

Bureau of Primary Health Care



Reporting Instructions for Health Centers



Bureau of Primary Health Care

Uniform Data System Reporting Instructions

For use to submit Calendar Year 2015 UDS Data

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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PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0193. Public reporting burden for this collection of information is estimated to average 170 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information + 22 hours per individual grant report. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10C-031, Rockville, Maryland, 20857.

DISCLAIMER

"This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA."

Introduction

This is the 20th edition of the Health Resources and Services Administration's Bureau of Primary Health Care's *Uniform Data System (UDS) Reporting Instructions for Health Centers*. It is designed for use in submitting Calendar Year 2015 UDS Data, and updates all instructions and modifications issued since the first UDS reporting year (1996). ***This manual supersedes all previous manuals, including instructions provided on the BPHC website prior to December 31, 2015.***

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

- 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 which describe how to address specific issues which have impact on multiple tables
- Sampling methodologies for selecting patient charts for clinical reviews
- Reporting instructions for the form which describes health center's Electronic Health Record (EHR) system capabilities and Quality Recognition
- A summary of the few remaining reporting differences between Section 330-grant supported health centers and look-alikes

The UDS Manual addresses the annual reporting requirements for recipients of the cluster of primary care grants funded by the Health Resources and Services Administration (HRSA) and other health centers designated as look-alikes and certain health centers funded under the Bureau of Health Workforce (BHW). (The authorizing statute is Section 330 of the Public Health Service Act, as amended.) The UDS Report is required of Health Center Program grantees with the following grants and other health centers which have been designated as look-alikes:

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

In addition to the Health Center Program grantees and look-alikes, certain primary care clinics and nurse managed health clinics funded under the HRSA Bureau of Health Workforce (BHW) must also submit a UDS report.

The UDS is a core set of information appropriate for reviewing the operation and performance of health centers. The data are collected and reviewed annually to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments.

UDS data help to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations. These data are compared with national data to review differences between the U.S. population at large and those individuals and families served by health centers for primary care. Much of these data as well as analysis of the data are routinely reported back to health centers through the Electronic Handbook (EHB) and to the public through the [Bureau's website](http://bphc.hrsa.gov/datareporting/index.html) at <http://bphc.hrsa.gov/datareporting/index.html>.

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 provides data on patients, services, staffing, and financing *across all programs*. The data reflect all activities that are considered “in scope” for the reporting agency, and its scope is the same as that which is defined in the health center’s notice of award. The Universal report is the source of unduplicated data on in scope programs.
- The **Grant Reports**, are *completed by a sub-set of grantees who receive 330 grants under multiple BPHC Health Center Program funding authorities*. Currently, only Section 330 grantees fill out 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 comparable data for that portion of the program that falls within the scope of a project *funded under a particular funding stream*. Separate Grant reports are required for each funding stream when grantees are funded through the Migrant Health Center, Health Care for the Homeless, and Public Housing Primary Care programs *unless* a grantee is funded under one and only one of these programs. No Grant report is submitted for the scope of activities supported by the Community Health Center Section 330(e) grant since reporting is included in the Universal report.

Health Center Program look-alikes submit a look-alike version of the UDS. It should be noted that BPHC has brought look-alikes into total conformance with the 330-funded UDS Report version, with the exception of a very small number of fields that do not apply to look-alikes. Differences between grantee and look-alike UDS reporting are highlighted in [Appendix E](#) and mentioned with each table where there is a difference. A small number of health centers have both Health Center Program grantee sites and look-alike sites, which are required to have separate scopes of project. These “dual status” health centers will complete both grantee and look-alike versions of the UDS, reporting data that represents the scope of project supported by Health Center Program grant funds in the grantee report and the scope of project represented by the look-alike designation in the look-alike report. While Health Center Program grant funds are not permitted to be used to operate sites and services included in the look-alike scope of project, some costs—especially of corporate executives and other non-clinical support staff, their space, etc. —may need to be allocated between the two reports. The look-alike version of the UDS is also found in the Electronic Handbook (EHB).

The separate “BHW primary care clinics” version of the UDS is filed by health clinics which receive grants from HRSA under this separate program. The BHW primary care clinic UDS report is aligned with the Health Center Program grantee UDS. A small number of health centers are funded by both the Section 330 Health Center Program and the BHW primary care clinics. They may have overlapping or different scopes of project. These “dual status” health centers will complete both grantee and BHW primary care clinics versions of the UDS, reporting data that represent the scope of project supported by Health Center Program grant funds in the 330 grant report and the scope of project represented by the BHW primary care clinics program

in the BHW primary care clinics report. The BHW primary care clinics version of the UDS is also found in the Electronic Handbook.

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

- 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, and language barriers
- Table 4: Patients by income (percent of poverty level) and primary third party medical insurance source; Table 4 also reports the number of “special population” patients receiving services, and managed care member months-
- 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: Quality of care measures
- Table 7: Health outcomes measures by race and ethnicity
- Table 8A: Direct and indirect expenses by cost center
- Table 9D: Full charges, collections, and allowances by payer type as well as sliding discounts and patient bad debt
- Table 9E: Other, non patient-service income

In addition to these data collection tables, health centers will report on quality recognition and health information technology (HIT) capabilities, including EHR interoperability. This additional form is included in the EHB along with the other tables and must be completed as part of your UDS report submission.

The UDS report is always a calendar year report. Agencies whose designation or funding begins, either in whole or in part, after the beginning of the year, or whose designation or funding is terminated, again either in whole or in part, before the end of the year, are still required to report on the entire year. Similarly, agencies with a fiscal year other than 1/1/15 to 12/31/15 will still report on the calendar year, not on their fiscal year. (Organizations designated or funded for the first time during the calendar year and those which were terminated during the year should discuss any issues with calendar year reporting with their assigned UDS Reviewer.)

NOTE: In this document, unless otherwise noted, the term “health center” is used 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 one of the three HRSA programs referenced above.

General Instructions

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

Who Submits UDS Reports and the UDS Reporting Period

UDS Reports should be submitted directly by the health center via the Electronic Handbooks (EHB). All health centers that were funded or designated in whole or in part before October 1, 2015, are required to report. Health centers must report activity for the **entire calendar year**, even if they were funded or designated, in whole or in part, for less than the full year, and even if they did not draw down any grant funds during the calendar year. Health centers which are funded or designated for the first time on or after October 1, 2015, are not required to submit a 2015 UDS report and will not have access to the reporting in the EHB. (Note – New Access Points (NAPs) were awarded in May and August of 2015. Therefore, all data related to these new sites must be included in the overall submission.)

The following reporting instructions apply to the limited number of “dual status” organizations. (“Dual status” occurs when a health center receives grant funding under section 330 for sites in the grant’s approved scope of project and, at the same time, operates at least one other site under a look-alike designation.) **Health centers which had a look-alike designation only prior to October and one or more look-alike site(s) received NAP funding:** Exclude the data related to the NAP site(s) from the look-alike UDS report for 2015 AND report the data related to the NAP site(s) in the grantee UDS report for 2015.

Under extenuating circumstances (e.g., the physical destruction of the health center) exemptions may be granted. Health centers must request such exemptions directly from the BPHC Office of Quality Improvement.

Due Dates and Revisions to Reports

UDS Reports may be submitted after January 1, 2016 and are **due February 15, 2016**. Between February 15 and March 31, health centers work with their UDS Reviewer to identify and correct potential data errors. Final corrected submissions are due by March 31, and changes after this date are not accepted. To request assistance at any time, please contact the *UDS Support Center at 1-866-UDS-HELP*.

How and Where to Submit Data

Uniform Data System (UDS) data are reported through an on-line 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/WebEPSEExternal/Interface/common/accesscontrol/login.aspx> to complete and submit their UDS Report. Users are able to submit the UDS Report using standard Web browsers¹ through a Section 508-compliant user interface. The system provides users with electronic forms that will guide them in completing their reports.

¹ While most browsers should work with the EHB, it is certified to work with Internet Explorer (IE) Version 8.0 through 10.0 or Firefox 3.6 or higher. Health centers having a problem with other browsers should consider using IE-8, 9, or 109 or Firefox 3.6 for this task. As a rule, IE-11 will also work, though it may result in a false error saying that the user is using an earlier version. More information about EHB’s [Recommended Settings](#) are available at <https://grants.hrsa.gov/2010/WebEPSEExternal/Interface/Common/BrowserSettingsExt.aspx?IsPopUp=false>.

Users 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 not considered “filed” until the responsible party at the health center takes this final action. This may be the CEO of the organization or the authority may be delegated to another party; however, submission carries with it the acknowledgement that the responsible party in the health center has reviewed and approved the data. Incomplete reports cannot be filed. Health centers may distribute the data entry responsibilities to multiple users, each using his/her own login and password. However, one individual must be designated as the UDS Contact (their name is entered into a field in the report) and this person should be able to explain all of the tables during the review process. Note that health center staff may be assigned either “view” or “edit” privileges, however these privileges are for the entire UDS, not just specific tables.

Automated edits will check for inconsistent or questionable quantitative and qualitative data to ensure accuracy. The EHB will provide users with a summary of which tables are complete as well as a list of audit questions which must be reviewed. Note that the audit questions are general and may not apply to some health centers unique circumstances. Data audit findings must be corrected or if the submitter thinks there is no error in the data reported, the accuracy of the data must be clearly explained, including detail about the unique circumstances.

Definitions of Visits, Providers, Patients, and FTEs

This section provides definitions which are critical for consistent reporting of UDS data across health centers. Most definitions have been in use for years or decades and permit comparisons with data from prior years, as well as comparisons across groups of submitting health centers or the U.S. population at large.

Visits

“Visits” are used both to determine who is counted as a patient (Tables 3A, 3B, 4, 5, 6A, 6B, and 7) and to report visits by type of provider staff (Table 5) and visits where selected diagnoses were made or where selected services were provided (Table 6A). 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 otherwise credentialed provider, who
- Exercises independent, professional judgment in the provision of services to the patient.

To be included as a visit, services rendered **must be documented in a chart in the possession of the health center**. (In the case where a clinic provider is documenting in a hospital or nursing home record, a discharge summary, which separately documents the details of the interactions from an outside institution, included in the health center medical records, is acceptable.) Not all health center staff may provide countable visits. [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. Note, however, that providers do many things, including interacting with patients, which do not meet the visit criteria. Visits, which are provided by contractors and **paid for by the health center**, including Migrant Voucher visits or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be visits to be counted on the UDS to the extent that they meet all other criteria. In these instances, 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-9/ICD-10 codes in order to ensure that the EHR can be used by the health center for reporting the UDS.

NOTE: This year marks the transition from ICD-9 to ICD-10 codes. This manual includes the necessary codes for reporting using data drawn from both ICD-9 and ICD-10 codes. Careful attention is required to ensure reported patient activity is unduplicated. Additional information is available on the conversion process at the [Centers for Medicare and Medicaid Services](#).

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

Further elaboration of the definitions and criteria for defining and reporting visits, along with additional limits, are included below. Table 5 provides further clarifications to these definitions. See page [59](#).

1. 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. 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. 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. 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)².

2. To meet the criterion for **documentation**, the service (and associated patient information) must be recorded in written or electronic form in a system which permits ready retrieval of current data for the patient. The patient record does not have to be a 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 (existing, previously registered) patients at a hospital or nursing home 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. Screenings such as those frequently conducted at health fairs or at schools, immunization drives for children or the elderly, services provided en-mass to identified groups, such as dental varnishes or sealants provided at schools, and similar public health efforts *are not counted as visits regardless of the level of documentation*.
3. **Group activities:** When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of service is noted in *each* person’s health record. Such visits are limited to behavioral health services. Examples of such non-medical "group visits" include family therapy or counseling sessions, and group mental health counseling during which several people receive services and the services are noted in each person’s health record. In such situations, *each* patient is normally billed for the service. 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. In addition, 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. Other categories of telemedicine, patient education or health education classes (e.g., diabetics learning about diet control) are not credited as visits.
4. **Location:** A visit may take place in the health center or at any other approved site or location in which project-supported activities are carried out. Examples of other sites and locations which may be approved include mobile vans, hospitals, patients’ homes, schools, nursing homes, homeless shelters, and extended care facilities. (If visits at these sites occur on a regularly scheduled basis the site *must* be an approved site within the scope of the agency’s grant.) Visits also include contacts with existing patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the

² As described in the Current Procedural Terminology, (CPT) 2014. American Medical Association

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 entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so. When a patient is first encountered in a hospital or nursing home or a similar facility, *which is not specifically approved as a service delivery site by BPHC*, none of the services for that patient are reported on the UDS.

5. **Ancillary services** including, but not limited to, drawing blood, collecting urine specimens, performing laboratory tests (including pregnancy tests and PPDs), taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions, including prescriptions for substance abuse prevention or treatment, do not constitute visits, regardless of the level or quantity of supportive services.
6. Under certain circumstances a patient may have more than one visit with the health center in a day. The number of visits per service delivery location per day is limited as follows. On any given day a patient may have, at a maximum:
 - One medical visit (physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse)
 - One dental visit (dentist or hygienist)
 - One other professional health visit *for each type* of other professional health provider (nutritionist, podiatrist, speech therapist, acupuncturist, etc.)
 - One vision services visit (ophthalmologist, optometrist)
 - One enabling service visit for each type of enabling provider (case management or health education)
 - One mental health visit
 - One substance abuse visit

*If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and an Internist treats hypertension) only one of these visits may be counted on the UDS. While some third party payers may recognize these as billable, only one of them is **countable**. The decision as to which provider gets credit for the visit on the UDS is up to the health center. Internally, the health center may follow any protocol it wishes in terms of crediting providers with work performed.*

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

7. Any given provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they are provided.
8. The visit criteria are **not met** in the following circumstances:
 - When a provider participates in a community meeting or group session that is *not* designed to provide clinical services; examples of such activities include information sessions for prospective patients, health presentations to community

groups (high school classes, parent teacher association (PTA), etc.), and information presentations about available health services at the center.

- When the *only* health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair or en-mass application of dental varnishes)
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services
- When the only services provided are lab tests, x-rays, sonography, mammography, retinography, immunizations or other injections, TB tests or readings, and/or prescription refills
- When narcotic agonists or antagonists or mixes of these are dispensed to a patient on a regular basis such as daily or weekly
- Services performed under the auspices of a women, infants, and children (WIC) program or a WIC contract

Further definitions of visits for different provider types follow.

- **Physician Visit:** A visit between a physician (including a licensed resident) and a patient
- **Nurse Practitioner (NP) Visit:** A visit between a nurse practitioner and a patient in which the practitioner acts as an independent provider
- **Physician Assistant (PA) Visit:** A visit between a physician assistant and a patient in which the practitioner acts as an independent provider
- **Certified Nurse Midwife (CNM) Visit:** A visit between a certified nurse midwife and a patient in which the practitioner acts as an independent provider
- **Nurse Visit (Medical):** A visit between an RN, LVN, or LPN and a patient in which the nurse acts as an independent provider of medical services exercising independent judgment. Services which meet these criteria may be provided under standing orders of a medical provider, under specific instructions from a previous visit, or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit, *but must still meet the requirement of exercising independent professional judgment*. This would include nurses who provide triage services, and visiting nurses who see patients on their own in the patients' homes and evaluate their condition. In order to be counted, the visits must be charged for and are generally coded as 99211 visits³. Administration or dispensing of drugs, giving vaccinations or Depo-Provera or other shots, wound care, taking health histories, and making referrals for or following up on external referrals are never counted as visits on the UDS. Nurses may not have a countable visit with a person who is not a registered patient of the health center. (Note that most States prohibit an LVN or an LPN from exercising independent judgment, in which case no visits would be counted for them. Note also that under no circumstances are services provided by medical assistants or other non-nursing personnel counted as nursing visits.)
- **Dental Services Visit:** A visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including

³As described in the Current Procedural Terminology, (CPT) 2014. American Medical Association

restoration; NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may *not* be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide independent services or the volume of service (number of procedures) provided. The application of dental varnishes, fluoride treatments, and dental screenings, especially in a group setting, or absent other comprehensive dental services, does not qualify as a visit. Under no circumstances may the services of students or anyone else other than a licensed dental provider be credited with dental visits, even if these individuals are working under the supervision of a licensed dental provider. Dental therapists, although licensed in some states, are not counted as dental providers for purposes of the UDS even though their services are billed and paid for. (They may be counted under the "other professional health" category.) Physicians and other medical providers who examine a patient's dentition or provide fluoride treatments are not credited with a dental visit.

- **Mental Health Visit:** A visit between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other masters prepared mental health providers licensed by specific States) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided. (NOTE: The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance abuse disorders. All visits, providers, and costs classified by a health centers as "behavioral health" visits must be parsed out into mental health or substance abuse.)
- **Substance Abuse Visit:** A visit between a substance abuse provider (e.g., a mental health provider, credentialed substance abuse counselor, or rehabilitation therapist) and a patient, during which alcohol, or drug abuse services (i.e., assessment and diagnosis, treatment, or aftercare) are provided; programs which 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.*

NOTE: The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance abuse disorders. All visits, providers, and costs classified by a health center as "behavioral health" visits must be parsed out into mental health or substance abuse.

- **Vision Services Visit:** A visit between a vision service provider and a patient during which eye exams are performed by an ophthalmologist or an optometrist for the purpose of early detection, care, treatment, and prevention for those with eye disease or chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses. These exams also provide opportunities to promote behavioral changes linked to eye health (e.g., smoking, excessive use of alcohol). Under no circumstances may the services of students or anyone other than a licensed vision services provider be credited with vision services visits. Retinography, whether performed by a licensed vision services provider or anyone else, is not considered a vision visit absent a more comprehensive vision exam by a vision service provider.
- **Other Professional Visit:** A visit with a health provider, besides those listed and described in this section of the manual, and a patient during which other forms of health services are provided. An extensive, but potentially not all-inclusive, list of other professionals is provided in [Appendix A](#). These professionals are usually, but not

always, licensed by some entity. They are generally credentialed and privileged by the health center's governing Board.

- **Case Management Visit:** A visit between a case management provider and a patient during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems; these must be face to face with the patient. Third party interactions on behalf of a patient are not counted as case management visits. When a case manager serves an entire family (e.g. in assisting in housing or Medicaid eligibility) only one visit is generated, generally for an adult member of the family, regardless of documentation in other charts. As a rule, case management services are provided to support the delivery of other health care services as described above and are not the only types of services provided to a patient.
- **Health Education Visit:** A one-on-one visit between a health education provider and a patient in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, or specific diseases such as diabetes or hypertension). As a rule, health education services are provided to support the delivery of other health care services, as described above and are not the only types of services provided to a patient. Participants in health education classes or other group activities are not considered to have had visits.

