

# UNIFORM DATA SYSTEM

## Preparing for and Understanding your 2016 UDS Submission

Bureau of Primary Health Care (BPHC)

November 3, 2016, from 1:00–2:30 p.m. (ET)

# Primary Care Mission and Strategies

*Improving the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.*



**Increase access to primary health care services**



**Modernize primary care infrastructure and delivery system**



**Improve health outcomes and health equity**



**Promote performance-driven, innovative organizations**

**Increase Value of Health Center Program**

# Objectives of this Webinar

- Understand the importance of the Uniform Data System (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 and key definitions
- Introduction to the tables and how to use UDS data
- Report preparation considerations
- Tips to ensure data accuracy
- Other considerations
- Questions

# UNIFORM DATA SYSTEM

IMPORTANCE OF THE UDS AND KEY  
DEFINITIONS

# What is the Uniform Data System?

- A standardized set of data reported by 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
- Report the approved scope of project for the period **January 1, 2016–December 31, 2016**

# 12 Tables Provide a Snapshot of Patients and Performance

<b>What is Reported?</b>	<b>Table(s)</b>
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
Patient diagnoses, quality of care provided, and health equity	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D, 9E
<b>Additional Reporting Requirement</b>	<b>Form</b>
Health information technology (HIT) capabilities, electronic health record (EHR) interoperability, Meaningful Use leveraging, telehealth, and medication-assisted treatment (MAT)	Form

# Why is the UDS important?

- UDS data are used to:
  - Ensure compliance with legislative and regulatory requirements
  - Improve health center performance and operations
  - Report overall program accomplishments
  - Identify trends over time
  - Provide data to support HRSA decisions to:
    - Establish or expand targeted programs
    - Identify effective services and interventions
  - Compare health centers to other primary care venues and the U.S. population at large
  - Help health center programs, partners, and communities better understand the patients served by health centers

# Health Center Impact

<b>CY 2015</b>	<b>Grantees</b>	<b>Look-alikes</b>	<b>BHW</b>
Number of health centers	1,375	54	48
Patients served	24,295,946	709,293	74,963
Agricultural workers or dependents	910,172	9,986	191
Homeless	1,191,772	12,876	2,081
Public housing	1,510,842	202,329	2,729
School-based	649,132	13,507	3,018
Veterans	305,520	2,979	554
Visits	96,951,585	2,660,131	222,167
Employed staff/volunteers - FTEs	188,852	4,947	551
At or below 200% poverty	92%	93%	85%
Uninsured	24%	19%	28%
Racial and/or ethnic minority	62%	75%	53%



# Key Definitions Used in UDS

# Patient Defined: Who counts?



- Patient (Tables ZIP, 3A, 3B, 4, and 5) = head count— total number of individuals who receive at least one “countable” visit during the reporting year
  - Patients are counted once and only once, regardless of the number or scope of visits
  - Not all contacts are counted as a visit
  - Must have at least one visit reported on Table 5 to count as a patient
- A patient may be counted only once in each category on Tables 6A, 6B, and 7

# Visit Defined: What counts?



- Visits are defined as face-to-face, one-on-one, contact between a patient and provider
  - Exception: behavioral health group visits and telemedicine
- Must be documented in the patient's chart
- Must be conducted by a provider who acts independently and exercises professional judgment in the provision of services to the patient
- Include visits provided by paid, volunteer, and contracted providers

# Visit Defined: What counts?



- Count paid referral, nursing home, hospital, and home visits
- Only one visit/patient/provider type/day
  - Unless two different providers at two different sites
- Only one visit/provider/patient/day regardless of number of services provided

# Visit Defined:

## What doesn'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

# Full-Time Equivalent Defined



- Who is counted? All personnel who contribute to the operations of the health center at approved locations and within the scope of the project
  - Employees, contracted staff, residents, locums, and volunteers
  - Do not count paid referral provider full-time equivalents (FTEs) when working on a fee-for-service basis

# How is FTE calculated?



- 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
- Report FTE 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



