurate data to BPHC!