Further definitions of interactions not counted as a visit.

- **Tests:** Tests are provided to support the services of the clinical programs. Neither laboratory tests (including PPDs, pregnancy tests, HbA1c tests, blood pressure tests, etc.) nor imaging tests (including sonography, radiology, mammography, retinography, computerized axial tomography scans, and other imaging) are counted as a visit by themselves.
- **Dispensing Medications:** Dispensing medications is not considered a visit. This includes dispensing medications from a pharmacy (whether by a Clinical Pharmacologist or a Pharmacist), giving any injection (including vaccines and family planning methods regardless of education provided at the same time), or providing narcotic agonists or antagonists or mixes of these (regardless of whether or not the patient is assessed at the time of the dispensing).

Patient

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

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

For each **Grant report**, patients reported are those who have at least one visit during the year within the scope of project activities supported by the specific BPHC grant. A patient counted in any cell on a Grant report is also included in the same cell on the Universal report. For this

reason, the number in any cell of a Grant report will never be greater than the number in the comparable cell of the Universal report.

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

During the course of addressing the health care needs of the community, health centers see many individuals who do not become patients as defined by and counted in the UDS process. “Patients,” as defined for the UDS, never include individuals who have such limited contacts with the health center, whether or not documentation is done on an individual basis. *Table 5 provides further clarifications to these definitions. See page 59.* These other service users include, but are not limited to, persons whose only contact is:

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

Provider

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient’s record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during a visit. Only one provider who exercises independent judgment is credited with the visit, even when two or more providers are present and participate. If two or more providers of the same type divide up the services for a patient (e.g., a family physician [FP] and a pediatrician both see a child or an ObGyn and an FP both see a pregnant woman for different purposes) only one 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 instructions for further instruction on counting interns or residents*). Where health center staff are following a patient in the hospital, the primary center staff person in attendance during the visit is the provider (and is credited with a visit), even if other staff from the health center and/or hospital are present. (*Appendix A provides a listing of personnel. Only personnel designated as a “provider” can generate visits for purposes of UDS reporting.*) With the exception of physicians, staff time may 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 full-time equivalent (FTE) between a medical Nurse and Health Educator. *Table 5 provides further clarifications to these definitions. See page 52.*)

Providers may be employees of the health center, contracted staff, or volunteers. Contract providers, who are part of the scope of the approved program, are paid by the center with grant funds or program income, serve center patients, and document their services in the center's records, are considered providers. (A discharge summary or similar document in the medical record will meet these criteria.) Also, contract providers paid for specific visits or services with grant funds or program income, who report patient visits to the direct recipient of a BPHC or BHW grant (e.g., under a migrant voucher program or contractors with homeless grantees) are considered providers and their activities are to be reported by the direct recipient of the BPHC or BHW grant. Since there is no time basis in their report, no FTE is reported for such individuals. Volunteer providers who serve center patients at the 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 a health center visit regardless of whether or not they provide discharge summaries or report the service in the patient's medical chart. *These providers are generally noted in column III of the grant application Form 5A.*

Full-Time Equivalent Staff

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 agency defines the number of hours for "full-time" work and may define it differently for different positions. For example, a physician can be hired as a full-time employee but only required to work nine 4-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. The full-time equivalent is based on employment contracts for clinicians and other exempt employees, and is adjusted for part-year employment.

A FTE is calculated based on paid hours for non-exempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40-hour work week (2,080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. Thus, if physicians work 36 hours per week, this would be considered 1.0 FTE, and an 18 hour per week physician would be considered as 0.5 FTE, regardless of whether other employees work 40-hour weeks. A FTE is also based on the part of the year that the employee works. An employee who works full time for 4 months out of the year would be reported as "0.33 FTE" (4 months ÷ 12 months).

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. Interns, residents, and volunteers are counted consistent with their time with the health center and their licensing. (See [Appendix B](#) for further discussion.) Individuals who are paid by the health center on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours (However, the visits performed by fee-for-service

providers are still counted.). Individuals who are hired to “fill in” for staff who are on vacation or other paid leave are to be counted, in addition to the FTE for those who they are filling in for. It is assumed that more than 1.0 FTE will need to be employed by a health center if it staffs a position for five or six days a week, 52 weeks per year.

Instructions by Table

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

Overview of UDS Report

The UDS includes two components:

- The **Universal Report** is completed by all health centers. This report provides data on services, staffing, and financing *across all programs*. The Universal report is the source of unduplicated data on health centers.
- **Grant Reports** are completed by a sub-set of grantees *who receive BPHC grants under multiple program authorizations*. Only BPHC grantees supported with multiple 330 funding streams complete Grant reports. These reports repeat all or part of the elements of five of the Universal report tables. Grant reports provide comparable data for that portion of their program that falls within the scope of a project *funded through a specific funding authority*. Separate Grant reports are required for Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees except for grantees funded under *only one* of these programs which receive no other 330-BPHC funding. No Grant report is submitted for the portion of multi-funded grantee's activities supported by the Community Health Center Section 330(e) grant. Community Health Center (CHC) grant reporting is included in the Universal report. (The EHB is programmed to display only those tables that are required of a health center. If Grant tables are not required, they will not appear in the EHB.)

The **Universal Report** provides a comprehensive picture of all activities within the scope of BPHC-supported projects. In this report, health centers report on the total unduplicated number of patients and activities for the reporting year which are *within the scope of projects supported by any and all primary care programs covered by the UDS*. If out of scope services or sites are brought into scope during the calendar year, data for these sites and services are to be included for the full calendar year, back to January 1, not just for the period after the date of the scope change.

For **Grant Reports**, grantees provide data on the patients and activities within that part of their program which is supported by a particular funding authority. Because a patient can receive services through more than one BPHC program, and not all grants are reported separately, totals from a health center's multiple Grant reports cannot be aggregated to generate any meaningful total and might not equal the total on the Universal report.

Once a patient has been identified as a recipient of *any* of the additional funding streams, *all of the data for that patient are reported on the Grant tables*. Thus, if a homeless patient is seen in the homeless medical van for medical services, all of 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 CHC grantee (section 330e) that also has Health Care for the Homeless support (section 330h) completes a Universal report and a Homeless Grant report, but does not complete a Grant report for the CHC grant.
- A CHC grantee (section 330e) that also has Migrant Health (section 330g) and Homeless (section 330h) support, completes a Universal report, a Grant report for the Homeless program, and a Grant report for the Migrant program.
- A grantee which is funded under the Health Care for the Homeless program (section 330h) and the Public Housing (section 330i) program completes a Universal report and two Grant reports—one for Homeless and one for Public Housing.
- A grantee which is funded only under the Health Care for the Homeless program (section 330h) will file only a Universal report, and will not file a Grant report.

*NOTE: The EHB reporting system will automatically identify the reports which must be filed and prompt the health center if some or all of the Universal 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 as to which reports are showing should be reported to the **UDS Support Center at 866-UDS-HELP.***

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

Table	Data Reported	Universal Report	Grant Reports
Service Area			
ZIP Code Table	Patients by ZIP Code by Health Insurance	X	Not reported for grant reports
Cover Sheet	No longer reported		
Table 1	No longer reported		
Table 2	No longer reported		
Patient Profile			
Table 3A	Patients by Age and Gender	X	X
Table 3B	Patients by Hispanic/Latino Ethnicity and Race; Patients best served in a language other than English	X	X
Table 4	Selected Patient Characteristics	X	X
Staffing and Utilization			
Table 5	Staffing and Utilization	X	<partial>
Table 5A	Tenure for Health Center Staff	X	
Clinical			
Table 6A	Selected Diagnoses and Services	X	X
Table 6B	Quality of Care Measures	X	
Table 7	Health Outcomes by Race and Ethnicity	X	

Table	Data Reported	Universal Report	Grant Reports
Financial			
Table 8A	Costs	X	
Table 8B	No longer Reported		
Table 9 (A-B-C)	No longer Reported		
Table 9D	Patient-Related Revenue	X	
Table 9E	Other Revenue	X	
Other Forms			
EHR Form	EHR Capabilities and Quality Recognition	X	

Look-Alike Tables

Look-alikes are health centers which meet all Health Center Program requirements but do not receive a Health Center Program grant. Look-alikes submit the entire UDS report (see [Appendix E](#) for details). (The cells for reporting details of special populations and receipt of a BPHC grant will be grayed out and uneditable, but will still exist on the report.) Look-alikes are to follow all the same rules that are provided in this manual.

There are a very small number of health centers which are Health Center Program grantees which *also* have one or more sites designated as a look-alike. These health centers will need to complete *both* grantee *and* look-alike UDS reports, limiting reporting to the approved scope of project for each respective program. Care must be taken to not include the same provider time, visits or associated costs in both reports, though it is expected that certain key staff (e.g., CEO, CFO, CMO, billing and collections staff) will have their time and cost allocated between the two programs and 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 sites.

The Bureau of Health Workforce (BHW) Primary Care Clinics Tables

The BHW primary care clinics program is a separately funded program operated by the HRSA Bureau of Health Workforce. BHW primary care clinics submit UDS reports which are the same as that submitted by those funded under the Health Center Program. The BHW primary care clinics program is to follow all the same rules that are provided in this manual.

There are a very small number of Health Center Program grantees which are also funded through the BHW primary care clinics program. These health centers will need to complete both grantee and BHW primary care clinics UDS reports, limiting reporting to the approved scope of project for each respective program. Care must be taken to include only those aspects of the funded programs which are provided in their separate Notices of Award. It is possible that the same patient will be reported on both reports if the patient is seen in both programs or if the BHW primary care clinics program is included in the scope of the Health Center program. In the event the BHW primary care clinics program is included in the scope of the Health Center Program, the staff, patients, costs, income, and expenses of the BHW primary care clinics program will be included in the Health Center report.

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. It is completed by all health centers.

Please note the following cross table checks:

- *The sum of patients reported on the ZIP code table must equal Table 3A, Line 39, Column A + B (total patients by age and gender).*
- *The total for Column B (Uninsured) must equal Table 4, Line 7, Column A + Column B.*
- *The total for Column C (Medicaid, CHIP, and Other Public) must equal Table 4, Line 8 + 10, Column A + Column B.*
- *The total for Column D (Medicare) must equal Table 4, Line 9, Column A + Column B.*
- *The total for Column E (Private) must equal Table 4, Line 11, Column A + Column B.*

Patients by ZIP Code

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

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

- **Homeless Patients:** While many homeless patients live doubled up or in shelters, transitional housing, or other locations *for which a ZIP code must be obtained*, others—especially those living on the street—do not know or will not share an exact location. Where a ZIP code location cannot be obtained, or the location offered is questionable, 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 on a mobile van, the ZIP code of the location where the van was parked that day should be used.
- **Migratory Agricultural Worker Patients:** Many, if not most, migratory agricultural workers are seasonal workers and their address ZIP code they use when they are working in the community should be used, not their 'downstream' address. Migratory agricultural workers, on the other hand, may have a permanent residence in a community far from the location of their work and the site where they are receiving services. *For the purpose of the UDS report*, health centers are to use the ZIP code of the patient's temporary housing location near the service delivery location. Patients, living in cars or on the land where a precise ZIP code is unavailable, should be reported using the ZIP code for the location (fixed site or mobile camp outreach) where they are being treated.
- **Foreign Nationals:** Persons from other countries who are residing in the United States either permanently or temporarily are coded with their current US ZIP code. Tourists and other persons passing through the US may have a permanent residence outside the country, but are coded 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, it is recognized that large centers, as well as those located in tourist or hunting/fishing locations, may draw a significant number of patients from a large number of ZIP codes outside of their normal service area. To ease the burden of reporting, *ZIP codes with ten or fewer patients may be aggregated and reported in the “Other” category.*

Source of Insurance

Medical insurance status must be obtained for all persons counted 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. Under no circumstances may they be shown as “uninsured” because they are not receiving a service that is covered by health insurance. Children seen in school based health center settings must have complete clinic intake forms which show insurance status, and ideally family income, before they can be counted as patients in the UDS.

Note: The U.S. Census reports data on health insurance. These data are becoming available in the [UDS Mapper](http://www.udsmapper.org/) at <http://www.udsmapper.org/> and make it possible for health centers and BPHC to look more closely at the question of underserved areas. Now that public data show the number of uninsured persons and persons with Medicaid/State Children’s Health Insurance Program (CHIP) at the ZIP code level, it is meaningful to bring comparable data into the UDS system. This will permit even more sophisticated analyses of service area overlaps and enhance capabilities to identify areas which may need new access points.

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, lumping together Medicaid, CHIP and Other Public into one category. Some specific rules guide reporting:

- Patients who have both Medicare and Medicaid, would 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, which is operated by a Private insurance company, are still to be classified as Medicaid, Medicare or CHIP, as appropriate.
- In rare instances, a patient may have an insurance which 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 still report the patient as being insured* and will report the type of insurance, even if they cannot or did not bill this insurance.
- 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, and the like are not classified as uninsured. In these instances, report the patient by type of insurance and record the ZIP code of the 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 of our patients?**

Yes. Although health centers are expected to report residence by ZIP code for all patients, it is recognized that large centers may draw a number of patients from a large number of ZIP codes which are outside of their normal service area. To ease the burden of reporting, ZIP codes with 10 or fewer patients may be aggregated and reported in an "Other" category.

3. **Do we need to collect information on and report on the primary medical insurance of all of our patients?**

Yes. Although the ZIP code of a patient may be unknown, medical insurance information must be obtained for every single 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. In order to understand the patient population being served, BPHC must know the medical insurance of all persons being counted in the program.

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 Table 4, Line 8 + 10, Column A + Column B,
 - the total for Column D (Medicare) must equal Table 4, Line 9, Column A + Column B;
 - the total for Column E (Private) must equal Table 4, Line 11, Column A + Column B.
 - If ZIP code information is missing for some patients, residence should be reported as unknown.

Table Patients by ZIP Code

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 Table 3A and 3B

Tables 3A and 3B provide demographic data on patients in the program and are included in *both* the Universal *and* Grant reports. All health centers must complete these tables.

For the **Universal Report**, patients counted include all individuals who (1) received at least one face-to-face visit (2) during the calendar year (3) for services, as described below, (4) which are within the scope of any of the programs covered by UDS. Regardless of the scope or volume of services received, each patient is to be counted only once on *Table 3A* and only once in *each of the two sections of Table 3B*: race and ethnicity, and language, if applicable.

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

A visit is face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient, and the services rendered must be documented to be counted as a visit. See the “Definitions of Visits, Providers, Patients, and FTE” section (page [8](#)) for complete definitions.

Table 3A: Patients by Age and Gender

Report the *number* of patients by appropriate categories for age and gender. For reporting purposes, *use the individual’s age on June 30, of the reporting period*. Health centers are to report gender according to what the patient self-identifies as during patient registration. 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: Patients by Hispanic or Latino Ethnicity / Race / Linguistic Barriers to Care

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

Hispanic/Latino Ethnicity

Table 3B collects information on whether or not patients consider themselves to be of Hispanic/Latino ethnicity *regardless of their race*.

- Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do not count persons from 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) and 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 totally 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/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 Islanders” 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, and Vietnam
- Line 2a. Native Hawaiian: Persons having origins in any of the original peoples of Hawaii
- Line 2b. Other Pacific Islanders: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia
- Line 2. “Total Hawaiian/Other Pacific Islander” must equal lines 2a+2b.

“American Indian/Alaska Native” (Line 4) includes persons who trace their origins to any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

“More than one race” (Line 6): “More than one race” should not appear as a selection option on your intake form. Use this line only if your system captures multiple races (but not a race and an ethnicity) and the patient has chosen two or more races. This is usually done with an intake form which lists the races and tells the patient to “check one or more” or “check all that apply.” “More than one race” must not be used as a default for 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 who are unable to distinguish a White Hispanic/Latino patient from a Black Hispanic/Latino patient (because their system only asks patients if they are White, Black, or Hispanic/Latino), are instructed to report these Hispanic/Latino patients on Line 7, column A, as “unreported” race but include 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

Health centers are designed to serve patients who face linguistic barriers to care, and are noted for having bi-lingual and multi-lingual staff as well as interpreters and translators. 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 Electronic Health Record (EHR). If an estimate is required, the estimate should be based on a sample where possible.

*Note: **This is the only place on the UDS where an estimate is accepted.***

Questions and Answers for Tables 3A and 3B

1. **Have the data elements for Table 3B changed?**

No.

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/Latino ethnicity reported?**

Table 3B, race and ethnicity data is reported in a matrix. Patients who in other systems might be reported as Hispanic/Latino, independent of race, are reported in Column A of the UDS as Hispanic/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. In order to count a patient as being of “more than one race” they must have the option of checking two or more boxes under race and have indeed checked more than one. This methodology is the same as used in the census and mandated by OMB.

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 [17](#)). Note the following:

- Persons who receive WIC services and no other services at the agency *are not* to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).
- Persons who only receive 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 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 very well 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 gender) must equal Table 3B, Line 8 Column D (total patients by Hispanic/Latino Ethnicity and Race); Total Patients by ZIP Code; Table 4, Line 6 (total patients by income); and Table 4 Line 12, Column A + B (total patients by insurance status). The sum of Table 3A, Lines 1-18, 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/Latino ethnicity of all our patients need to be collected and reported?**
Yes. The UDS requires the classification of race and Hispanic/Latino ethnicity information in order to assess health disparities across sub-populations. The format for the classification of this information has been stipulated by OMB, and the UDS manual follows the standards established by OMB. 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.

Table 3A: Patients by Age and Gender

Reporting Period: January 1, 2015 through December 31, 2015

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: Patients by Hispanic or Latino Ethnicity/Race/Linguistic Barriers to Care

Reporting Period: January 1, 2015 through December 31, 2015

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 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	

Instructions for Table 4: Selected Patient Characteristics

Table 4 provides descriptive data on selected characteristics of health center patients. The table is included in *both* the Universal *and* Grant reports. *All health centers report this table.*

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

The following cross table checks should be noted:

- *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).*

Income as a Percent of Poverty Level, Lines 1-6

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

Income is defined in ranges relative to the Federal poverty guidelines (e.g., 100 percent and below the Federal poverty level). In determining a patient's income relative to the poverty level, health centers should use official poverty guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register during the first quarter of each year. The [guidelines for CY 2015](http://aspe.hhs.gov/poverty/15poverty.cfm) are available online at <http://aspe.hhs.gov/poverty/15poverty.cfm>.