- Who is counted?
  - Selected providers and key management
  - Staff who contribute to the operations of the health center at approved locations and within the scope of the project
- Specifically:
  - Full- and part-time staff
    - Employees (full- and part-time or -year), onsite contracted staff, and NHSC assignees
  - Other service providers
    - Residents, locum tenens, on-call providers, volunteers, and offsite contract providers
  - Include persons working on last day of the year and those who have the day off but are scheduled to return
  - Do not count paid referral providers or individuals who may work many hours but do not have a regular schedule
  - For health centers that have added a site or are newly funded or designated, track tenure back to when the site or entity began serving patients

# What to Include in the Tenure Count?



- The number of persons in their current position as of December 31
  - This is a head count, not FTE calculation
- The number of consecutive months for each person
  - Months reported would be greater than 12 if the person held the position for more than one year

# Prenatal Patient Defined



Prenatal care patients are those who were:

- Provided all prenatal care by the health center, including delivery
- Provided all prenatal care but were 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
- Regardless of whether they began prenatal care at health center or were referred to it
  - Note: age is as of June 30

# Universe Defined



- Universe (denominator): The number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated
  - Tables 6B and 7, Column A

## Example: Section C – Childhood Immunization Status

Line	Childhood Immunization Status	Total Number of 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 have received age-appropriate vaccines by their 2nd birthday	Universe or Denominator		

# Sample or EHR Defined



- Patients in EHR or a sample of patients
- Must be:
  - All patients who fit the criteria; same number as reported in Column A, or
  - A number equal to or greater than 80 percent of all patients who fit the criteria; no less than 80 percent of Column A, or
  - A random sample of 70 patient charts who fit the criteria; only if health centers do not have at least 80 percent of all patient records in the HIT/EHR for any given measure or if the missing cases would bias the findings

## Example: Section C – Childhood Immunization Status

Line	Childhood Immunization Status	Total Number of 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 have received age-appropriate vaccines by their 2nd birthday		Sample or Universe	

# Measurement Standard Defined



- Measurement standard (numerator): Number of charts whose clinical record indicates that the measurement rules and criteria have been met
  - Tables 6B and 7, Column C

## Example: Section C – Childhood Immunization Status

Line	Childhood Immunization Status	Total Number of 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 have received age-appropriate vaccines by their 2nd birthday			Records meeting the measurement standard



# INTRODUCTION TO THE TABLES

## How to Use the UDS Data

# Patient Profile Tables

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



## Patients by ZIP code (by primary medical insurance)

- Report all ZIP codes with 11 or more patients
- Totals by insurance will need to match Table 4 classifications

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>					
<b>Other ZIP Codes</b>					
<b>Unknown Residence</b>					
<b>Total</b>					

# Patient Profile Tables

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



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		

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

- Report patients according to their **sex at birth** (no longer self-reported gender) **(New)**

\* Excerpt from Table 3A

# Patient Profile Tables

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



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.	<b>Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)</b>				
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported/Refused to report race				
8.	<b>Total Patients (Sum Lines 1 + 2 + 3 to 7)</b>				

## Table 3B: Demographic Characteristics

- Report all patients by **ethnicity and race** (Lines 1–8) and a count of 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	

# Patient Profile Tables

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



## Table 3B: Demographic Characteristics, *continued*

- Report patients by **sexual orientation** (Lines 13–19) **(New)**
- Patients by **gender identity** (Lines 20–26) **(New)**

*Note: Also known as SOGI*

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.	<b>Total Patients (Sum Lines 13 to 18)</b>	

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.	<b>Total Patients (Sum Lines 20 to 25)</b>	

Line	Characteristic	Number of Patients (a)				
<b>Income as Percent of Poverty Guideline</b>						
1.	100% and below					
2.	101 - 150%					
3.	151 - 200%					
4.	Over 200%					
5.	Unknown					
6.	<b>Total (Sum lines 1-5)</b>					
<b>Principal Third Party Medical Insurance</b>						
7.	None/Uninsured					
8a.	Regular Medicaid (Title XIX)					
8b.	CHIP Medicaid					
8.	<b>Total Medicaid (Line 8a + 8b)</b>					
9a.	Dually Eligible (Medicare and Medicaid)					
9.	<b>Medicare</b> (Inclusive of dually eligible and other Title XVIII beneficiaries)					
10a.	Other Public Insurance Non-CHIP (specify:)					
10b.	Other Public Insurance CHIP					
10.	<b>Total Public Insurance (Line 10a + 10b)</b>					
11.	<b>Private Insurance</b>					
12.	<b>TOTAL (Sum Lines 7 + 8 + 9 + 10 + 11)</b>					
<b>Managed Care Utilization</b>						
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.	<b>Total Member months (Sum Lines 13a + 13b)</b>					
<b>Special Populations</b>						
14.	Migratory (330g grantees only)					
15.	Seasonal (330g grantees only)					
16.	<b>Total Agricultural Workers or Dependents</b> (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.	<b>Total Homeless</b> (All Health Centers Report This Line)					
24.	<b>Total School-Based Health Center Patients</b> (All Health Centers Report This Line)					
25.	<b>Total Veterans</b> (All Health Centers Report This Line)					
26.	<b>Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site</b> (All Health Centers Report This Line)					

# Patient Profile Tables

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

## Table 4: Patients by Income, Insurance, Managed Care, and Target Populations

- Report patient **income** as defined by Federal Poverty Guidelines
- Report primary **medical care insurance** of patient
- Report **monthly enrollment of members in managed care contracts**
- Report total number of **agricultural workers, homeless, school-based, and veterans served**
- Report all patients seen at a site located in or immediately accessible to a **public housing site**

# Patient Profile Tables

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



- How to use patient profile data:
  - Describes the patients you serve and demonstrates if you served the target populations proposed in your application
  - Permits 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)
  - Quantifies the special populations and individuals served with financial, cultural, racial/ethnic, and linguistic barriers to care
  - These numbers are 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 **FTEs, visits, and patients**
- **New** lines have been added to report staff of dental therapists (and their patient activity), quality improvement staff, and community health workers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
8	<b>Total Physicians (Sum lines 1-7)</b>			
10a	<b>Total NP, PA, and CNMs (Sum lines 9a - 10)</b>			
15	<b>Total Medical (Sum lines 8+10a through 14)</b>			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	<b>Total Dental Services (Sum lines 16-18)</b>			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	<b>Total Mental Health (Sum lines 20a-c)</b>			
21	<b>Substance Abuse Services</b>			
22	<b>Other Professional Services (specify__)</b>			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	<b>Total Vision Services (Sum lines 22a-c)</b>			
23	<b>Pharmacy Personnel</b>			
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	<b>Total Enabling Services (Sum lines 24-28)</b>			
29a	<b>Other Programs/Services (specify__)</b>			
29b	<b>Quality Improvement Staff</b>			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
33	<b>Total Facility and Non-Clinical Support Staff (Sum lines 30a - 32)</b>			
34	<b>Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)</b>			

\* Excerpt from Table 5

# Staffing, Tenure, and Utilization Profile

Tables 5 and 5A



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				
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				

## Table 5A: Tenure for Health Center Staff

- Report a **head count** of persons as of December 31
- Report **months of service** for selected staff categories and positions
- From personnel records
- Dental therapists have been added (***New***)
- **Do not report FTE as persons—NOT the same thing**

# Staffing, Tenure, and Utilization Profile

Tables 5 and 5A



- How to use staffing and utilization data:
  - Describes what staffing resources you have to provide services to your patients
  - Demonstrates retention of staff
  - Describes comprehensive services provided to patients to demonstrate quantity of services (e.g., medical, dental, enabling) offered and number of patients receiving the services

# Clinical Profile Tables

## Tables 6A, 6B, and 7



Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
<b>Selected Infectious and Parasitic Diseases</b>			
1-2. Symptomatic HIV, 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		
<b>Selected Diseases of the Respiratory System</b>			
5. Asthma	J45-		
6. Chronic obstructive pulmonary diseases	J40- through J44-, J47-		
<b>Selected Other Medical Conditions</b>			
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-		
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		

\*Excerpted from Table 6B

## Table 6A: Selected Diagnoses and Services Rendered

- Report number of visits with the selected service or diagnosis
- Report number of unduplicated patients receiving the service or with the diagnosis
- Codes have completely transitioned to ICD-10 (ICD-9 is no longer reported)