Every patient reported on Table 3A must be reported once (and only once) on Table 4 Lines 1 through 5. The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income). The same is true for Grant reports.

Principal Third Party Medical Insurance Source, Lines 7-12

This portion of the table provides data on patients 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.

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 program. *Do not count* patients as uninsured just because their medical insurance did not *pay* for their visit. For example:

- A patient with Medicare who was seen for a dental visit which was not paid for by Medicare is still classified as having Medicare for this table.
- A patient with Private insurance that has a \$2000 deductible but 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 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 s/he does not have access to the parent's information.
- 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.

Medicaid (Line 8a, 8b, and 8)

State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act; Medicaid includes programs called by state-specific names (e.g., California's "Medi-Cal" program). In some States, the Children's Health Insurance Program (CHIP) is also included in the Medicaid program—see below. While Medicaid coverage is generally funded by Federal and State funds, some States also have "State-only" programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients or pregnant women) and these individuals are also reported as having Medicaid on Lines 8a or 8b and 8. NOTE: Individuals who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the State Medicaid Agency are still reported as "Medicaid," *not* as Privately insured. NOTE ALSO: 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, covered in statute by the Children’s Health Insurance Program Reauthorization Act (also known as CHIP-RA) provides primary health care coverage for children and, on a State by State basis, others—especially 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.)

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.

Dually Eligible Medicare and Medicaid (Line 9a)

Patients who have 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, providing a broad set of benefits for eligible individuals; include public paid or subsidized private insurance not listed elsewhere. ACA 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), ADAP pharmaceutical coverage for HIV patients, etc. Also, **do not include** persons covered by workers’ compensation, as this is not health insurance for the patient, it is liability insurance for the employer.

Other Public (CHIP) (Line 10b)

In those States where CHIP is contracted through a private third party 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 which are run through the private sector, are often covered through HMOs. The coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and counted on

Line 10b. 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 under the ACA.

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 ACA-supported Federal or State exchanges. In those States that are making use of Medicaid expansion to support 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, line 11. Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, 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—BPHC requires that health centers obtain medical insurance information from all patients in order to maximize third party payments.

The following cross table checks should be noted:

- *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.

Source of Insurance

Health centers should report the patient's *primary health insurance* covering medical care, if any, *as of the last visit* during the reporting period. **Primary insurance** is defined as the insurance plan/program that the health center would normally *bill first* for routine medical services rendered. NOTE: Patients, who have both Medicare and Medicaid, would be reported as Medicare patients, line 9, because Medicare is billed before Medicaid. *In addition to* reporting these patients on line 9 as Medicare, these patients will be reported on line 9a, 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.

In rare instances a patient may have an insurance which 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 private insurance where the health centers' providers are not on that payer's panel. In these instances the health center will still report the patient as being insured and report the type of insurance.

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. This is not the case with persons in other facility settings, such as those in residential drug programs, college dorms, military barracks, and the like. In these instances, health centers must obtain their coverage information and report the patients by their medical insurance, if they have insurance, not as uninsured. *Similarly, patients whose services are subsidized through State/local government "indigent care programs" are considered to be uninsured.* Examples of State government "indigent care programs" include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.

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

- **Medicaid:** Line 8b includes Medicaid-CHIP enrolled patients only; Line 8a includes all other enrolled patients; and Line 8 is the sum of 8a + 8b.
- **Other Public:** Line 10b includes CHIP enrolled patients who are covered by a plan other than Medicaid; Line 10a includes all other persons with other public insurance (Health centers are asked to describe the programs so the UDS Reviewer can make sure that the classification of the program as Other Public is appropriate.); and Line 10 is the sum of 10a + 10b.

Managed Care Utilization, Lines 13a-13c

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

Member Months for Managed Care (Capitated) (Line 13a): Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month. A patient is in a capitated plan if the contract between the health center and the Health Maintenance Organization (HMO) or Accountable Care Organization (ACO) stipulates that for a flat payment per month, the health center will perform all of 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-RA, it is common for there to be a second “wrap-around” payment for managed care visits to adjust total payment to FQHC/PPS rates.

Member Months for Managed Care (Fee-for-Service) (Line 13b): Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery provider (at the health center) for 1 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.

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

NOTE ALSO: If patients are enrolled in a managed care program that permits them to receive care from any of a number of providers, including the health center and its providers, 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.

As a rule, there is a relationship between the member months reported on Lines 13a and 13b and the insured persons on Lines 7 through 11. It would be unusual (though not impossible) for the number of member months for any one payer (e.g., Medicaid) to exceed 12 times the number of Medicaid patients reported on Line 8.

As a rule, there is a relationship between the capitated member months reported on Line 13a and 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.

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 populations also provide additional information on their seasonal and/or housing characteristics.

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 or their family members, or other individuals described in the statute at Section 330(g)(1)(B). (See definitions below.) Only Section 330(g) Migrant Health Center grantees

provide separate totals for migratory and for seasonal agricultural workers on Lines 14 and 15. For Section 330(g) grantees, Lines 14 + 15 = Line 16.

Definitions of Migratory and Seasonal Agricultural Workers:

- **Migratory Agricultural Workers:** Defined by section 330(g) of the Public Health Service Act, a migratory agricultural worker is an individual *whose principal employment is in agriculture* 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 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 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 Section 330(h) Homeless Health Center grantees provide separate totals for patients by housing location 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.

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

- The shelter arrangement reported is the patient’s arrangement as of the first visit during the reporting period. This is normally assumed to be where the person was housed the prior night.
- Persons who spent the prior night incarcerated, in an institutional treatment program (mental health, substance abuse, etc.) or in a hospital should be reported based on where they intend to spend the night after their visit/release. If they do not know, report them on Line 20: Street.
- Patients currently residing in a jail or an institutional treatment program are not considered to be 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 6 months and 2 years—in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay some or all of 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.
- **Line 20 – Street:** This category includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
- **Line 21 – Other:** This category may be used to report previously homeless patients who were housed when first seen, but who were still eligible for the program. (HCH rules permit patients who are no longer homeless as a result of becoming residents of permanent housing to continue to be seen for 12 months after their last visit as homeless persons.) Patients who reside in SRO (single room occupancy) hotels or motels, other day-to-day paid housing, as well as 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 grant or designation application and scope of project description are to report the total number of patients who received primary health care services at the school service delivery sites(s) listed. A school based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services. Services are targeted to the students at the school, but may also be provided to their children, siblings, or parents, and may occasionally include persons residing in the immediate vicinity of the school. 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.

Public Housing, Line 26

All health centers should report on public housing patients, consistent with the reporting practice for other statutorily required special populations. Patients should be counted as residents of public housing if they are served at health center sites that meet the statutory Public Housing Primary Care (PHPC) definition (located in or immediately accessible to public housing) regardless of whether the health center site receives PHPC funding. 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 [HUD Website](http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph) 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?**
Yes. Patients who have *both* Medicare *and* Medicaid insurance (commonly referred to as Dually Eligible or Medi-Medi) are to be reported on line 9a, Dually Eligible, *in addition to* line 9, Medicare. They are *not* reported on line 8 – Medicaid. This new line 9a, Dually Eligible, is a sub set of the total patients reported on line 9, Medicare.
2. **If we do not receive direct support under the Health Care for the Homeless, Agricultural Worker Health, or Public Housing Primary Care programs, do we need to report the total number of special population patients served?**
Yes. All health centers, regardless of whether they 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 dependents), 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 clinic), and Line 26 (total number of patients served in a public housing health center)—regardless of whether or not special funding was ever obtained for that clinic), and Line 25 (Veterans). Health centers who did not receive homeless funding are not required (or able) to complete the shelter arrangement details on Lines 17-22. They enter the total only. Health centers who did not receive agricultural 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 s/he is included in one of these special populations and to add this as an item on the patient's profile so it can be reported. See below for specific instructions on reporting of public housing patients.
5. **Who are we to report as Public Housing Patients 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 site is actually funded under section 330(i). The center would serve a preponderance of public housing resident, though others living close by can also use the center.
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 presume that they have the same kind of medical insurance. If they *do not* have dental insurance you *may not* assume that they are uninsured for medical care, and must obtain this information from the patient.

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, and not require documents to prove this.
8. **We serve students at the school based clinic. 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 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 the ACA's 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.

Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2015 through December 31, 2015

Line	Characteristic	Number of Patients				
Line	Income as Percent of Poverty Level	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)					
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 Public Housing Patients (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). All health centers complete Table 5. Unlike Tables 3A, 3B, and 4, where an unduplicated count of patients is reported, Column C is designed to report the number of unduplicated patients *within each of seven service categories*: medical, dental, mental health, substance abuse, vision, other professional, and enabling. While 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. (NOTE: Staffing data are reported only on the Universal table, not the Grant report tables.)

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

Staff Full Time Equivalents (FTEs), Column A

Table 5 includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the project for all of the sites covered by the UDS. (The FTE column is completed only on the Universal report. Staff is not separated according to the different BPHC funding streams.) *All staff are to be reported in terms of annualized FTEs*. A person who works 20 hours per week (i.e., 50% time in a 40-hour work week) is reported as “0.5 FTE.” Positions with less than a 40-hour base, especially clinicians, should be calculated on whatever they have as a base for that position. Agencies which have a 35-hour work week would consider 17.5 hours worked to be 0.5 FTE. Similarly, an employee who works 4 months out of the year would be reported as “0.33 FTE” (4 months ÷ 12 months). (See the “Full-Time Equivalent Employee” section, page [24](#) of this manual for detailed instructions on calculating 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. Thus, FTEs reported on Table 5 Column A include paid staff, volunteers, contracted personnel (paid based on worked hours or FTE), interns, residents, and preceptors. Individuals who are paid by the health center on a fee-for-service basis only are not counted in the FTE column since 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.

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

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

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of “direct patient care” or “face-to-face hours” they provide. Providers who have released time to compensate for on-call hours or who receive paid leave for continuing education or other reasons are still considered full-time if this is how they were hired. (Similarly, providers who routinely are required to work more than 40 hours per week are not counted as more than 1.0 FTE.) The time spent by providers performing tasks in what could be considered “non-clinical” activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in 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 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. 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):** M.D.s and D.O.s, except psychiatrists, ophthalmologists, pathologists, and radiologists; (Psychiatrists, ophthalmologists, pathologists, and radiologists 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):** N.P.s and A.P.N.s, except psychiatric nurse practitioners who are included on Line 20b, Other Licensed Mental Health Providers, and 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 *full time or dedicated time* devoted specifically to medical care services is reported here.

- **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; physician time would not be included here even if they were taking x-rays or performing sonograms. No visits are recorded for these workers.
- **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, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Staff who support the quality assurance/quality improvement or Electronic Health Records (EHR) program are reported as Other Medical Personnel to the extent that they are working with the medical part of the quality improvement (QI) system. If they are, for example, working with the dental QI system, they would be reported on line 18, etc. Do not report medical records and patient support staff here—they are reported on Line 32, Patient Support Staff. No visits are recorded for these workers.
- **NOTE: Quality Assurance/Quality Improvement and EHR Personnel:** Individuals in any or all of the above positions may be involved in quality improvement or quality assurance and EHR activities. They will be classified on the line that describes their main responsibility, not on the "IT" line. Individuals fulfilling help-desk, training, and technical assistance quality assurance and/or EHR functions who do not have a position that places them on one of the other Medical lines are included as "other medical personnel".

Dental Services (Lines 16-19)

- **Dentists (Line 16):** General practitioners, oral surgeons, periodontists, and endodontists; note: dental health technicians are not classified here; they are reported on Line 18, Other Dental Personnel.
- **Dental Hygienists (Line 17)**
- **Other Dental Personnel (Line 18):** Dental assistants, aides, and technicians; no visits are recorded for these workers.

Mental Health Services

NOTE: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between Lines 20a through 20c and Line 21 [Substance Abuse Services], as appropriate, unless they choose to identify all services as Mental Health Services.

- **Psychiatrists (Line 20a)**
- **Licensed Clinical Psychologists (Line 20a1)**
- **Licensed Clinical Social Workers (Line 20a2)**

- **Other Licensed Mental Health Providers (Line 20b):** Including psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed 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; 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, an L.C.S.W. doing a Psychology internship may be counted on the L.C.S.W. line.) Regardless of any billing practices at the center, these individuals are credited with their own visits and no other person is to be credited with these visits.

Substance Abuse Services (Line 21)

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

Other Professional Health Services (Line 22)

Other Professional Health Services includes a broad array of providers of care. Some common professions include occupational and physical therapists, dietitians, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and community health aides and practitioners. Optometrists, previously included on this line, are reported on Line 22b. NOTE: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff. (A more complete list is included in [Appendix A](#).) Services other than those listed above or in [Appendix A](#) must be described in a clear detailed statement. Health centers are encouraged to check the reporting of such services with the UDS Support Center or their UDS Reviewer. There is a “specify” box for this line that must be completed for all services. Explain the other professional health services as specifically as possible.

Vision Services (Lines 22a-22d)

Persons working in the area of eye care, specifically:

- **Ophthalmologists (Line 22a):** Medical doctors specializing in medical and surgical eye problems
- **Optometrists (Line 22b):** Optometrists (O.D.)—non-physicians who largely perform vision correction exams and prescribe glasses for patients
- **Other Vision Care Staff (Line 22c):** Ophthalmologist/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 on any lines of the UDS. Note that the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from

pharmaceutical companies (Pharmacy Assistance Programs [PAP]) is 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 pharmacy visits are recorded on Table 5*. Clinical pharmacists must be reported on Line 23 and may not be allocated to other clinical or non-clinical lines, nor may their interaction with patients be counted elsewhere.

Enabling Services (Lines 24-29)

Specific types of enabling services are listed below and are reported on Lines 24 through 28. “Enabling services,” and especially “other enabling services” (Line 28), are not to be used as a catch-all for services which are not included on other lines. Often such services belong on Line 29a (other related services) or are services which 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. Health centers are encouraged to check such services with the UDS Support Center or their UDS Reviewer prior to submission.

- **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, 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. Nurses, social workers, and other professional staff who are specifically allocated to this task during assigned hours, may be included here, but not when these services are an integral part of their other function. (Thus, none of the time of a nurse providing comprehensive nursing support including making an appointment for a patient with another provider is counted here.)
- **Patient and Community Education Specialists (Line 25):** Health educators, with or without specific degrees in this area; family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach may also be included here. Services may be one-to-one with the patient or in a group; however, *group visits are not reported in Column B*.
- **Outreach Workers (Line 26):** Individuals conducting case finding, education, or other services to identify potential 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):** All staff providing assistance in securing access to available health, social service, pharmacy, and other

assistance programs, including Medicaid, Medicare, WIC, SSI, food stamps (SNAP), TANF, Pharmacy Assistance Programs, and related assistance programs; staff hired under the HRSA Outreach and Enrollment grants is included on this line. No visits are recorded for any of these workers.

- **Interpretation Staff (Line 27b):** Staff whose *full time or dedicated time* is devoted to translation and/or interpretation services. *Do not include* that portion of the time of a nurse, medical assistant, or other support staff who provides interpretation or translation during the course of his/her other activities. No visits are recorded for these workers.
- **Personnel Performing Other Enabling Service Activities (Line 28):** All other staff performing enabling services not described above; there is a “specify” field that must be used to describe what these staff are doing. “Other enabling services” is not to be used as an all-inclusive category for services which are not included on other lines. Often such services belong on Line 29a (Other Programs and Related Services Staff) or are services which are not reported on the UDS. Be sure to include a clear detailed statement of what is being reported. Health centers are encouraged to check such services with the UDS support center or their reviewer. No visits are recorded for these workers.

Other Programs and Related Services Staff (Line 29a)

Some health centers, especially “umbrella agencies,” operate programs which, while within their scope of service and often important to the overall health of their patients, are not directly a part of the listed medical, dental, behavioral, or other health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, child care, frail elderly support programs, Adult Day Health Care programs, fitness or exercise programs, public/retail pharmacies, etc. The staff members for these programs are reported under Other Programs and Related Services. There is a “specify” field that must be used to describe what these staff members are doing. No visits are recorded for these workers.

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

- **Management and Support Staff (Line 30a):** Management team including Chief Executive Officer, Chief Financial Officer, Chief Information Officer, and Chief Medical Officer; other non-clinical staff and office support (secretaries, administrative assistants, file clerks, etc.) for health center operations within the scope of the program; in the case of the Medical Director or other individuals whose time is split between clinical and non-clinical activities, report only that portion of their full-time equivalent corresponding to the 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)
- **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; staff managing the hardware and software of an EHR/EMR system are reported on Line 30c, but design of medical forms, data entry, and analysis of EHR data, as well as help-

desk, training and technical assistance functions are included as part of the other medical personnel functions reported on Line 12.

- **Facility Staff (Line 31):** Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff; if facility functions are contracted (e.g., janitorial services) do not attempt to create an FTE, but the costs will be shown on the facility line on Table 8A.
- **Patient Services Support Staff (Line 32):** Intake staff, front desk staff, and medical/patient records; eligibility assistance workers are reported on Line 27a, not here.

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

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)	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. <i>Note that the cost categories are not in the same sequential order as they appear on Table 5.</i>	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

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8, Line:
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
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

Clinic Visits, Column B

A **visit** is a documented, face-to-face contact between a patient and a provider who exercises his/her independent, professional judgment in the provision of services to the patient. (See “Definitions of Visits, Providers, Patients, and FTE” section, page [17](#), for further details on the definition of visits). Health centers report visits which occurred during the reporting year which were rendered by the staff identified in Column A, regardless of whether the staff is salaried, contracted or donated.

No visits are reported for personnel who are not “providers who exercise independent professional judgment” within the meaning of the definition above. In addition, BPHC has chosen not to require reporting health centers to report on visits for certain other classes of staff, even if they do exercise professional judgment. The cells applicable to these staff (e.g., laboratory, transportation, outreach, pharmacy) are blocked out in Column B.

Visits that are for administration of pharmaceuticals (such as Coumadin administration), follow up to care (such as return diabetes and hypertension checkups) and wound care (which are following up to the original primary care visit) would not count as per the definitions. In addition, group visits, allergy shots, lab tests (including Tb tests, Tb readings, pregnancy tests, BPs etc.) vaccinations, or prescription refills (including Depo-Provera shots) cannot be counted as 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 that 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 health center’s staff are similarly not counted if provided under some other arrangement.