# Clinical Profile Tables

Tables 6A, 6B, and 7



- **Tables 6B and 7:** Virtually all of the UDS quality of care measures are now aligned with the Centers for Medicare and Medicaid Services (CMS) e-CQMs for Eligible Professionals *(New)*
  - ✓ To ensure standardization, be sure to use the June 2015 eReporting update must be used for the 2016 reporting period *even though later versions are available*
- Details on the measure criteria and major differences between 2015 and 2016 reporting will be presented in detail in the all day PCA trainings and the Clinical Measures webinar on December 14

# Clinical Profile Tables

## Table 6B



### Table 6B: Quality of Care

- Report on selected [quality of care measures](#)
- These process measures serve as a proxy for good long-term health outcomes:
  - If patients receive timely acute and/or preventive care, we can expect improved health status
- Measures:
  - Early entry into prenatal care
  - Childhood immunization status
  - Cervical cancer screening
  - Weight assessment and counseling for nutrition and physical activity for children and adolescents
  - Preventive care screening: Body mass index (BMI) screening and follow-up
  - Preventive care screening: Tobacco use: Screening and cessation intervention
  - Use of appropriate medications for asthma
  - Coronary artery disease (CAD): Lipid therapy
  - Ischemic vascular disease (IVD): Use of Aspirin or another antithrombotic
  - Colorectal cancer screening
  - HIV linkage to care
  - Preventive care screening: Screening for clinical depression and follow-up
  - Dental sealants for children between 6-9 years

# Clinical Profile Tables

## Table 7



### Table 7: Health Outcomes and Disparities

- Report on selected **health outcome and disparities measures**
- These intermediate outcome measures serve as a proxy for good long-term health outcomes:
  - If measurable outcomes are improved, then later negative health outcomes will be less likely in the future
- Report by race and ethnicity
- Measures:
  - Low birth weight
  - Controlling high blood pressure
  - Diabetes: Hemoglobin A1c poor control

# Clinical Profile Tables

Tables 6A, 6B, and 7



- How to use clinical profile data:
  - Demonstrates achievements in national benchmarks for routine and preventive care, chronic care, prenatal care, and healthy behaviors
  - Quantifies the comprehensiveness and continuity of services provided
  - Identifies opportunities for monitoring and improving quality improvement activities
  - Promotes 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 (Line 16, Column A) to each cost center in Column B
- **New** lines have been added to report costs for quality improvement, community health workers, and dental therapists costs (added on dental line)



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)
<b>Financial Costs for Medical Care</b>				
1	Medical Staff			blank
2	Lab and X-ray			blank
3	Medical/Other Direct			blank
4	<b>Total Medical Care Services (Sum lines 1-3)</b>	blank	blank	blank
<b>Financial Costs for Other Clinical Services</b>				
5	Dental			blank
6	Mental Health			blank
7	Substance Abuse			blank
8a	Pharmacy not including pharmaceuticals			blank
8b	Pharmaceuticals		blank	blank
9	Other Professional (Specify: ___)			blank
9a	Vision			blank
10	<b>Total Other Clinical Services (Sum lines 5-9a)</b>	blank	blank	blank
<b>Financial Costs of Enabling and Other Program Related Services</b>				
11a	Case Management		blank	blank
11b	Transportation		blank	blank
11c	Outreach		blank	blank
11d	Patient and Community Education		blank	blank
11e	Eligibility Assistance		blank	blank
11f	Interpretation Services		blank	blank
11g	Other Enabling Services (Specify: ___)		blank	blank
11h	Community Health Workers		blank	blank
11	<b>Total Enabling Services Cost (Sum lines 11a-11h)</b>	blank		blank
12	Other Related Services (Specify: ___)			blank
12a	Quality Improvement			blank
13	<b>Total Enabling and Other Services (Sum lines 11, 12, and 12a)</b>	blank	blank	blank
<b>Facility and Non-Clinical Support Services and Tools</b>				
14	Facility		blank	blank
15	Non-Clinical Support Services		blank	blank
16	<b>Total Facility and Non-Clinical Support Services (Sum lines 14 and 15)</b>	blank	blank	blank
17	<b>Total Accrued Costs (Sum lines 4+10+13+16)</b>	blank	blank	blank
18	Value of Donated Facilities, Services and Supplies (specify: ___)		blank	
19	<b>Total with Donations (Sum lines 17 and 18)</b>	blank	blank	