Patients, Column C

A patient is an individual who has at least one reportable visit during the reporting year. (See “Definitions of Visits, Providers, Patients, and FTE” section, page [17](#) for further details.) 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) for each service.***

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

- Medical services (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)

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

Questions and Answers for Table 5

- 1. Are there changes to this table?**
No.
- 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 agency 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 which 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 one 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, 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% (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 service you provide is 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 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 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 of the staff are volunteers. Some services do not, in fact, involve staff. Spending funds on bus tokens, for example, would involve money 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 which must be explained, but it is not an error.
8. **Where does “Behavioral Health” get reported?**

“Behavioral Health” in some systems is just another name for mental health, and the staff and visits are reported on Lines 20a through 20c. But some health centers have merged the roles of “Mental Health Provider” and “Substance Abuse Provider” into a single role which they call “Behavioral Health Provider.” In this instance, the 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 that 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 as mental health. Under no circumstances would it be counted as “one of each.” The provider will also need to be classified as mental health for this visit as must be the cost of the provider on Table 8A. This does not apply to physicians, who would count the visit as a medical visit.
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](#).
12. **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 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.

13 We employ community health workers at our health center. Where are they reported?

The title “community health worker” is used differently by different health centers, and often includes an individual performing multiple tasks within the same health center. The following table provides some guidance for reporting these staff. Count these workers on the line that most closely matches their work responsibilities.

Services Performed	UDS Line / Title
Assisting medical providers by vitaling patients, placing them in exam rooms, and providing basic health screening services	12: Other medical
Assisting dental patients before, during, or after the visit by getting patient history and by chairing patients	18: Dental assistants, aides
Serving as a community health aide/practitioner (Alaska only)	22: Other professional
Working with vision patients before and after the visit by getting patient history, bringing patients to exam room and optical department	22c: Other vision care
Assisting patients in the management of their health and social needs	24: Case managers
Providing health education on topics related to chronic disease prevention, physical activity, and nutrition	25: Patient/community education
Conducting assessments and case findings and facilitating patient’s access to health center services	26: Outreach
Assisting new/returning patients to qualify for the health center’s sliding discounts or other benefit programs	27a: Eligibility assistance

Table 5: Staffing and Utilization

Reporting Period: January 1, 2015 through December 31, 2015

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			
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			
22d	Total Vision Services (Lines 22a–c)			
23	Pharmacy Personnel			
24	Case Managers			
25	Patient/Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify ___)			
29	Total Enabling Services (Lines 24–28)			
29a	Other Programs/Services (specify ___)			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
33	Total Facility and Non-Clinical Support Staff (Lines 30a–32)			
34	Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+33)			

Instructions for Table 5A: Tenure for Health Center Staff

Table 5A data are reported in the **Universal** report, only. It is completed by all health centers. This table provides information on the tenure of health center providers and key management staff, and 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 the 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. Specifically, lines for non-providers, other than health center management staff, are excluded, as are providers of “Other Professional” and Enabling services.

Definitions

Full and Part Time Staff, Column A

Full and part time staff are individuals who are considered regular employees of the health center. They may be paid in a number of different ways and may work different amounts of time. Future employment may be limited by the expiration of a contract or may be “open-ended” with no specific end date. The following are considered full and part time staff and are reported in Column A, with months in current position reported in Column B:

Full Time Staff

Are employed by the health center, receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to IRS on a form W2. Staff may or may not have a contract. Staff are considered to be full time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if full time employees get 8 hours off for a holiday, these staff also receive 8 hours off.) They may have assigned work hours which are less than 40 per week, and may actually end up working more than those assigned hours.

Part Time Staff

Are employed by the health center, but for less 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 IRS on a form W2. Staff may or may not have a contract. Staff are considered to be part time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if a full time employee receives 8 hours off for a holiday, a 75% part time staff person would receive 6 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 working at the time of the census or be under agreement to return to the clinic in 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

Are contracted by and work at the health center. They work regular assigned hours every day or week or month. They may or may not receive benefits appropriate to their FTE. They do not

have withholding taxes deducted from their paychecks and they have their income reported to IRS on a form 1099. Do not include contract physicians who are paid by the visit to deliver services in their own offices or hospitalists.

NHSC Assignees

Are members of the National Health Service Corps who are assigned by the Corps to the health center. This includes members of the “ready reserve.” These individuals are employees of the U.S. Government. The health center may or may not have a contract with the NHSC to pay a specific amount to cover 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 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, FMLA) but may also be used when the center is unable to hire a full or part time staff person for a position and 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. Generally locums cannot be hired by the center as a full or part time employee without paying a fee to the agency.

On-call Providers

On-call providers also work at a health center on an “as needed” basis, and are also most commonly used to fill in for a part time absence of another provider (e.g., on a day off or to cover for a provider who is on vacation, sick leave, FMLA) but may also be used for an extended period when the center is unable to hire a full or part time staff person for a position. Unlike locums, on-call providers are paid by the health center. They may or may not receive benefits, and may or may not have payroll and income taxes withheld. On-call providers are generally not covered by 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 which may include a large number of hours or just a few hours a month. They are generally scheduled by the session. Volunteer providers are not paid by the health center and do not receive benefits. They are not covered by FTCA though they may be covered by the center’s gap insurance.

Residents/Trainees

Many health centers are involved in training programs which involve the trainee providing services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) are licensed in their own right:

- In the case of medical residents, they are included on the line for which they are 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. A 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 be able 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 2 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 organizations—especially smaller and more remote organizations—use consultants to fill administrative, non-clinical management positions because they are unable to recruit health center management staff or are unable to support a full time person in that role. These individuals may be considered for inclusion on Lines 30a1, 30a2, 30a3, and 30a4.

Persons (Columns A and C)

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

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

- Be employed full time
- Be employed part time on a regular basis with a regular schedule
- 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 a regular schedule for at least 6 months

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

Total Months (Columns B and D)

The number of months reported for each person being included on Table 5A, is equal to the number of continuous months (rounded up to the next whole number) that that person has been in his/her current position. For example:

- Persons who have been continuously employed (contracted for) in their current position, regardless of whether or not the census day is a regular work day: Report the number of months *since they were hired*.
- Persons who have been employed more than once and whose employment was terminated between the two (or more) periods: Report the number of months since they were *most recently* hired.
- Persons who have served multiple positions in a health center (e.g., a long term physician who was recently promoted to medical director): Report the number of months *since they began the position they are being counted for*.
- Persons who are 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 9 months as medical director.)

Instructions for Columns

Full and Part Time Staff, Column A

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

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

reported on a given line on Table 5A will have been reported on the same line on Table 5, 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 1 staff person.

Months, Columns B and D

Report the total number of continuous months with the health center for those persons identified in column A or C, for example:

- A full time physician who has worked since 1/1/2012 is credited with 48 months. (4 full years × 12 months)
- Two half time physicians who began working on 7/1/2001 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 7/1/2004, is credited with 138 months. (11.5 years × 12 months)
- A cardiologist who has worked the first and third Wednesday of every month since 1/18/2012 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 1/1/2012 and medical director since 7/1/2015 is credited with 48 months as a pediatrician and 6 months as a medical director.

Questions and Answers for Table 5A

1. **Are there changes to this table?**

No.

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 year, report them as 1 person.

3. **If someone fills two roles at the health center, how do I choose which line to report them on?**

If an individual serves multiple roles for the health center (at the end of the year), report them as 1 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 2015, 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, 2011 will be counted as having 60 months tenure, even though funding or designation occurred in 2015. 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. While 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 organization in November, you would not report them on Table 5A since 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, 2015 through December 31, 2015

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				
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

Beginning with 2012, data reported on Table 6A include *all* visits with the designated diagnoses and *all* patients who received these diagnoses, regardless of whether it was a primary diagnosis, a secondary diagnosis, a tertiary diagnosis, or any other level. The Centers for Medicare and Medicaid Services (CMS) is requiring entities that bill Medicare to cease using ICD-9 codes and begin using ICD-10 codes on October 1, 2015. Because data reported on Table 6A is reported for the entire calendar year, it will require the use of both ICD-9 and ICD-10 to report 2015 data. Health centers should refer to the table for both ICD-9 and ICD-10 codes used for the specified diagnosis. The ICD-10 codes are notably different from the ICD-9 codes and it is important that health centers use the appropriate coding based on the service and where multiple codes may be indicated on a patient's chart, special attention is required to ensure that patients and their visits are unduplicated. Please note the ICD-10 transition will not affect CPT coding which is used to describe the services reported on this table.

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 electronic health records. As a subset of diagnoses and services, 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 which are generally regarded as sentinel indicators of access to primary care or are of special interest to HRSA. *Diagnoses reported on this table are those made by a medical, dental, mental health, 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 both recorded on both the line for hypertension and the line for diabetes.

The table is included in *both* the Universal report and Grant reports.

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

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

Selected Diagnoses: Lines 1 through 20d present the name and applicable ICD-9-CM and 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-9-CM or 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 are reported on Table 6A if they are included in the codes provided.

The ICD-10 codes are notably different from the ICD-9 codes and it is important that health centers use the appropriate coding based on the service and where multiple codes may be indicated on a patient's chart, special attention is required to ensure that patients and their visits are unduplicated. This manual includes the necessary codes for reporting using data drawn from both ICD-9 and ICD-10 codes. Additional information is available on the [conversion process](https://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp) at https://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp.

Selected Tests/Screenings/Preventive Services: Lines 21 through 26d present the name and applicable ICD-9-CM and ICD-10 diagnostic and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served or of particular interest to HRSA and are services performed by the health center or by contracted paid referral. On several lines both CPT codes and ICD-9 and ICD-10 codes are provided. Health centers may use *either* the CPT codes *or* the ICD-9 and ICD-10 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-9 “V-Codes” and comparable ICD-10 codes for mammography and Pap tests are listed to ensure capture of procedures which 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 which are included in the UDS. In these instances, health centers should add these codes to the published list for reporting purposes.

Health centers must actually perform the test in their labs or collect the sample and transfer it to a reference lab for the test which is paid for by third party payer to be counted. Do not report referrals or orders for tests or procedures, such as mammograms, x-rays, or tomography, which 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.) The only exception to this is lab tests ordered by a health center, but paid for by a third party payer including Medicare and Medicaid are to be included, as are mammograms performed by a health center, but read by an outside radiologist who then bills a third party.

Selected Dental Services: Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services may be performed *only by a dental provider who is reported on Lines 16–17 on Table 5 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 that fluoride treatments or varnishes which are applied outside of a comprehensive treatment plan, especially when provided as part of a community service at schools, are not to be counted nor does this activity generate a visit reported on Table 5. Dental services reported on Table 6A must be provided directly by a licensed dental provider.

Please note: Only services which are provided at a “countable” visit are reported on Table 6A; included in these would be services “attendant to” a countable visit. Thus, if a provider asks that a patient come back in 30 days for a flu shot, when that patient presents, the shot is counted because it is 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.

Multiple Entities Involved with Services: Care must be taken when multiple entities are involved with a service. In general:

- 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), 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 company⁴ 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 which sends the results back to the provider to be acted on and bills the health center which 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 which may send the results back to the provider to be acted on *but which does not bill the health center*, that test is *not* counted. Thus a health center which sends a patient to the County Health Department for a mammogram 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.

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 EHR or visit/billing record. If a visit has a diagnosis which is among the many diagnoses not listed on Table 6A, it is not reported. All visits are entered into an 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-9 or ICD-10) codes or procedure (ADA or CPT-4) codes. *During one visit, more than one test, screening, or preventive service may be provided.* If these procedures or tests are on different lines, each would be counted. If they are on the same line, only one would be counted. For example:

⁴ 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.

- One visit may involve more than one of the identified services in which case each should be reported. For example, if during a visit both a Pap test and an HIV test were provided then a visit would be reported on both Lines 21 (HIV Test) and 23 (Pap test).
- If a patient receives multiple immunizations at one visit, only one visit should be reported on Line 24.
- Services are reported *in addition to* diagnoses. A hypertensive patient who also receives an HIV test would be counted once on the hypertension Line 11 and once on the HIV test Line 21.
- 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 the flu shot line (Line 24a), but not on any diagnostic line.
- If a patient had more than one tooth filled during a visit, only one visit for restorative services (Line 32) should be reported, not one per tooth.

Number of Patients, Column B

Lines 1–20d: Patients by Diagnosis

For Column B, report each individual who had one or more visits during the year which was reported in the corresponding Column A. A patient is counted once and only once on any given line, regardless of the number of visits made for that specific diagnosis 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 of* Lines 9 and 11, regardless of how many times they were seen. Where multiple codes may be indicated on a patient's chart, special attention is required to ensure that patients are unduplicated by diagnosis. This may be a significant issue in 2015's data where a patient seen for multiple visits in 2015 is likely to have an ICD-9 diagnosis *and* an ICD-10 diagnosis for the same condition. Since both ICD-9 and ICD-10 diagnosis will be reported on the same UDS Table 6A line, the patient must be counted only once in Column B.

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 was 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. Where multiple codes may be indicated on a patient's chart, special attention is required to ensure that patients are unduplicated by service.

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. The Centers for Medicare and Medicaid Services (CMS) is requiring entities that bill Medicare to cease using ICD-9 codes and begin using ICD-10 codes on October 1, 2015. Because data reported on Table 6A is reported for the entire calendar year, it will require the use of both ICD-9 and ICD-10 to report 2015 data. Health centers should refer to the table for both ICD-9 and ICD-10 codes used for the specified diagnosis. The ICD-10 codes are notably different from the ICD-9 codes and it is important that health centers use the appropriate coding based on the service and where multiple codes may be indicated on a patient's chart, special attention is required to ensure that patients and their visits are unduplicated.. Please note the ICD-10 transition will not affect CPT coding which is used to describe the services reported on this table.

In addition, line 1-2a, First time diagnosis of HIV, has been removed from this table and is now reported only on table 6B, line 20.

2. If a case manager or health educator serves a patient who is, for example, a diabetic, we often show that diagnostic code for the visit. Should this be reported on Table 6A?

No. Report only visits with medical, dental, mental health, substance abuse, and vision providers on Table 6A. Note that diagnoses

3. The instructions call for diagnoses and services at visits. If we provide the service, but it is not counted as a visit (such as an immunization given at a health fair) should it be reported on this table?

Services given at health fairs are not counted, regardless of who provides the service or the level of documentation that is done. If a service is provided *as a result of a prescription or plan from an earlier visit that was counted it is counted*. For example, if a provider asked a woman to come back in 4 months for a mammogram that is done at the health center, it would be counted. But if the service is a self-referral where no clinical visit is necessary or provided (such as an HIV test at a health fair or a senior citizen coming in for a flu shot) *it is not counted*.

4. Some diagnostic and/or procedure codes in my system are different from the codes listed. What do I do?

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

Line #	Problem	Potential Solution
1	HIV diagnoses are kept confidential and alternative diagnostic codes are used	Include the alternative codes used at your center on these lines as well
23	Pap tests are charged to State BCCCP program using a special code	Add these special codes to the other codes listed

Line #	Problem	Potential Solution
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 EHRs.” There are some services for which I do not bill and/or for which there are no visits in my system. What do I do?

Referrals for which you do not pay (e.g., sending women to the County Health Department for a mammogram) are *not to be counted*. While health centers are only required to report data derived from billing systems or EHRs, 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 or another of the templates available. In order 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 which the clinic does not charge for because they received it free from the Vaccine for Children program, the regular code with an extension may be used to indicate that it is not to be billed or the code may have a zero charge attached to it.

Line #	Problem	Potential Solution
21	HIV tests are collected by us, but processed and paid for by the State and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge. Alternatively, you may use the correct code with a “.52” extension to indicate you did not do the complete test.
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. Alternatively, you may use the correct code with a “.52” extension which indicates that not all components of the service was provided by the health center.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the correct code with a “.52” extension to indicate you did not do the technical component of the test.
24	Flu shots and other vaccinations are not counted because the vaccines are obtained at no cost to the center.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the correct code with a “.52” extension to indicate you did not do the technical component of the test.

Line #	Problem	Potential Solution
25	Contraceptive management is funded under Title X or a State family planning program and does not have a V-25 or Z30 diagnosis attached to it.	Preferred: Add a “dummy code” you can map to the V-25 code. Alternative: Code with both the V-25/Z30 and the State mandated code but suppress printing of the V-25/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 (i.e., SBIRT and/or treatment of counseling for mental health and/or substance use disorders) provided during a medical visit.