# Financial Profile Tables

## Tables 8A, 9D, and 9E



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

Line	Payer Category
1	Medicaid Non-Managed Care
2a.	Medicaid Managed Care (capitated)
2b.	Medicaid Managed Care (fee-for-service)
<b>3</b>	<b>Total Medicaid (Sum lines 1+2a+2b)</b>
4	Medicare Non-Managed Care
5a.	Medicare Managed Care (capitated)
5b.	Medicare Managed Care (fee-for-service)
<b>6</b>	<b>Total Medicare (Sum lines 4+5a+5b)</b>
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)
<b>9</b>	<b>Total Other Public (Sum lines 7+8a+8b)</b>
10	Private Non-Managed Care
11a.	Private Managed Care (capitated)
11b.	Private Managed Care (fee-for-service)
<b>12</b>	<b>Total Private (Sum lines 10+11a+11b)</b>
<b>13</b>	<b>Self Pay</b>
<b>14</b>	<b>Total (Lines 3+6+9+12+13)</b>

### Table 9D: Patient-Related Revenue

- Report **charges for patient services** during 2016 by payer type
- Report **cash income** received during the year
- Report each by payer: Medicaid, Medicare, other public, private, self-pay
- Report each by sub-category: non-managed care, capitated, managed care, and fee-for-service managed care

# Financial Profile Tables

## Tables 8A, 9D, and 9E



Line	Source	Amount
<b>BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)</b>		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	<b>Total Health Center (Sum lines 1a through 1e)</b>	blank
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1	<b>Total BHPC Grants ((Sum Lines 1g +1j +1k)</b>	blank
<b>Other Federal Grants</b>		
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify:____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5	<b>Total Other Federal Grants (Sum lines 2-3a)</b>	blank
<b>Non-Federal Grants Or Contracts</b>		
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	<b>Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)</b>	Blank
10	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:____)	
11	<b>Total Revenue (Sum lines 1+5+9+10)</b>	blank

### Table 9E: Other Revenues

- Report:
  - Income received in 2016 (on a cash basis) from **grants, contracts, and other non-patient service-related sources**
  - Based on the line of the last party to have the money before 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

# Financial Profile Tables

## Tables 8A, 9D, and 9E

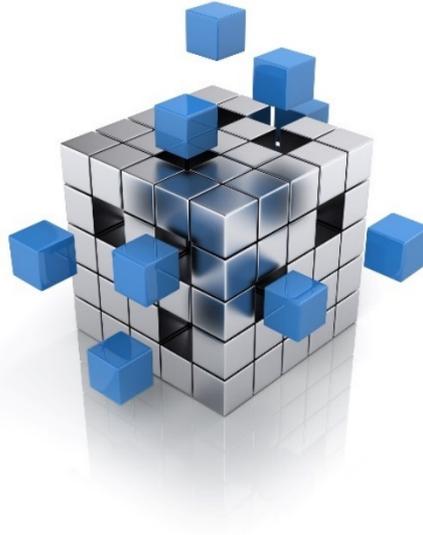


- How to use financial profile data:
  - Describes how expenses that can be related to revenues can be used to evaluate profitability
  - Describes diversification of funding sources
  - Calculates performance measures used by BPHC (such as medical costs per medical visit and per patient, payer, and grant mix)

# Health Information Technology Capabilities Form



- Report on a series of questions on **health information technology (HIT) capabilities, including electronic health record (EHR) interoperability and leverage for 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])
- **New** questions have been added regarding **telehealth** capacity and use, along with **medication-assisted treatment (MAT)** for opioid use disorder
- Use of HIT Form
  - Demonstrates HIT and EHR capabilities and quality recognition achievements



# 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:

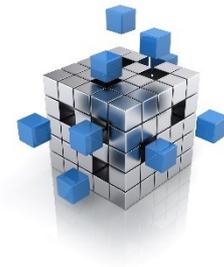
- Residence address (for ZIP code)\*
- Date of birth
- Sex at birth
- Race and ethnicity
- Language
- Gender identity
- Sexual orientation
- Income (based on federal poverty guidelines) \*
- Primary medical insurance\*
- Demographic status (agricultural worker, homeless, veteran) \*



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

\* To be updated regularly

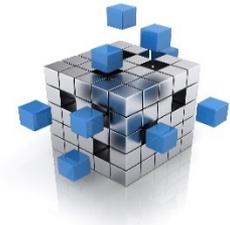
# Staffing and Utilization Profile Considerations



- Ensure tenure calculations follow UDS definitions
  - Staffing data is 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 (detailed methods discussed in trainings)
- Refer to Appendix A personnel list for staff titles that align with Table 5 lines
- Ensure data entered for Table 5 aligns with Table 8A costs

Staff entering Table 5 FTE need to coordinate with staff entering Table 8A costs to ensure alignment

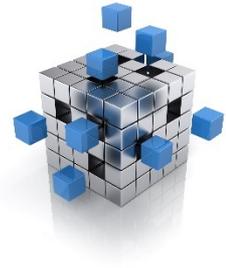
# Clinical Profile Considerations



- Understand data sources—typically billing, practice management, 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

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 for reclassification of 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



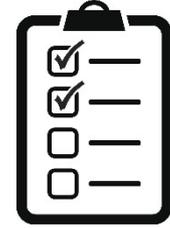
## TIPS TO ENSURE DATA ACCURACY

# Tips to Ensure Data Accuracy



- Develop checklist to verify data elements on each table
- Run the EHB audit report, review edits, and correct or respond with clear explanations about data validity
  - Work as a team to understand and address issues
  - Verify data coming out of systems and correct query logic when there are errors
  - Explain large inter-year changes in data
- Review the issues raised by your reviewer and work with your team to resolve data issues

# ZIP Code Table Data Checks



- ZIP code data should be checked if there are:
  - A high number of patients reported on the “unknown” line
  - Invalid ZIP codes
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4

# Table 3A Data Checks



- Table 3A data should be checked if there are:
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4
  - Inconsistencies between identified universe counts for clinical measures by age and/or sex
  - Age ranges or sex that you appear to no longer report
  - Grant report values that exceed the universal report for the corresponding cell (*applicable to those with multiple funding streams*)
  - Ages not based on June 30 of the reporting year

# Table 3B Data Checks



- Table 3B data should be checked if there are:
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4
  - Inconsistencies between data sources and reporting across Tables 3B and 7
  - No patients reported who are best served in a language other than English, but patients with linguistic barriers are served
  - Exactly the same number of males and females on both Tables 3A and 3B
  - Large number of patients reported on the 'chose not to disclose' lines in the sexual orientation and gender identity sections
  - Grant report values that exceed the universal report for the corresponding cell (*applicable to those with multiple funding streams*)

# Table 4 Table Checks



- Table 4 data should be checked if there are:
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4
  - A high number of patients with unknown income
  - A high number of uninsured patients, especially given transitions to insurance
  - Large numbers of adults reported as being insured by CHIP
  - Public employees insurance, state or local safety net programs, and/or grant-supported clinical care programs (e.g., BCCCP, Title X) in place and patients are reported as having other public insurance
  - No patients are reported as being dually eligible

# Table 4 Data Checks, *continued*



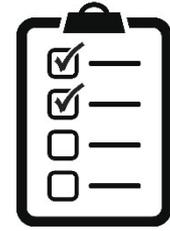
- Table 4 data should be checked if there are:
  - Enrollees reported for behavioral health or dental only managed care plans or missing enrollment data
  - Primary care case management (PCCM) programs or CMS PCMH demonstration grants reported as managed care
  - Mismatches between insurance and managed care and revenue
  - No special populations served
  - Grant report values that exceed the universal report for the corresponding cell (*applicable to those with multiple grants*)

# Table 5 Data Checks



- Table 5 data should be checked if there are:
  - More total patients on Table 3A than total patients reported on Table 5 in Column C
  - Multiple types of services provided (e.g., medical, dental, mental health) but total patients on Table 5 equals total patients on Table 3A
  - Staffing FTE or service category reported but no costs on Table 8A or vice versa
  - Head counts reported rather than FTE
  - Visits per patient averages that are unusually high or low
  - Grant report values that exceed the universal report for the corresponding cell (*applicable to those with multiple streams*)