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2015 through December 31, 2015

Table 6A: Selected Diagnoses

Diagnostic Category		Applicable ICD-9-CM Code	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	042 , 079.53, V08	B20, B97.35, O98.7, Z21		
3.	Tuberculosis	010.xx – 018.xx	A15- thru A19-		
4.	Sexually transmitted infections	090.xx – 099.xx	A50- thru A64- (Exclude A63.0), M02.3-, N34.1		
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32, V02.61	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51		
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71, V02.62	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52		
Selected Diseases of the Respiratory System					
5.	Asthma	493.xx	J45-		
6.	Chronic obstructive pulmonary diseases	490.xx – 492.xx	J40- thru J44- and J47-		
Selected Other Medical Conditions					
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.71-, C50.81-, C50.91-, C79.81, D48.6-, R92-		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x	C53-, C79.82, D06-, R87.61-, R87.810, R87.820		

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis (b)
9.	Diabetes mellitus	250.xx; 648.0x	E10- thru E13-, O24- (Exclude O24.41-)		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx	I01-, I02- (exclude I02.9), I20- thru I25, I26- thru I28-, I30- thru I52-		
11.	Hypertension	401.xx – 405.xx;	I10- thru I15-		
12.	Contact dermatitis and other eczema	692.xx	L23- thru L25-, L30- (Exclude L30.1, L30.3, L30.4, L30.5), L55- thru L59 (Exclude L57.0 thru L57.4)		
13.	Dehydration	276.5x	E86-		
14.	Exposure to heat or cold	991.xx – 992.xx	T33.XXXA, T34.XXXA, T67.XXXA, T68.XXXA, T69.XXXA		
14 a.	Overweight and obesity	ICD-9 : 278.0 – 278.03 or V85.xx excluding V85.0, V85.1, V85.51 V85.52	E66-, Z68- (Excluding Z68.1, Z68.20-24, Z68.51, Z68.52)		
Selected Childhood Conditions (limited to ages 0 thru 17)					
15.	Otitis media and Eustachian tube disorders	381.xx – 382.xx	H65- thru H69-		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)	A33-, P20- thru P29- (exclude P22.0, P29.3); P35- thru P96- (exclude P50-, P51-, P52-, P54-, P91.6-, P92-, P96.81), R78.81, R78.89		

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis (b)
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.	260.xx – 269.xx (excluding 268.2); 779.3x; 783.3x – 783.4x;	E40-E46, E50- thru E63- (exclude E64-), P92-, R62- (exclude R62.7), R63.2, R63.3		
Selected Mental Health and Substance Abuse Conditions					
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x	F10-, G62.1		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 292.9, 304.xx, 305.2x – 305.9x 357.6x, 648.3x	F11- thru F19- (Exclude F17-), G62.0, O99.32-		
19 a.	Tobacco use disorder	305.1	F17-		
20 a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx	F30- thru F39-		
20 b.	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3,309.81	F40- thru F42- F43.0, F43.1-		
20 c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx	F90- thru F91-		
20 d.	Other mental disorders, excluding drug or alcohol dependence	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 307.xx, 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)	F01- thru F09-, F20- thru F29-, F43- thru F48- (exclude F43.1-), F50- thru F59- (exclude F55-), F60- thru 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-9-CM or CPT-4/II Code	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; 86701-86703; 87390-87391	CPT-4: 86689; 86701-86703; 87390-87391		
21 a.	Hepatitis B test	CPT-4: 86704, 86706, 87515-17	CPT-4: 86704, 86706, 87515-17		
21 b.	Hepatitis C test	CPT-4: 86803-04, 87520-22	CPT-4: 86803-04, 87520-22		
22.	Mammogram	CPT-4: 77052, 77057 OR ICD-9: V76.11; V76.12	CPT-4: 77052, 77057 OR ICD-10: Z12.31		
23.	Pap test	CPT-4: 88141-88155; 88164-88167, 88174-88175 OR ICD-9: V72.3; V72.31, V72.32; V76.2	CPT-4: 88141-88155; 88164-88167, 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 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748	CPT-4: 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24 a.	Seasonal Flu vaccine	CPT-4: 90654 – 90662, 90672-90673, 90685-90688	CPT-4: 90654 – 90662, 90672-90673, 90685-90688		
25.	Contraceptive management	ICD-9: V25.xx	ICD-10: Z30-		

Service Category		Applicable ICD-9-CM or CPT-4/II Code	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99391-99393; 99381-99383;	CPT-4: 99391-99393; 99381-99383;		
26 a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	CPT-4: 83655		
26 b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408-99409	CPT-4: 99408-99409		
26 c.	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; HCPCS: S9075, CPT-II: 4000F, 4001F	CPT-4: 99406 and 99407; HCPCS: S9075, CPT-II: 4000F, 4001F		
26 d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	CPT-4: 92002, 92004, 92012, 92014		

Service Category		Applicable ADA Code	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services					
27.	I. Emergency Services	ADA : D9110	ADA : D9110		
28.	II. Oral Exams	ADA : D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	ADA : D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180		
29.	Prophylaxis – adult or child	ADA : D1110, D1120,	ADA : D1110, D1120,		
30.	Sealants	ADA : D1351	ADA : D1351		
31.	Fluoride treatment – adult or child	ADA :, D1206, D1208	ADA :, D1206, D1208		
32.	III. Restorative Services	ADA : D21xx – D29xx	ADA : D21xx – D29xx		

Service Category		Applicable ADA Code	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
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-D7294	ADA : D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290-D7294		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA : D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	ADA : D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes:

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2014. American Academy of Professional Coders
- International Classification of Diseases, 2014, Complete Draft Code Set (ICD-10-CM). American Academy of Professional Coders
- Current Procedural Terminology, (CPT) 2014. American Medical Association.
- Current Dental Terminology, (CDT) 2015 – Dental Procedure Codes. American Dental Association (ADA).

NOTE: x or - in a code denotes any number including the absence of a number in that place. ICD-10 codes all have at least 4-digits.

Instructions for Table 6B: Quality of Care Measures

Table 6B is included only in the Universal report. It is completed by all health centers. Beginning with CY 2015 reporting, additional reporting changes have been made to this table and are outlined in the instructions below.

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.

These quality of care measures are “process measures” which means that they document services which 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 improved health status. Thus, by increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, we can expect improved health status of the patient population in the future. Specifically:

PLEASE NOTE IMPORTANT CLARIFICATION FOR 2015

In order to streamline the process for reporting on clinical quality measures, and encourage the use of electronic health records to report on the full universe of patients for the UDS clinical performance measures in Table 6B and Table 7, health centers may use an EHR in lieu of a chart sample if at least 80% of all health center patient records are included in the EHR for any given measure.

- **Trimester of entry into prenatal care:** *If women enter care in their first trimester, then the probability of adverse birth outcome will be reduced.*
- **Childhood immunization:** *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 HPV infection and cervical cancer.*
- **Weight assessment and counseling for children and adolescents:** *If clinicians ensure that their patients' body mass indicator (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.*
- **Adult Weight screening and follow-up:** *If clinicians routinely calculate and record the BMI for their adult patients, and if they identify patients with weight problems and develop a follow-up plan for overweight and underweight patients, then the likelihood of the debilitating sequela of serious weight problems can be reduced.*
- **Tobacco use 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.*

- **Asthma pharmacologic therapy:** *If patients identified with persistent asthma are provided with appropriate pharmacological intervention, then they will be less likely to have asthma attacks, they will require fewer emergency room visits, and be less likely to develop complications related to asthma including death.*
- **Coronary artery disease (CAD): Lipid therapy:** *If clinicians ensure that 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): Aspirin or antithrombotic therapy:** *If clinicians ensure that patients with established ischemic vascular disease (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 50 to 75 years old 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 initial HIV diagnosis, then the probability of HIV-related complications and transmission of disease are reduced.*
- **Patients screened for depression and follow-up:** *If patients age 12 and older 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:** *If patients age 6 through 9 with moderate to high risk for caries are provided sealants on first permanent molars, then they will be less likely to experience dental decay.*

While the selected quality of care measures give a good overall description of the overall quality of primary care being provided at the center, it is clear that this is a subset of possible quality of care measures. The clinical quality measures described in this manual must be reported by all health centers. However, individual health centers may use additional measures, including modified versions of these measures in their grant applications, or for other internal purposes at their discretion. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) is encouraged for organizations capable of appropriately using this resource as defined below to support the data reporting of these quality of care measures.

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.

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
- 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” includes patients who:

- Receive all their prenatal care from the health center
- Were referred by the health center for all their prenatal care or began prenatal care with another provider but transferred to the health center
- Began prenatal care with the health center, but were transferred to another provider at some point during their prenatal care
- 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: Trimester of Entry into Prenatal Care (Lines 7–9)

Performance Measure: The performance measure is “Proportion of prenatal care patients who entered treatment during their first trimester.” The measure itself, which is not dependent on which category of performance measurement achievement a woman might fall into, is calculated as follows:

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

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

Detailed Instructions for Clinical Measure

All patients who received prenatal care, either directly or through a referral, including, but not limited to, the delivery of a child 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 which 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 or when they do lab tests, or 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): Includes 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 conception.⁵ 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): Includes 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 26th week after conception. 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 in 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): Includes women who were prenatal care patients during the reporting period and whose “first visit” occurred when they were estimated to be 27

⁵ The end of the 13th week is used if health center calculates pregnancy as of conception. Obstetricians may count time from last reported menstrual period (LMP). Since this is two weeks earlier than conception, the first trimester would be considered up through 15 weeks post-LMP. The second trimester is through 28 weeks post-LMP. Trimester may be based on other data if conception or LMP data are not available.

weeks or more after conception. 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 since it would require women to have begun care and then transferred in a very short period of time.)

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received 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 M: Other Quality of Care Measures

In these sections, health centers will report on the findings of their reviews of services provided to targeted populations of 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. These targeted populations, reported in Column A, are:

Section C: Childhood Immunization (Line 10)

Children with at least one medical visit during the reporting period, who had their third birthday during the reporting period, and who were first seen ever by the health center prior to their third birthday are reported on Line 10. For the purposes of this year's reporting this includes children whose date of birth is between January 1, 2012, and December 31, 2012.

Section D: Cervical Cancer Screening (Line 11)

Women aged 21 through 64 with at least one medical visit during the reporting period, who were first seen by the health center at some point prior to their 65th birthday are reported on Line 11. For the purposes of this year's reporting this includes women whose date of birth is between January 1, 1951, and December 31, 1991. (NOTE: This is the same measure that had been previously called "Women 24 through 64" for clarity purposes. No women aged 21, 22, or 23 in the reporting period should be included in the calculation of this measure.)

Section E: Weight Assessment and Counseling for Children and Adolescents (Line 12)

Children and adolescents aged 3 through 17 with at least one medical visit during the reporting period, who had their third birthday during or prior to the reporting period, and who were first seen ever by the health center prior to their 18th birthday are reported on Line 12. For the purposes of this year's reporting this includes children and adolescents whose date of birth is between January 1, 1998, and December 31, 2012.

Section F: Adult Weight Screening and Follow-up (Line 13)

Adults age 18 or older, with at least one medical visit during the reporting period and seen after their 18th birthday are reported on Line 13. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1997.

Section G: Tobacco Use Screening and Cessation Intervention (Line 14a)

Adults age 18 or older, seen after 18th birthday, with at least one medical visit during the reporting period, and with at least two medical visits ever, are reported on Line 14. For the purposes of this year's reporting this includes all medical patients born on or before December 31, 1997.

Section H: Asthma Pharmacologic Therapy (Line 16)

Patients age 5 through 40 with at least one medical visit during the reporting period and at least two visits ever, with a diagnosis of mild, moderate or severe persistent asthma are reported on Line 16. For the purposes of this year's reporting this includes all patients with persistent asthma born between January 1, 1975, and December 31, 2010.

Section I: Coronary Artery Disease (CAD): Lipid Therapy (Line 17)

Adults age 18 or older, seen after their 18th birthday, who had at least one medical visit during the reporting period, and with at least two medical visits ever, who have an active diagnosis of CAD including myocardial infarction (MI) or who have had cardiac surgery, are reported on Line 17. For the purposes of this year's reporting this includes medical patients meeting the clinical profile who were born on or before December 31, 1997.

Section J: Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy (Line 18)

Adults age 18 or older, seen after 18th birthday, who had at least one medical visit during the reporting period who, (1) during the current or prior year, were diagnosed with IVD OR (2) were discharged after coronary artery bypass surgery (CABG) or percutaneous transluminal coronary angioplasty (PTCA) or acute myocardial infarction (AMI) between January 1, and November 1, *of the year prior to the measurement year* are reported on Line 18. For the purposes of this year's reporting this includes all medical patients meeting the clinical profile who were born on or before December 31, 1997.

Section K: Colorectal Cancer Screening (Line 19)

Adults age 51 through 74, who had at least one medical visit during the reporting period, are reported on Line 19. For the purposes of this year's reporting this includes medical patients whose date of birth is between January 1, 1941, and December 31, 1964.

Section L: HIV Linkage to Care (Line 20)

Patients who were diagnosed for the first time ever with HIV between October 1, 2014, and September 30, 2015 are reported on Line 20.

Section M: Patients Screened for Depression and Follow-up (Line 21)

Patients age 12 and older, who had at least one medical visit during the reporting period, are reported on Line 21. For the purposes of this year's reporting this includes medical patients who were born on or before December 31, 2003.

Section N: Dental Sealants (Line 22)

Patients age 6 through 9, who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting period who are at moderate to high risk for caries, are reported on Line 22. For the purposes of this year's reporting this includes all dental patients meeting the assessment profile whose date of birth is between January 1, 2006, and December 31, 2009.

Data for Columns B and C of these sections may be obtained from an Electronic Health Record (EHR) that includes at least 80% of the patients who fit the criteria described in this section or

from an audit of charts selected through a process of scientific random sampling (methods described in [Appendix C](#)).

Column Instructions

Column A: Number of Patients in the “Universe”

Enter the total number of health center patients who fit the detailed criteria described below. Column A will reflect the *total number of patients meeting the criteria in the agency’s total patient population including all sites and all programs*.

Because the initial patient population for each measure is defined in terms of age (or age and gender), 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 2) Table 3A measures age as of June 30 of the calendar year but Table 6B defines specific time period (i.e., by December 31) to measure age. 3) Some Table 6B measures require that the patient has had more than one visit, but Table 3A reflects patients with one or more visit.

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

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will be:

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

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 as 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 EHR if:

- The EHR does *not include* a minimum of 80% of health center patients who meets the criteria described below for inclusion in the specific measure’s universe.
- The EHR does *not exclude* every single health center patient who meets one or more exclusion criteria described below for exclusion from the universe.
- 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 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 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 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 EHR is used, the number in Column B (records reviewed) must be no less than 80% 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

Enter the total number of records which meet the measurement standard as discussed below. The number in Column C (patients meeting the measurement standard) may never exceed the number in Column B (patient records reviewed).

Defining the Universe: "Criteria" vs. "Exclusions" in EHRs vs. Chart Reviews

Because the UDS follows the structure developed for Meaningful Use and other systems, 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 EHR report or identify charts to be replaced in a chart review process.

In the discussion which follows the concepts of "conditions" or "criteria" are at times juxtaposed with "exclusions." This is partly because of the differing language and procedures in an EHR (or PMS) based report versus a Chart Audit report. In an EHR or PMS review, all criteria for a measure must be able to be found in the EHR and must be in the EHR for each and every patient at the health center. To the extent that they cannot be found, they will distort the findings, and means that the EHR must not be used. If, for example, the EHR cannot differentiate between a medical patient and a dental-only patient, then the EHR cannot be used to review the immunization of 3 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, you can ask that all 3 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 criteria that they must be medical patients for the immunization measure.)

Detailed Instructions for Clinical Measures

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

In this section, when conditions are linked with "**and**" it means that each of the conditions must be met independently. If some, but not all of the conditions are met, the services for that patient are considered to have failed to meet the measurement standard. Where conditions are linked with "**or**" it means that if either of the conditions is met the measure is satisfied.

Note that some of the newer measures do not correspond directly with traditional ICD-9, ICD-10, or CPT codes. As a result, we have also included some CPT Category II codes (shown as CPT-II) which are specific to performance measures. These may be found in an appendix to most CPT manuals titled Category II Codes.

Childhood Immunization (Line 10)

Performance Measure: The performance measure is “Percentage of children with their 3rd birthday during the measurement year who are fully immunized before their third birthday.” This is calculated as follows:

- **Numerator:** Number of children among those included in the denominator who were fully immunized before their 3rd birthday; 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 prior to their third birthday:⁶
 - 4 DTP/DTaP,
 - 3 IPV,
 - 1 MMR,
 - 3 Hib,
 - 3 HepB,
 - 1VZV (Varicella), and
 - 4 Pneumococcal conjugate
- **Denominator: Number** of all children with at least one medical visit during the reporting period, who had their 3rd birthday during the reporting period; for measurement year 2015, this includes all children with date of birth between January 1, 2012, and December 31, 2012. Children who were never seen by the clinic prior to their third birthday are to be excluded. There will no doubt be a number of children for whom no vaccination information is available and/or who were first seen at a point when there was simply not enough time to fully immunize them prior to their third birthday. They still must be included in the universe and thus in the denominator.

Total Number of Patients with 3rd Birthday during Measurement Year, Column (A)

Enter number of children who:

- Were born between January 1, 2012, and December 31, 2012, **and**
- Had at least one medical visit during the reporting year, including children who were seen only for the treatment of an acute or chronic condition and those who were never seen for well child care **and**
- Were seen for the first time ever prior to their third birthday. (This could have been in 2012, 2013, 2014, or 2015.)

Include all children meeting this criterion regardless of whether they came to the health center for well child⁷ services or other medical services which include vaccinations or they came for treatment of an injury or illness. *Note that children whose only service was receipt of a vaccination, and who never received other services, are not to be counted as patients on any of the demographic tables and are not included in the universe for this table.*

Children who had a contraindication for a specific vaccine should be included in the universe. In your review, they should be counted as being “compliant” for that specific

⁶ This measure is aligned with the Healthy People 2020 IID-8 measure.

⁷ 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.

vaccine and then reviewed for the administration of the rest of the vaccines. Contraindications should be looked for as far back as possible in the patient's history. The following may be used to identify contraindications which permit allowable vaccination-exclusions:

- Any particular vaccine: Allergic reaction to the vaccine or its components: ICD-9: 999.4; ICD-10: T80.51-
- 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: 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.
- VZV, MMR:
 - Immunodeficiency, including genetic (congenital) immunodeficiency syndromes ICD-9: 279; ICD-10: 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: B20, Z21
 - Cancer of lymphoreticular or histiocytic tissue ICD-9: 200-202; ICD-10: 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: C90-, C88- (exclude C88.0). Leukemia ICD-9: 204-208; ICD-10: 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
- IPV: Allergic reaction to streptomycin, polymyxin B, or neomycin
- Hib: None
- Hepatitis B: Allergic reaction to common baker's yeast
- Pneumococcal conjugate: None

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. This will be all patients who fit the criteria; or, if an EHR is used to report, a number equal to no less than 80% of Column A; or, a scientifically drawn sample of 70 patients from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, if the health center only has immunization data for those patients in their immunization registry, this would be unacceptable even if it were greater than 80% of the patients in Column A.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients Immunized, Column (C)

Enter in Column C the number of children from Column B who have received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate prior to their 3rd birthday. 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 third 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 pertussis vaccine.
- **IPV:** At least three polio vaccinations (IPV) with different dates of service before the child's third 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 third birthday
- **HIB:** Three H influenza type B (HiB) vaccinations, with different dates of service before the child's third 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 third 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 third birthday
- **Pneumococcal conjugate:** At least four pneumococcal conjugate vaccinations before the child's third birthday

The following ICD-9, ICD-10, 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. NOTE ALSO: Many State and county entities participating in the Vaccines for Children (VFC) program assign their own unique codes to some or all of these vaccines. It is the intent of this report to include all such codes as well.

- **DTaP:** CPT (90698, 90700, 90701, 90720, 90721, 90723); ICD-9 (99.39)
- **Diphtheria and tetanus:** CPT (90702)
- **Diphtheria:** CPT (90719); ICD-9(VO2.4*, 032*, 99.36); ICD-10 (Z22.2, A36-)
- **Tetanus:** CPT (90703); ICD-9 (037*, 99.38); ICD-10 (A35)
- **Pertussis:** ICD-9 (033*, 99.37); ICD-10 (A37-)

- **IPV:** CPT (90698, 90713, 90723); ICD-9 (V12.02*, 045*, 99.41); ICD-10 (Z86.12, A80-)
- **MMR:** CPT (90707, 90710)
- **Measles and Rubella:** CPT (90708)
- **Measles:** CPT (90705); ICD-9 (055*, 99.45); ICD-10 (B05-)
- **Mumps:** CPT (90704); ICD-9 (072*, 99.46); ICD-10 (B26-)
- **Rubella:** CPT (90706); ICD-9 (056*, 99.47); ICD-10 (B06-)
- **Hib:** CPT (90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748); ICD-9 (041.5*, 038.41*, 320.0*, 482.2*); ICD-10: 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 (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 (B01-, B02-)
- **Pneumococcal conjugate:** CPT (90669, 90670)

*Indicates evidence of disease. A patient who has evidence of the disease prior to age 3 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 including the specific dates and types of immunizations administered. Immunization information may also be obtained from an immunization registry maintained by the State or other public body as long as it shows comparable information, but immunization registries generally do not update the 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 which fail do not meet the measurement standard, including:

- Parental failure to bring in the patient
- Parents who refuse for personal or religious reasons
- 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)

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

- **Numerator:** Number of female patients 24–64 years of age receiving one or more documented Pap tests during the measurement year or during the **2** calendar years prior to the measurement year among those women included in the denominator; **or**, for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, if the test was done during the measurement year or during the **4** calendar years prior to the measurement year
- **Denominator:** Number of all female patients age 24–64 years of age during the measurement year who had at least one medical visit during the reporting year; for measurement year 2015, this includes women with a date of birth between January 1, 1951, and December 31, 1991.

Total Number of Female Patients 24-64 Years of Age, Column (A)

Criteria: Enter the number of all female patients who:

- Were born between January 1, 1951, and December 31, 1991, **and**
- Were first seen by health center prior to their 65th birthday, **and**
- Had at least one medical visit in a clinical setting⁸ during 2015.

Exclusions: Women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient’s history, through either administrative data or medical record review. Surgical codes for hysterectomy are: CPT (51925, 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: 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.

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients from the universe (Column A) for whom data have been reviewed. This will *either* be all patients who fit the criteria **or** (if an EHR

⁸ The requirement of “in a medical setting” is explicitly designed to exclude from the universe women encountered by homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit Pap tests to be conducted. Mobile clinics that are designated by the 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.

is used to report, a number equal to no less than 80% of Column A), **or** a scientifically drawn sample of 70 patients selected from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients or exclude one or more of their sites which may not yet be included in their EHR. If a woman in the random selection is found to meet the exclusion criteria, the record is removed from the sample and another woman should be randomly selected to replace her. This can best be accomplished by selecting replacement cases at the same time that the random sample is identified.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate "Women's Health" database that is restricted to women who are specifically receiving health care focused on the reproductive system.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients Tested, Column (C)

Criteria: Enter the total number of female patients included in the sample, who either:

- Received one or more Pap tests in a 3-year period from 2013 through 2015 **or**
- Received one or more Pap tests in a 5-year period from 2011 through 2015 **and** was 30 years of age or older at the time of her last Pap test **and** chose to have a Pap test and an HPV test done simultaneously.

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 which documents the name, date, and results from a test performed by another provider which is based on communications between the clinic and the provider is also acceptable.

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

- CPT: PAP = 88141-88155, 88164-88167, 88174-88175; HPV = 87620-87622
- ICD-9-CM: 91.46, V72.32; ICD-10-CM: Z01.42
- CPT-II: 3015F = Pap test

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

Weight Assessment and Counseling for Children and Adolescents (Line 12)

Performance Measure: The performance measure is “Percentage of patients aged 3 -17 years of age who had evidence of BMI *percentile* documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement year.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement year
- **Denominator:** Number of patients who were 3 years of age through adolescents who were aged 17 at some point during the measurement year, who had at least one medical visit during the reporting year, and were seen by the health center for the first time prior to their 18th birthday; for measurement year 2015, this includes patients with a date of birth between January 1, 1998, and December 31, 2012.

Total Number of Patients 3 through 17 Years of Age, Column (A)

Criteria: Enter the number of all patients who:

- Were born between January 1, 1998, and December 31, 2012, *and*
- Were first seen ever by the health center prior to their 18th birthday, *and*
- Had at least one medical visit⁹ in a clinical setting¹⁰ during 2015.

Exclusions: Pregnant patients

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria **or** if an EHR is used to report, a number no less than 80% of Column A) *or* a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population. Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center’s EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate “well child” database that is restricted to children who are specifically receiving well child care.

⁹ Health centers should add to their universe those patients whose only visits were well child visits (99382-99384, 99392-99394), 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.

¹⁰ The requirement of “in a medical setting” is explicitly designed to exclude from the universe children and adolescents whose only visits have been in homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting such as a shelter which cannot be configured to permit weight and height measurements. Mobile clinics that are designated by the health center as approved “sites” are considered to be clinical settings and children and adolescents seen in these clinics are included in the universe.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Documented Counseling and BMI Percentile, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that their BMI percentile (not just height and weight or numeric BMI score from which the BMI percentile can be calculated) was documented during the measurement year **and** that they received counseling on nutrition during the measurement year **and** counseling on physical activity during the measurement year.

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

- ICD-9 code V85.5x and ICD-10 code Z68.5- are for recording BMI percentile. Presence is sufficient, but not necessary.
- Codes 97802-97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary.
- ICD-9 code V65.41 and ICD-10 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.

Adult Weight Screening and Follow-Up (Line 13)

Performance Measure: The performance measure is “Percentage of patients aged 18 and older with a documented BMI during the most recent visit or within the 6 months prior to that visit **and** when the BMI is outside of normal parameters a follow-up plan is documented.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit **or** within 6 months of the most recent visit **and** if the most recent BMI is outside of normal parameters, a follow-up plan is documented
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year; for measurement year 2015, this includes patients with a date of birth on or before December 31, 1997.

Total Number of Patients Age 18 and Over, Column (A)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1997 **and**
- Were last seen by the health center after their 18th birthday, **and**
- Had at least one medical visit in a clinical setting¹¹ during 2015.

¹¹ The requirement of “in a medical/clinical setting” is explicitly designed to exclude from the universe patients whose only visits have been in homeless or agricultural worker programs in a field setting such as a park or encampment, or in an outreach setting

Exclusions:

- Pregnant women
- Terminally ill patients (no definition is provided)

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria **or** if an EHR is used to report, a number no less than 80% of Column A) **or** a scientifically drawn sample of 70 patients selected from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate database that is restricted to enrollees in a managed care plan who must be provided with weight tracking services. This would be unacceptable even if it were greater than 80% of the patients in Column A.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Documented BMI and Follow-Up Plan if Weight is Outside Parameters, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that their BMI (not just height and weight) was documented during their last visit or within 6 months prior to that visit, **and** which demonstrates that they received a follow-up plan to address their weight if they:

- Were under age 65 **and** their BMI was greater than or equal to 25, **or**
- Were age 65 or older **and** their BMI was greater than or equal to 30, **or**
- Were under age 65 **and** their BMI was under 18.5, **or**
- Were age 65 or older **and** their BMI was under 23.

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: 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

such as a shelter which 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 patients seen in these clinics are included in the universe.

fact that an EHR is capable of calculating BMI does not replace the presence of the BMI itself.

Tobacco Use Screening and Cessation Intervention (Line 14a)

Performance Measure: The performance measure is “Percentage of patients aged 18 and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit **or** within 24 months of the most recent visit and received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least *two*¹² medical visits ever; for measurement year 2015, this includes patients with a date of birth on or before December 31, 1997.

Total Number of Patients Age 18 and Over, Column (A)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1997, **and**
- Were last seen by health center after their 18th birthday, **and**
- Had at least one medical visit during 2015, **and**
- Had at least two medical visits ever.

Exclusions: None

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria **or** if an EHR is used to report, this will be a number no less than 80% of Column A **or** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center’s EHR is only able to provide data for a subset of column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

¹² Two visits are specified in order to ensure that the patient has a relationship with the health center. The universe *may* be enlarged to include other patients whose relationship is demonstrated by having had a behavioral assessment, concomitant occupational therapy, or concomitant mental health visits; however health centers are not expected to search for these patients.

Number of Patients Queried about Tobacco Use and Received Cessation Counseling Intervention, As Appropriate, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that 1) they had been asked about their use of any and all forms of tobacco at their most recent visit or at a visit within 24 months of the last visit **and** 2) if they are found to be a tobacco user:

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

- 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: 99406-07 = Smoking and tobacco use cessation counseling—sufficient, but not necessary
- 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

Asthma Pharmacologic Therapy (Line 16)

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

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided inhaled corticosteroid or an accepted alternative medication
- **Denominator:** Number of patients who were 5 through 40 years of age at some point during the measurement year, who have been seen at least twice in the practice and who had at least one medical visit during the reporting year, who had an active diagnosis of persistent asthma; for measurement year 2015, this includes patients with a date of birth between January 1, 1975, and December 31, 2010.

Total Number of Patients Age 5 through 40, Column (A)

Criteria: Enter the number of all patients who:

- Were born on or after January 1, 1975, and on or before December 31, 2010, **and**
- Were last seen by health center while they were age 5 through 40 years, **and**

- Have been seen at least twice (not necessarily in the current year), **and**
- Had at least one medical visit during 2015, **and**
- Were diagnosed with ***persistent***¹³ asthma **or** have persistent asthma as a current diagnosis on a chronic illness form or template.

Exclusions:

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

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria OR, if an EHR is used to report, this will be a number no less than 80% of Column A OR a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and *must not* be restricted by any variable related to the test measure.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Persistent Asthma with Pharmacologic Treatment Documented, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that they had:

- Received a prescription for or were using an inhaled corticosteroid, **or**
- Received a prescription for or were using an acceptable pharmacological agent, specifically: inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

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

- ICD-9 (493.x) and ICD-10 (J45.x, J45.9x) = Asthma (to narrow the population to be sampled if *persistent* asthma cannot be determined)

¹³ It is the clear intent that the universe be limited to patients with *persistent* asthma and, specifically, that patients with mild intermittent asthma, for which no daily medication is needed, be excluded from the universe. But, while there are CPT Category II codes that differentiate between these conditions, there are no traditional ICD-9 codes which do so. However, there are ICD-10 codes which do. [Appendix C](#) describes sampling techniques that can be used to find these patients if CPT-II codes are not being used.

- 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 CPT-II/ICD-9/ICD-10 codes will be useful in identifying patients to be excluded from the universe:

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

Coronary Artery Disease (CAD): Lipid Therapy (Line 17)

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

- **Numerator:** Number of patients in the denominator who received a prescription for or were provided or were taking lipid lowering medications
- **Denominator:** Number of patients who were seen during the measurement year after their 18th birthday, who had at least one medical visit during the reporting year, with at least two medical visits ever, and who had an active diagnosis of coronary artery disease (CAD) including any diagnosis for myocardial infarction (MI) or who had had cardiac surgery in the past; for measurement year 2015, this includes patients with a date of birth on or before December 31, 1997.

Total Number of Patients Age 18 and Older with CAD Diagnosis, Column (A)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1997, **and**
- Were last seen by health center after their 18th birthday, **and**
- Had at least one medical visit during 2015, **and**
- Had at least two medical visits ever, **and**
- Have an active diagnosis of coronary artery disease (CAD) **or** were diagnosed as having had a myocardial infarction (MI) **or** have had cardiac surgery¹⁴.

Exclusions:

- Individuals whose last 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

Number of Charts Sampled or EHR Total, Column (B)

¹⁴ 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 EHR reporting capabilities to identify patients with a history of pertinent cardiac surgeries.

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria **or**, if an EHR is used to report, this will be a number no less than 80% of Column A **or** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a list of those only seen by their cardiologist.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients Prescribed a Lipid Lowering Therapy, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that they had

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

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

- CAD and MI = ICD-9 (410.xx, 411.xx, 412, 413.xx, 414.0x, 414.8, 414.9); ICD-10 (I20-, I21- thru I24-, I25- (excludes I20.0, I25.3, I25.4-, I25.82, I25.83, I25.84))
- History of surgeries = ICD-9 (V45.81, V45.82); ICD-10 (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): Aspirin or Anti-Thrombotic Therapy (Line 18)

Performance Measure: The performance measure is "Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year *or* who had a diagnosis of ischemic vascular disease during 2015 who had documentation of use of aspirin or another antithrombotic." This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed, or used
- **Denominator:** Number of patients who were aged 18 and older at some point during the measurement year, who had at least one medical visit during the reporting year, who had an active diagnosis of ischemic vascular disease (IVD) during the current or prior year OR had been discharged after AMI or CABG or PTCA in the prior year; for

measurement year 2015, this includes patients with a date of birth before December 31, 1997.

Total Number of Patients Age 18 and Older with IVD Diagnosis, Column (A)

Criteria: Enter the number of all patients who:

- Were born on or before December 31, 1997, **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 2015, **and**
- Had an active diagnosis of ischemic vascular disease (IVD) during 2014 or 2015 OR had been discharged after AMI or CABG or PTCA during 2014.

Exclusions: None

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria OR, if an EHR is used to report, this will be a number no less than 80% of Column A OR a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a list of only those seen by their cardiologist.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Aspirin or Other Anti-Thrombotic Use, Column (C)

Enter the total number of patients identified in Column B whose 2015 medical record demonstrates that they had

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

The following CPT/ICD-9/ICD-10 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: I20-, I21-, I24-, I25-, I63- thru I63.2-, 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 I25.4-, I25.82, I25.83, I25.84)

- History of surgeries = CPT (33510-33514, 33516-33519, 33521-33523, 33533--33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943)

Colorectal Cancer Screening (Line 19)

Performance Measure: The performance measure is “Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer.” This is calculated as follows:

- **Numerator:** Number of patients aged 51 through 74 with appropriate screening for colorectal cancer
- **Denominator:** Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year.¹⁵

NOTE: Though age 50 to 75 is in the title of this measure, the detail calls for persons to be screened within a year of turning 50 and prior to reaching age 75. For measurement year 2015, this includes patients whose date of birth is between January 1, 1941, and December 31, 1964.

Documented colonoscopy conducted during the measurement year or the previous 9 years or flexible sigmoidoscopy conducted during the measurement year or the previous 4 years meet the measurement standard criteria. 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 EHR or other computerized system. It is possible that the procedures were performed elsewhere, but confirmation of this is required by having in the chart either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results of the test. Fecal occult blood test (FOBT), including the fecal immunochemical test (FIT), can also be used to document meeting the measurement standard. Since 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 2014, (for example) would still need one in 2015 even if the patient did not present in the clinic after June of 2015. Stool specimens for FOBT, including FIT, should be collected by patients at home, as recommended by the manufacturer. An in-office obtained stool specimen (including a sample obtained through a digital rectal examination) does not meet the measurement standard, nor does it comply with manufacturers’ recommendations or national screening guidelines. Test kits can be mailed to patients during the year, but receipt and processing of the test sample is required. Evidence of mailing is not, in and of itself, sufficient.

Total Number of Patients Age 51 through 74, Column (A)

Criteria: Enter the number of all patients who:

- Were born between January 1, 1941, and December 31, 1964, **and**
- Had at least one medical visit during 2015.

Exclusions: Patients who have or who have had colorectal cancer or colectomy

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria OR, if an EHR is used to report, this will be a number no less than 80% of Column A OR a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

¹⁵ The CMS Meaningful Use criteria for this measure includes persons seen at any point within the last two years, however, for the purposes of reporting in UDS Table 6B, medical patients must have had one medical visit during the current measurement year.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and *must not* be restricted by any variable related to the test measure.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Appropriate Screening for Colorectal Cancer, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that they had:

- a colonoscopy after January 1, 2006, **or**
- a flexible sigmoidoscopy after January 1, 2011, **or**
- a fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test *during* the measurement year.

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

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

HIV Linkage to Care (Line 20)

Performance Measure: The performance measure is “Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.”¹⁶ This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis
- **Denominator:** Number of patients first diagnosed with HIV between October 1, of the prior year through September 30, of the current measurement year

Total Number of Patients with a First Time Ever Diagnosis of HIV, Column (A)

Criteria: Enter the number of all patients who:

- Were diagnosed with HIV for the first time ever¹⁷ between October 1, 2014, and September 30, 2015¹⁸, **and**

¹⁶ Note that this measure does not conform to the calendar year reporting requirement.

- Had at least one medical visit during 2015 or 2014.

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

Exclusions: None

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. For this measure, this will almost always be all patients who fit the criteria (i.e., the same number as in Column A) *or*, if an EHR is used to report, this will be a number no less than 80% of Column A *OR* a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.. If a sample is to be used it must be a sample of 70 and must be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and must not be restricted by any variable related to the test measure.

In the event that fewer than 70 patients meet the criteria (which will likely be the case for most health centers for this measure) and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Appropriate Follow-Up, Column (C)

Enter the total number of patients identified in Column B whose record demonstrates that, within 90 days of the visit where they were tested positive for HIV they had

- A medical visit with a health center provider who initiates treatment for HIV, **or**
- 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 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 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: Within 90 days of HIV diagnosis actual treatment must be initiated, not just a referral made or education provided or retesting at the referral site.

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

- ICD-9 = 042, 079.53, V08; ICD-10 = B20, B97.35, Z21

¹⁷“Patients first diagnosed with HIV” is defined as patients who received a reactive initial HIV test confirmed by a positive supplemental HIV test.

¹⁸ 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.

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

Patients Screened for Depression and Follow-Up (Line 21)

Performance Measure: The performance measure is “Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.” This is calculated as follows:

- **Numerator:** Number of patients aged 12 and older who were 1) screened for depression with a standardized tool and, if screened positive for depression, 2) had a follow-up plan documented.
- **Denominator:** Number of patients who were aged 12 or older at some point during the measurement year and who had at least one medical visit during the reporting year; for measurement year 2015, this includes patients whose date of birth is on or before December 31, 2003.

Total Number of Patients Aged 12 or Older, Column (A)

Criteria: Enter the number of patients who:

- Were born on or before December 31, 2003, *and*
- Had at least one medical visit during 2015.