# Table 5A Data Checks



- Table 5A data should be checked if there are:
  - Unusually high average tenures by provider type
  - Average tenures less than twelve months for long-standing organizations and/or providers
  - Head counts equal to FTE

# Table 6A Data Checks



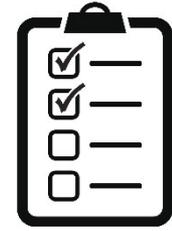
- Table 6A data should be checked if there are:
  - Average visits per patient that are unusually high or low
  - Mismatches in services reported on Table 6A as compared to Table 5 (e.g., dental on Table 5 but no dental services on 6A)
  - Significant differences in universe counts (hypertension, diabetes) reported on Table 7 as compared to Table 6A patients seen with diagnosis
  - Apparent reporting of primary diagnosis only
  - Grant report values that exceed the universal report for the corresponding cell (*applicable to those with multiple grants*)

# Table 6B Data Checks



- Table 6B data should be checked if there are:
  - Prenatal patients who started the prior year missing from prenatal count
  - No prenatal care patients reported
  - No prenatal care patients reported as having initiated care with another provider (but some have transferred into your care)
  - All prenatal care being referred out, but all prenatal care patients are reported as originating care elsewhere

# Table 6B Data Checks, *continued*



- Table 6B data should be checked if there are:
  - Large under- or over-counts in the universe/prevalence as compared to patients in age range who received medical care (or dental care for dental measure)
  - 0% or 100% compliance
  - Patients missing from universe count who are relevant to the measure (e.g., immunization measure is missing pediatric patients seen by one clinic that sees a large number of infants)
  - Sampling of charts being used—ensure employing a random sample

# Table 7 Data Checks



- Table 7 data should be checked if there are:
  - High or low proportion of deliveries as compared to prenatal care patient count
  - No indication of multiple births reflected in larger prenatal programs
  - Inconsistencies between race and ethnicity data reported on Table 7 as compared to Table 3B, resulting in high or low outcome or prevalence data
  - Large under- or over-counts in the universe/prevalence as compared to patients in age range who received medical care
  - 0% or 100% compliance
  - Patients missing from universe count who are relevant to the measure (e.g., new site specializing in chronic diseases—hypertension and diabetes—not yet integrated with current EHR)

# Table 8A Data Checks



- Table 8A data should be checked if there are:
  - Costs reported but no staffing FTE or service category reported on Table 5 or vice versa
  - Very high or low costs per FTE
  - Inconsistent overhead allocation methods
  - Very high or very low allocations of non-clinical support and/or facility costs as a percent of total costs
  - Unexplainably high or low costs per patient or costs per visit
  - Significant surplus or deficit possibly due to reporting methodology errors
  - Donations missing (volunteers, pro bono, vaccines, supplies, services)

# Table 9D Data Checks



- Table 9D data should be checked if there are:
  - Mismatches between payer categories (Table 9D) and insurance and/or managed care enrollment (Table 4)
    - Insurance and/or managed care reporting but no or low charges or vice versa
    - Charges as a percent of total are not similar to insurance coverage percent
  - No reclassification of charges to appropriate payer lines
  - Retroactive settlements and receipts not included in collections

# Table 9D Data Checks, *continued*

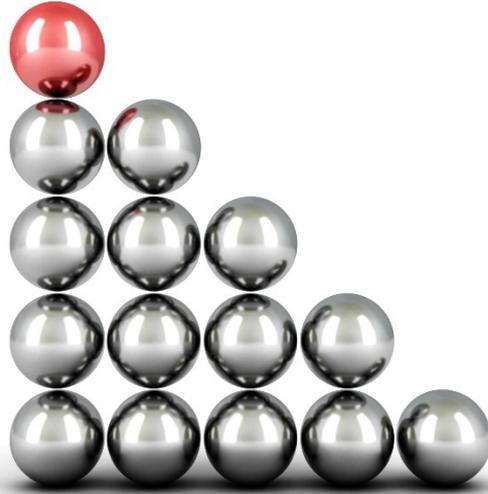


- Table 9D data should be checked if there are:
  - Capitation lines with balances
  - Multi-year negative accounts receivables (for self-pay)
  - Average charges per patient or visit that are high or low
  - Significant surplus or deficit, possibly due to reporting methodology errors (accrued vs. cash, missing revenue or costs)