Exclusions:

- Patients with an active diagnosis for depression or bipolar disorder
- Patients who are already participating in on-going treatment for depression

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria OR, if an EHR is used to report, this will be a number no less than 80% of Column A OR a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. 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 that result in oversampling some group of patients.

If a health center’s EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate “behavioral health” database that is restricted to patients who are in their integrated care program.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Appropriate Screening for Depression and Follow-Up, If Appropriate, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that they had a standardized depression screening test during the measurement year:

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

The following CPT-II codes will be useful in identifying meeting the measurement standard:

- CPT-II = 3725F

Dental Sealants (Line 22)

Performance Measure: The performance measure is “Percentage of children, aged 6 through 9, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period.” This is calculated as follows:

- **Numerator:** Number of dental patients aged 6 through 9 who were at moderate to high risk for caries who received a sealant on a permanent first molar tooth in the measurement year.
- **Denominator:** Number of dental patients aged 6 through 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year and documented as having moderate to high risk for caries; for measurement year 2015, this includes patients whose date of birth is between January 1, 2006 and December 31, 2009.

Total Number of Patients Aged 6 through 9, Column (A)

Criteria: Enter the number of dental patients who:

- Were born between January 1, 2006 and December 31, 2009, **and**
- Had at least one oral assessment or comprehensive or periodic oral evaluation visit¹⁹ during 2015, **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)

Number of Charts Sampled or EHR Total, Column (B)

Enter the total number of health center dental patients included in the universe (Column A) for whom data have been reviewed. This will be *either* all patients who fit the criteria OR if an EHR is used to report, this will be a number no less than 80% of Column A OR a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column A). Larger samples will not be accepted. Health centers *may not* choose to select the same number

¹⁹ As defined on the UDS. See visit criteria described on Table 5, page [59](#)

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

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and *must not* be restricted by any variable related to the test measure.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Number of Patients with Sealants to First Molars, Column (C)

Enter the total number of patients identified in Column B whose 2015 record demonstrates that they had a sealant on a permanent first molar during the measurement year.

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

Questions and Answers for Table 6B

1. Are there any changes to the table this year?

Yes, a new dental sealant measure has been added.

In addition, as with Tables 6A and 7, use of both ICD-9 and ICD-10 codes will apply to identify patients with specific diagnosis. Careful attention is required to ensure that patients are only counted once with the condition although both ICD-9 and ICD-10 codes may both be used to help identify a patient with specific diagnosis.

Also, if a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and *must not* be restricted by any variable related to the test measure. In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

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. Once a patient enters a health center's system of medical care, the center is expected to be responsible for providing all needed preventive health care and/or document that 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?

Once the patient has been seen in your clinic, you are responsible for providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to coordinate care and document Pap test results by contacting providers of Pap tests directly in order to obtain appropriate documentation. The woman would be considered to be a part of your universe if she received *any* medical visit(s) in 2015. If there is no copy of the results of her Pap test included in her chart, she would be considered having not 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 in order to obtain documentation by fax, or by requesting health center patients to mail a copy of their immunization history, or by finding the child in a State or county immunization registry or through other appropriate means.

7. Some of the immunization details are different than those used by CDC in the CASA or CO-CASA reviews of our clinic. May we use these CDC standards to report on the UDS?

No. HRSA is now using one of the Healthy People 2020 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, or to meet the CMS Meaningful Use criteria, 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 oversample specific sites or providers to facilitate internal QI activities.

9. What happens if the CPT or ICD codes change again?

The codes are reviewed annually by the UDS Support Center staff. If you think that there is a CPT or ICD code for a measure which is not being reflected in the list, contact the UDS Support Center. It will review the code with BPHC and incorporate approved changes to codes into the manual for future reporting.

10. Is the Pap test review for women starting at age 21 or at age 24?

For this measure you will look only at women who were 24 years or older (up to age 65) at some point in 2015. You will not look at any women who were 21, 22, or 23 years old at the end of 2015. Because the measure asks about Pap tests *administered* in 2015 or in 2014 or in 2013, it is possible that a 24 year old woman would have been 21 in 2013. 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 24 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 24 through 64 in 2015, 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 which, 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. **I have a patient who turned 2 in November 2015. Should she be included in the Child and Adolescent weight measure? Does this measure start at age 2 or age 3?**

No—do not include the child. The measure looks at children who were two, but allows the measurement to be recorded up to one year after her second birthday. Since she still has ten months for her BMI percentile to be charted and for her parents to receive counseling, she would not be included in the universe. For this measure you will look only at children and adolescents who were 3 years or older (through age 17) at some point in 2015. You will not look at any child or adolescent who had not yet turned 3 or who was over 17 years old at the end of 2015. For children who are 3, the documentation for weight assessment and counseling may have been when they were 2.

14. **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 2-year period, it is reasonable to follow such a protocol if it has been approved by your clinical staff.

15. **The measure says that there must be effective intervention for tobacco users. Are there specific interventions that must be used in order to consider them effective?**

No. This is at the discretion of the 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.

16. **If our provider documents that s/he 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.

17. **Who are we to consider as having been first diagnosed with HIV?**

Line 20, HIV Linkage to Care asks for a count of the number 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 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-9 or ICD-10 or CPT codes to identify this condition. Health centers should either modify their EHR to record this information or keep track of the patients who are identified in a separate system.

18. 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 EHR consistent with internal medical records policies, at which point they could be used in the calculated performance rate.

19. Can we use National Quality Forum (NQF) or Clinical Quality Measures (CQMs) directly to report on the clinical measures?

Not directly. Health centers must report on the clinical measures outlined according to the UDS definitions outlined in this manual although the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) may be used by organizations capable of appropriately using this resource to support the reporting of quality of care measures.

20. 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 with elevated risk for caries in the universe count.

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2015 through December 31, 2015

**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 - Trimester of Entry into Prenatal Care

Line	Trimester of 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

Line	Childhood Immunization	Total Number of patients with 3rd birthday during measurement year (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Children who have received age appropriate vaccines prior to their 3 rd birthday during measurement year (on or prior to December 31)			

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total number of Female Patients 24-64 years of Age (a)	Number Charts Sampled or EHR total (b)	Number of Patients Tested (c)
11	MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

Section E - Weight Assessment and Counseling for Children and Adolescents

Line	Weight Assessment and Counseling for Children and Adolescents	Total patients aged 3-17 on December 31 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Children and adolescents aged 3 until 17 during measurement year (on or prior to 31 December) with a BMI percentile, and counseling on nutrition and physical activity documented for the current year			

Section F - Adult Weight Screening and Follow-Up

Line	Adult Weight Screening and Follow-Up	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Patients aged 18 and older with (1) BMI charted <i>and</i> (2) follow-up plan documented <i>if</i> patients are overweight or underweight			

Section G - Tobacco Use Screening and Cessation Intervention

Line	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 <i>and</i> provided Intervention if a Tobacco User (c)
14a	MEASURE: Patients aged 18 and older who (1) were screened for tobacco use one or more times in the measurement year or the prior year <i>and</i> (2) for those found to be a tobacco user, received cessation counseling intervention or medication			

Section H - Asthma Pharmacologic Therapy

Line	Asthma Pharmacologic Therapy	Total Patients aged 5 - 40 with persistent asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

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

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: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy			

Section J - Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy

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

Section K - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients 51 through 74 Years of age (a)	Charts Sampled or EHR Total (b)	Number of Patients With Appropriate Screening For Colorectal Cancer (c)
19	MEASURE: Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer			

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: 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 - Patients Screened for Depression and Follow-Up

Line	Patients Screened for Depression and Follow-Up	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: Patients aged 12 and older who were (1) screened for depression with a standardized tool <i>and</i> if screening was positive (2) had a follow-up plan documented			

Section N – Dental Sealants

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

Instructions for Table 7: Health Outcomes and Disparities

This table reports data on health status measures for birth weight, diabetes, and hypertension by race and Hispanic/Latino ethnicity. All health centers submit Table 7. This table is submitted only in the Universal report.

These measures are “process 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. Increasing the proportion of patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. Specifically:

- **Low 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.*
- **Controlled Hypertension:** *If there is less uncontrolled hypertension, then there will be less cardiovascular damage, fewer heart attacks, less organ damage later in life.*
- **Poorly Controlled Diabetes:** *If there is less poorly controlled diabetes, then there will be fewer long-term complications such as amputations, blindness, and end-organ damage.*

Table 7 reports health outcome data by race and Hispanic/Latino ethnicity to provide information on health centers’ efforts to help to reduce health disparities. Race and Hispanic/Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. *Care must be taken by health centers which have separate reporting systems for patient registration and clinical data to ensure that race and ethnicity data across the systems are aligned.* Health centers who report on a sample of patients – and even those who report on their entire universe of patients – are cautioned against using their data to evaluate disparities in their own systems given small sample sizes. On a national level, however, reported data permits HRSA to evaluate impact on disparities for all BPHC-funded programs.

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. (This line is not reported by the race or Hispanic/Latino ethnicity of the women delivered.) On this line ONLY, the health center is to include deliveries of women who were not part of the 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 clinicians” 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.

Deliveries and Birth Weight Measure by Race and Hispanic/Latino Ethnicity, Section A (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.

Prior to 2014, only those health centers who directly provided some or all of a patient's prenatal care reported. Now, all health centers must report all of their patients who delivered during the reporting period, and all children born to them, in Columns 1a–1d. Included in this population will be any woman who has been a patient of the health center in the past and who tests positive for pregnancy by the health center, even if that woman is referred to another provider for some or all of her prenatal care.

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 of their 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 delivery.

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

Performance Measure: The performance measure is “Proportion of patients born to health center patients whose birth weight was *below* normal (less than 2500 grams).” Note that this is a “negative” measure. -- For this measure the higher the number of infants born with below normal birth weight, the worse the performance on the measure. While data are provided for each racial and ethnicity category, the performance measure looks only at the totals²⁰. The measure itself, which is not dependent on which category of failure to meet the measurement standard an infant falls in, is calculated as follows:

- **Numerator:** Number of children born with a birth weight of under 2500 grams (Line i, columns 1b + 1c)
- **Denominator:** Number of children born (Line i, 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. (Do not report still-births or miscarriages.) 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: Health centers must report birth weights for live children of **all** women who were in their prenatal care program or who were referred for care, and who delivered during the reporting*

²⁰ However, during the review of the UDS report, reviewers will question unusually high or low birth weights for individual race or ethnicity categories.

period. 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.

Very Low Birth Weight (Column 1b)

Report the total number of live children whose weight at birth was less than 1500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

Low Birth Weight (Column 1c)

Report the total number of live children whose weight at birth was 1500 grams through 2499 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

Normal Birth Weight (Column 1d)

Report the total number of live children whose weight at birth was equal to or greater than 2500 grams. Be careful not to confuse pounds and ounces for grams when reporting this number.

Race and Ethnicity of Mothers and Infants Born to Prenatal Care Patients Who Delivered During the Year (Lines 1a - i)

Women (column 1a) and children (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, from their birth certificates, or from their parent.

Hypertension by Race and Hispanic/Latino Ethnicity, Section B (Columns 2a-2c)

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

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates or search parameters permit the recovery of a minimum of 80% of the records of the patients which fit the measurement profile.

If a health center's EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of column A and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate "chronic disease tracking system" that is restricted to patients enrolled in their hypertension treatment program.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the numbers in Column B must be the same as in Column A.

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

Section B of Table 7 reports on all health center adult patients, who are 18 to 85 years of age (i.e., prior to 85th birthday), who have been diagnosed as hypertensive at any time before June

30, of the measurement year and who have been seen in the health center for medical visits at least *twice* during the reporting year. (The diagnosis may have first been made in a year prior to the measurement year or at the last visit of the year or at any time in between.)

Performance Measure: The performance measure is “Proportion of patients born between January 1, 1931, and December 31, 1997, with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading.” (NOTE: Many health centers use a different measure for their quality assurance process for their diabetic or dialysis patients or for older patients. This may well be appropriate, but for the purposes of UDS reporting, BP less than 140/90 measure must be used.) This is calculated as follows:

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

Total Patients Aged 18 to 85 with Hypertension, Column 2a

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

- Were born between January 1, 1931, and December 31, 1997, **and**
- Have been seen at least twice during the reporting year for *any reportable* medical visit, **and**
- Have been diagnosed with hypertension (HTN) before June 30, of the measurement year as evidenced by an ICD-9 code of 401.xx - 405.xx or ICD-10 code of I10- thru I15-. The diagnosis and notation of hypertension may appear during or prior to 2015.

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

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

Number of Charts Sampled or EHR Total, Column 2b

Enter the total number of hypertensive health center patients by race and Hispanic/Latino ethnicity (Column 2a) included in the universe for whom data have been reviewed. This will *either* be a minimum of 80% or more of the patients who fit the criteria **or** a scientifically drawn sample of 70 patients drawn from all patients who fit the criteria.

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire universe identified in Column 2a. 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 that result in oversampling some group of patients. The sampling method is described in [Appendix C](#). If an EHR is present, it may be used in lieu of a chart review of a sample of charts if and only if:

- The EHR includes at least 80% of the clinic patients between the ages of 18 and 85, with diagnosed hypertension, regardless of whether or not they were specifically treated for hypertension.
- Blood pressure is regularly recorded in the EHR for all patients.
- The EHR has been in place throughout the reporting year.

If the EHR is to be used, the number in Column 2b will be a value no less than 80% of patients reported in Column 2a. NOTE: Health centers who have I2I-Track, PC-DEMS, PECS, or other disease tracking systems may use them to report the universe *only if* it can be limited to a calendar year report and *only if* it includes all required data elements, i.e., it includes data for the required time frame for all hypertensive patients from all service sites.

In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

Patients with Controlled Blood Pressure, Column 2c

Hypertensive patients born between January 1, 1931, and December 31, 1997, whose charts have been reviewed (those identified in Column 2b) whose systolic blood pressure measurement was less than 140 mm Hg *and* whose diastolic blood pressure was less than 90 mm Hg at the time of their last measurement in 2014, are reported in Column 2c by race and Hispanic/Latino ethnicity. (Patients who have not had their blood pressure tested during the reporting year will be considered to have failed the performance measure. They are counted in Columns 2a and 2b, but not in Column 2c.)

Important Notes about Race and Hispanic/Latino Ethnicity Numbers

Comparisons are made between the universe reported on Table 7, Column 2a, and the data reported on Table 3B. Under no circumstances may a health center report more hypertensive Hispanic/Latinos or more hypertensive patients of any given race in Column 2a than are reported for that race or for the Hispanic/Latino ethnic group on Table 3B.

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

Diabetes by Race and Hispanic/Latino Ethnicity, Section C (Columns 3a-3f)

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

Data for this section may be obtained from an audit of charts selected through a process of scientific random sampling or through the use of Electronic Health Records whose templates or

search parameters permit the recovery of a minimum of 80% of the records of the patients which fit the measurement profile.

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

This section of Table 7 reports on all health center patients 18 to 75 (i.e., prior to 75th birthday), who have been diagnosed as diabetic at some point during their time as patients at the health center.

Performance Measure: The performance measure is “Proportion of adult patients born between January 1, 1941, and December 31, 1997, with a diagnosis of Type I or Type II diabetes, whose most recent hemoglobin A1c (HbA1c) during the measurement year was greater than 9%, or was missing a result, or if an HbA1c test was not done during the measurement year.” Health centers now report results in two categories: less than 8% and greater than 9%. 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. While data are provided for each race and ethnicity category, the performance measure looks only at the totals. The measure itself is calculated as follows:

- **Numerator:** Number of adult patients whose most recent hemoglobin A1c level during the measurement year is > 9% or who had no test during the year among those patients included in the denominator
- **Denominator:** Number of adult patients aged 18 to 75, as of December 31, of the measurement year:
 - With a diagnosis of Type I or II diabetes, **and**
 - Who have been seen in the clinic for medical visits at least twice during the reporting year, **and**
 - Do not meet any of the exclusion criteria

Total Patients Aged 18 to 75 with Type I or II Diabetes, Column 3a

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

- Were born between January 1, 1941, and December 31, 1997, **and**
- Have been seen at least twice for medical care during the reporting year, **and**
- Have a diagnosis of diabetes. It does not matter if diabetes was treated or is currently being treated or when the diagnosis was made. The notation of diabetes may appear during or prior to the 2015 measurement year. To confirm the diagnosis of diabetes, one of the following must be found in the medical record:
 - ICD-9-CM Codes 250.xx or 648.0x or ICD-10 Codes E10-, E11- O24- (Excludes E28.2, E09-, E16.4, E16.8, O99.81, T38.0xxA)
 - Diabetic patients may also be identified from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics).
 - Note that unlike the hypertension measure, the diabetes measure calls for reporting on all diabetic patients regardless of when they were first diagnosed. It

specifically *does not make use* of the June 30 date used to identify hypertensive patients.

Exclusions: Exclude any patients with a diagnosis of polycystic ovaries (ICD-9 code 256.4 or ICD-10 code E28.2) that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year²¹. Note that patients with gestational diabetes (ICD-9 code 648.8x or ICD-10 code O99.81) or steroid-induced diabetes (ICD-9 code 962.0, 249.xx, or 251.8 or ICD-10 code E16.4, E16.8) reported during the measurement year are *not* to be included.

Number of Charts Sampled or EHR Total, Column 3b

Enter the total number of diabetic health center patients by race and Hispanic/Latino ethnicity included in the universe (Column 3a) for whom data have been reviewed. This will either be a minimum of 80% or more of the patients who fit the criteria, or a scientifically drawn sample of 70 from all patients who fit the criteria (using the methodology described in [Appendix C](#)).

If a sample is to be used it *must* be a sample of 70 and *must* be drawn from the entire patient population who fit the criteria (the universe reported in Column 3a). Larger samples will not be accepted. 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 that result in oversampling some group of patients. If an EHR is present, it may be used in lieu of a chart review of a sample of charts if and only if:

- The EHR includes at least 80% of all diabetic patients seen within the measurement year and can exclude from the universe those not seen during the measurement year,
- Every item in the criteria is regularly recorded for all patients, and
- The EHR has been in place throughout the performance year, and ideally for at least 3 years to permit identification of all diabetic patients.

If a health center's EHR is only able to provide data for a subset of Column 3a, it must be greater than or equal to 80% of column 3a and *must not* be restricted by any variable related to the test measure. For example, the health center may not use a separate "chronic disease tracking system" that is restricted to patients enrolled in their diabetes treatment program.

In the event that fewer than 70 patients meet the criteria and are reported in Column 3a, the numbers in Column 3b must be the same as in Column 3a.