# Table 9E Data Checks



- Table 9E data should be checked if there are:
  - Pharmaceutical sales to patients, capital received as a loan, or value of donated services reported as other revenue
  - Grant funds that pay for units of service reported as state or local grants
  - Private contracts with tribes or state insurance plans reported as indigent care program dollars
  - Revenue reported by originator, not “last party”
  - Significant surplus or deficit, possibly due to reporting methodology errors (accrued vs. cash, missing revenue or costs)



## OTHER CONSIDERATIONS

# 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

- Programming electronic health record (EHR)
  - Ensure EHR has latest specifications in place
- Working 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 is being extracted to create your report
  - Know who to contact if you have questions or concerns
- Testing accuracy and assessing ability to use EHR for performance measurement
  - Understand what UDS reporting capabilities your EHR provides and consider whether it requires any configurations
    - Refined systems should be tested to ensure validity of data and optimize workflow

# Training on UDS



- Staff involved in UDS reporting need to understand how to support the 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 Reporting Instructions
- Contact UDS Support Line for content questions throughout the year: 866-UDS HELP or [udshelp330@bphcdata.net](mailto:udshelp330@bphcdata.net)



# Critical Dates in the UDS Process



2016



2017

**OCT. 2016 – JAN. 2017**  
**CONTENT TRAININGS:**  
*In-person trainings, modules, and webinars are available prior to submission*

**JAN. 1, 2017 – FEB. 15, 2017**  
**DATA ENTRY:**  
*Report through EHB (“Electronic Handbooks”) beginning 1/1/2017*

**FEB. 15, 2017 – MAR. 31, 2017**  
**REPORT AND REVIEW**  
**PROCESS:**  
*Work with UDS reviewer to address data issues and finalize data submission*

**JUN. 2017 – SEP. 2017**  
**REPORT FEEDBACK:**  
*Rollups, trend, and comparison reports available*

# UDS Resources



- Training opportunities can be found at [BPHC Training Website](#)
- UDS Support:
  - 866-837-4357
  - [udshelp330@bphcdata.net](mailto:udshelp330@bphcdata.net)
- HRSA Electronic Handbook can be accessed [here](#)
- 2016 Uniform Data System Reporting Instructions can be accessed at [BPHC's Data Reporting Website](#)

# Electronic Handbook Resources



- Electronic Handbook (EHB) training is available through HELP in application and through an online training module
- EHB incorporates hundreds of edits to alert you to possible problems that require follow-up
- EHB assistance is available through:
  - HRSA Call Center for EHB account access and roles: 877-464-4772 or [HRSA Electronic Handbooks Contact Center](#)
  - BPHC Help Desk for EHB system issues: 877-974-2742 or [BPHC Helpline](#)

# Other UDS Webinars

- ***UDS for BHW Grantees***
  - November 17, 2016 1PM – 2:30 PM Eastern Time (ET)
  - [https://hrsaseminar.adobeconnect.com/uds\\_for\\_bhw\\_grantees/](https://hrsaseminar.adobeconnect.com/uds_for_bhw_grantees/)
- ***Introduction to Clinical Measures***
  - December 14, 2016, 1PM – 2:30 PM (ET)
  - <https://hrsaseminar.adobeconnect.com/introduction-to-clinical-measures/>
- ***Using UDS Data and Reports for Program Evaluation and Quality Improvement***
  - January 11, 2017, 1PM – 2:30 PM (ET)
  - Webinar connection to be announced

# Strategies for Successful Reporting

- Work as a team
  - Tables are inter-related
- Adhere to definitions and instructions
  - Refer to manual, fact sheets, and other resources
- Check your data before submitting
  - Check data trends and relationships across tables, review last year's reviewer's letter, and compare data to benchmarks
  - Address edits in EHB by correcting or providing explanations that demonstrate your understanding
  - "Number is correct" is not sufficient
  - Report on time, but do not submit incomplete reports
- Work with your reviewer

# QUESTIONS FROM TA POD



# Thank you!

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