Reported Hemoglobin A1c Levels, Columns 3d1 and 3f

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

²¹ If a search is made for pharmaceuticals that are used to treat diabetes, a person with these various conditions might be identified in error—hence this exclusion. If no search is done for pharmacy identification of patients, this can be ignored.

- **Patients with HbA1c < 8% (Column 3d1):** Number of patients included in Column 3b whose most recent HbA1c was less than 8%
- **Patients with HbA1c > 9% or No Test During Year (Column 3f):** Number of patients included in Column 3b whose most recent HbA1c was greater than 9% **and** patients who did not receive an HbA1c test during the reporting year or whose test result is missing

Note that patients with HbA1c levels equal to or greater than 8% and less than or equal to 9% will not be reported beginning in CY 2015. That means that the two “results” columns (3d1 and 3f) will not equal the total records reviewed (column 3b). Important Notes about Race and Hispanic/Latino Ethnicity Numbers

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

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

Questions and Answers for Table 7

1. Are there any changes to the table this year?

Yes. Beginning with data from 2015, the number of categories for reporting diabetic HbA1c has been reduced. Only the HbA1c categories of “less than 8%” (Column d1) and “greater than 9% or No Test During the Year” (Column 3f) are reported.

In addition, as with Tables 6A and 6B, use of both ICD-9 and ICD-10 codes will apply to identify patients with specific diagnosis. Careful attention is required to ensure that patients are only counted once with the condition although both ICD-9 and ICD-10 codes may both be used to help identify a patient with specific diagnosis.

Also, if a health center’s EHR is only able to provide data for a subset of Column A, it must be greater than or equal to 80% of Column A and *must not* be restricted by any variable related to the test measure. In the event that fewer than 70 patients meet the criteria and are reported in Column A, the number in Column B must be the same as in Column A.

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/Latino. Patients, who provide a race but do not answer affirmatively to a question about Hispanic/Latino ethnicity, are to be classified as Non-Hispanic/Latino and reported on the appropriate race line, Line 2a–2g. Patients who indicate they are Hispanic/Latino, but do not provide a race are reported on Line 1g.

3. Data are requested by race and Hispanic/Latino ethnicity. How are these to be coded?

Race and Hispanic/Latino ethnicity are coded on this table in the exact same manner that is used for coding on Table 3B. Refer to instructions for Table 3B for further information. 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 that 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 in order to obtain documentation by FAX, or by requesting health center patients to mail a copy of test results, or through other appropriate means. Health center patients should not be requested to return to the center merely to provide test documentation, however failure to document results means that the patient must be reported as 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 oversample 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 babies' 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 child is reported in columns 1b, 1c, or 1d.

Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2015 through December 31, 2015

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

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				
	<i>Subtotal Hispanic/Latino</i>				
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				
	<i>Subtotal Non-Hispanic/Latino</i>				
Unreported/Refused to Report Ethnicity					
h	Unreported/Refused to Report Race and Ethnicity				
i	Total				

Section B: Hypertension by Race and Hispanic/Latino Ethnicity

Line #	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a	Asian			
1b1	Native Hawaiian			
1b2	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			
	<i>Subtotal Hispanic/Latino</i>			
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			
	<i>Subtotal Non-Hispanic/Latino</i>			
Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity			
i	<i>Total</i>			

Section C: Diabetes by Race and Hispanic/Latino Ethnicity

Line #	Race and Ethnicity	Total Patients 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				
	<i>Subtotal Hispanic/Latino</i>				
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				
	<i>Subtotal Non-Hispanic/Latino</i>				
Unreported/Refused to Report Ethnicity					
h	Unreported/Refused to Report Race and Ethnicity				
i	<i>Total</i>				

Instructions for Table 8A: Financial Costs

Table 8A must be completed by all health centers. It is included only in the Universal report. Table 8A reports the total cost of all activities which are within the scope of the project(s) supported, in whole or in part, by (1) any of the four BPHC grant programs covered by the UDS including costs covered by an ACA grant, **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 supported clinic or look-alike if they are included in the scope of both grants. Under no circumstances would the same costs be covered in both a BPHC grant funded program 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. (Hence, only depreciation is reported for capital investments including ACA 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 may 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 system:

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, 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, rest rooms, and utility closets. Note that hallways and similar shared space *within a dedicated* area are assigned to that area. For example, the hallways inside of the medical suite that connects the exam rooms and the doctor's offices and the medical supply closets are considered medical space, not "common space."

For reporting purposes, the cost of the square footage associated with space owned by the health center and leased or rented to other parties should not be reported on Line 14, or anywhere, if it is considered to be outside of the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Program Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenue (Line 10).

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 varies 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* facility costs have been allocated, and should include the facility costs allocated to the non-clinical support services cost center. The non-clinical support services cost is generally allocated based on a straight-line allocation method. The proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to each service category should be used to allocate non-clinical support services cost. For example, if medical staff account for 50 percent of net cost (excluding facility and non-clinical support services costs) then 50 percent of non-clinical support services cost is allocated to medical staff. 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 may be reduced or eliminated and allocated to all other cost centers.

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 which are based on "cost" are calculated based on total costs shown on Line 17 and exclude the value of donated services supplies or facilities.

BPHC Major Service Categories (Line Definitions)

Medical Care Services (Lines 1-4)

This category includes costs for medical care personnel; services provided under agreement; laboratory and X-ray (including sonography, mammography); 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 CME). It does not include costs associated with pharmacy, dental care, substance abuse specialists, mental health (psychiatrists, clinical psychologists, clinical social workers, etc.), vision care (ophthalmologists, optometrists, optometric assistants, etc.) or enabling (case management, education specialists, etc.) services. Note that for the purposes of the UDS, psychiatry and ophthalmology are not counted in the medical cost centers.

Medical Staff Costs

Report all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, and for all medical care staff including nurses, medical assistants, etc., *but specifically excluding* lab and x-ray staff. The costs for staff dedicated to the operation of the EHR are also included on Line 1. (See further discussion of EHR staff on Table 5.) The accrued cost (if any) of 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 on Line 1. Include the cost of any medical visit paid for directly by the center, such as at-risk specialty care from an HMO contract or other specialty care, on Line 1. The costs of intake, medical records, and billing and collections are considered non-clinical costs that are reported on Line 15, and then allocated in Column B.

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

Medical Lab and X-Ray Costs (Line 2)

Include all costs for medical lab and x-ray (including sonography and mammography), including salaries and fringe benefits for personnel supported directly or under contract, for lab and x-ray staff; and all other direct costs including, but not limited to, supplies, equipment depreciation, related travel, contracted or vouchered lab and x-ray services. The costs of intake, medical records, billing, and collections are considered non-clinical support services costs and should be included on Line 15, and allocated in Column B. Note that dental lab and x-ray costs are reported on the dental line, Line 5. If there are costs for retinography (for example, for diabetic patients), these would be reflected in vision services below 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 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).

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. (Note that dental therapists are reported as "Other Professional Health" on Table 8a and Table 5.)

Mental Health (Line 6)

Report all direct costs for the provision of mental health services, *other than substance abuse services* including, but not limited to, staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology but must be consistent 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 [61](#).)

Substance Abuse (Line 7)

Report all direct costs for the provision of substance abuse services including, but not limited to, staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs, as should associated staff on Table 5. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology but must be consistent with the reporting on Table 5. Non-clinical support services and facility costs associated with the substance abuse program should be shown first on Lines 14 and 15 Column A, and then allocated to Substance Abuse in Column B. (See also Q & A discussion for Table 5 on page [61](#).)

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 100% of the 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 shown on Line 11e – Eligibility Assistance. 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 inventory fees, ordering fees, or a charge for 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 injectable drugs which may be used (and directly dispensed) in the health center. 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 may well be lower than what would be calculated using a straight-line methodology), 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, occupational and physical therapy. (A more complete list appears at [Appendix A](#).) Included in direct costs are provider and support staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Non-clinical support services and facility costs should be shown first on Lines 14 and 15 Column A, and then allocated to "Other Professional" in Column B. Note that there is a cell to "specify" the other professional costs reported on this line.

Vision (Line 9a)

Report all direct costs for the provision of vision services including optometry, ophthalmology, and vision support staff. Included in direct costs are staff, fringe benefits, supplies (including frames and lenses), equipment depreciation, related travel, and contracted services. 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 Program Related Services (Lines 11-13)

This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, eligibility assistance—including pharmacy assistance program eligibility, environmental risk reduction, and other services that support and assist in the delivery of primary 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.

Enabling (Line 11)

Enabling services include a wide range of services which 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–11g are used to detail six 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 at page 57. 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.

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 but are not traditionally considered health care programs. In rare instances they may include costs that are recovered elsewhere. 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.

Total Enabling and Other Program Related Services (Line 13)

The sum of Lines 11 + 12

Facility and Non-Clinical Support Services Costs (Lines 14-16)

This includes all traditional facility and non-clinical support services costs that are later allocated to other cost centers. Specifically:

Facility Costs (Line 14)

Facility costs include rent and/or depreciation, facility (mortgage) interest payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs. 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, 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. 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 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 in 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) ²²

It is the sum of Lines 4 + 10 + 13 + 16.

Value of Donated Facilities, Services, and Supplies (Line 18)

Include here the total imputed value of all in-kind and donated services, facilities, and supplies (including donated pharmaceuticals) applicable to the reporting period that are within your scope of project, using the methodology discussed below. In-kind services and donations include all services (generally volunteers, but sometimes paid staff donated to the 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 and which you included in your budget as donated. Line 18 reports the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment. The value of these services should not be included in Column A on the lines above.

The estimated reasonable acquisition cost should be calculated according to the cost that would be required to obtain similar services, supplies, equipment, or facilities within the immediate area at the time of the donation. Donated pharmaceuticals (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 National Health Service Corps (NHSC) Federal assignee(s), including "ready responders," should also be

²² This is the amount that is used in any BPHC calculation which is based on total cost.

included in this category. NHSC-furnished equipment, including a dental operator, 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)

It is the sum of Lines 17 and 18, Column C.

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

FTEs reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1–12: Medical providers and clinical support staff	1: Medical staff
13–14: Lab and X-ray	2: Lab and X-ray
16–18: Dental (e.g., dentists, dental hygienists)	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. <i>Note that the cost categories are not in the same sequential order as they appear on Table 5.</i>	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
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
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

Conversion from Fiscal to Calendar Year

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

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. EXAMPLE: A health center whose fiscal year ends March 31, 2015, allocates 25 percent of costs in each cost category to the 2015 calendar year.

Step 2: Using the trial balance for the end of December 2015, determine the total cost for the remainder of the calendar year for each column. For example, a health center whose fiscal year ends March 31, 2015, would use the 9-month trial balance for December 31. (NOTE: Health centers who do not accrue depreciation monthly should adjust depreciation to an annual total.)

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

Note that accounting software which permits the reporting on any fiscal period is becoming much more common and readily available. Estimating methods such as those discussed here should be avoided whenever possible.

Questions and Answers for Table 8A

1. Are there any changes to this table?

No.

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 2-hour period, the amount shown is what you would pay an optometrist for 2 hours of work, not the total charges for the five visits. *However*, if you refer a patient for a service to a provider outside of your site who donates these services *neither the charge nor the value of the time or service is reported on the UDS*. For example, if you refer a patient to the county hospital for a hip replacement which is provided to your patient at no cost to you or the patient, neither the time of the surgical team nor the UCR charge for the service is reported on the UDS. The same would be true of mammograms done at the County Health Department.

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, Line 18. This is NOT the retail cost of the drug; it is the 340(b) price of the drug—an amount which is generally 40%–60% of the average wholesale price (AWP). *Technically*, if the drug is donated directly to the patient, even though it may be sent to the health center, this is not a donation to the center and need not be accounted for or reported. But since we are interested in knowing the total value of supplies provided to you *directly or indirectly*, 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 of these funds. If providers are permitted to retain some or all of these funds they are to be reported on Line 1. In addition, the Meaningful Use EHR payments received from Medicare or Medicaid are reported on Table 9E, Line 3a.

Table 8A: Financial Costs

Reporting Period: January 1, 2015 through December 31, 2015

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 Program Related Services				
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11f.	Interpretation Services			
11g.	Other Enabling Services (Specify: _____)			
11.	Total Enabling Services Cost (Sum Lines 11a through 11g)			
12.	Other Related Services (Specify: _____)			
13.	Total Enabling and Other Services (Sum Lines 11 and 12)			
Facility and Non-Clinical Support Services and Totals				
14.	Facility			
15.	Non-Clinical Support Services			
16.	Total Facility and Non-Clinical Support Services (Sum Lines 14 and 15)			
17.	Total Accrued Costs (Sum Lines 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services, and Supplies (specify: _____)			
19.	Total With Donations (Sum Lines 17 and 18)			

Instructions for Table 9D: Patient Related Revenue

Table 9D must be completed by all health centers covered by the UDS. It is included only in the Universal report. Beginning with the 2014 data report, look-like programs complete the entire Table 9D. 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 [151](#)) 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) which list each of the services provided using CPT codes and the charge associated with each of these charges; the third party payer pays 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. 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 the entire bill generally based on agreed upon maximums or discounts. In addition, 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 –on Line 1. Note also that

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. Also included here will be a portion of the charges for "cross-over" services that are reclassified to Medicaid after being initially submitted to Medicare. In a small number of cases, Medicaid patients are enrolled in a “share of cost” program where they pay some portion of the fee as a co-payment or a deductible. In this case, the patient’s share of the cost is reclassified to self-pay. 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 176.

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 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 176.

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. With the implementation of health reform, we also anticipate a potential growth in State insurance plans, which will join plans such as Washington’s Basic Health Plan or Massachusetts’ Commonwealth Plan. ***Other Public does not include State or local indigent care programs.*** Patients whose only payment source is one of these State or local indigent care programs are reported as "uninsured" on Table 4 and their charges, 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 by the Affordable Care Act, are not reported here. They are reported as Private unless they can be identified as being enrolled through purchased subsidies from the ACA Medicaid Expansion program and therefore reported as Medicaid.

NOTE: Reporting on State or local indigent care programs that subsidize services rendered to the uninsured is 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*, Line 6a and specify the program paying for the services.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program, with your UDS Reviewer, or the UDS 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 which 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. Insurance purchased through the ACA-supported state exchanges are reported here unless they can be identified as being enrolled through purchased subsidies from the ACA 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 services, 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 should always 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 and contracted payments from third parties is then adjusted as “contractual allowances” (see below). Some patients have more than one source of payment for their services. In these instances, a charge will initially be made to one carrier, who may deny some or all of the charge. The unpaid portion 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 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, which 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 these pharmaceuticals, should, however, be included.

Pharmaceuticals which are dispensed through a (340(b)) contract pharmacy are to be reported at their usual (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 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, court settlements, and other payments which are also recorded in Columns c1, c2, c3, and/or c4.* Also included are *payments to pharmacies* by patients and third parties for pharmaceuticals dispensed to patients on behalf of the health center. Note: Charges and collections for deductibles and co-payments which are charged to, paid by, and/or due from patients are recorded as “self-pay” on Line 13.

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

In addition to including them in Column B, details on some payments by third parties which may have their origin in prior periods, which are included in Column B, are also broken out and reported in column 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, managed care withholds, and paybacks to FQHC 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 – used with all Medicaid payments in some states) from Medicare, Medicaid, or Other Public payers that cover *services provided during the current reporting period.*

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—used generally in some states) from Medicare, Medicaid, or Other Public payers that cover *services provided during previous reporting periods. Include the prior-year component of multi-year settlements here.*

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

Enter other cash payments including managed care risk pool redistribution, incentives including “pay for performance” incentives, and withholds, 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 which 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, Line 3a.

Column C4 – Penalty/Payback

Enter payments made 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. 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 what they receive. These amounts are reported in Column D. *Allowances must be reduced by the net amount of retroactive settlements and receipts* (reported in Columns c1, c2, and c3.), including current and prior year FQHC reconciliations, managed care pool distributions and other payments. *This will often result in a negative number being reported as the allowance in Column D.*

If, as a result of a contract or agreement, Medicaid, Medicare, other third-parties, or other public 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.

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.)

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 don't carry any receivables. For Capitated Plans (Lines 2a, 5a, 8a, and 11a *only*) the allowance column (Column D) should be the arithmetic difference between the charge recorded in Column A and the collection in Column B unless there were early or late capitation payments (received in a month other than when they were earned) and which span the beginning or end of the calendar year.

Also note that Line 13 Column D is blanked out because 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, as determined by the health center's sliding discount schedule. This would include discounts to required co-payments, as applicable.

NOTE: Only the patient may be granted a sliding discount based on his/her 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. It must either be collected or written off as a bad debt. Bad debt write off (Line 13, Column F) may occur due to the 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% of the poverty level, 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% of poverty (for example, the Title X Family planning program which mandates discounts up to 250% of the FPL). 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 agency from writing off 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, 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, 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. Because the table is on a "cash" basis, the columns for amount collected and for allowances will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will be remaining in accounts receivable at the end of the year. The one exception is on the capitated lines (Lines 2a, 5a, 8a, and 11a) where allowances are the difference between charges and collections by definition, provided there are no early or late capitation payments that cross the calendar year change.

5. **If we have not received any reconciliation payments for the reporting period what do we show in Column c1 (current year reconciliations)?**

You would then report only current *wrap-around* payments in Column c1. If you have no reconciliation payments *or* wrap-around payments 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/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 174. In general, the full charge is reported in column A by payer. Thus, 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, 2015 through December 31, 2015

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)			Penalty/Payback (c4)	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)				
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)									
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	Total Other Public (Lines 7+ 8a +8b)									

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)			
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	Total Private (Lines 10 + 11a + 11b)									
13.	Self-pay									
14.	TOTAL (Lines 3 + 6 + 9 + 12 + 13)									

Instructions for Table 9E: Other Revenue

Table 9E must be completed by all health centers covered by the UDS. It is included only in the Universal report. 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 any of the four BPHC grant programs, the FQHC 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 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, but are always passed through the State, and are reported on Line 6 as State funds, not on Line 3 as Federal. An exception to the rule is for the Medicare and Medicaid EHR Incentive Grants received for eligible providers (Line 3a). In rare cases these payments may be made directly to the clinic’s providers. It is presumed that, as employees, these funds will be turned over to the clinic. These dollars are reported on Line 3a even though the payment may come from the provider and not directly from the CMS. (See below for further details on Meaningful Use [MU] funds.)

BPHC Grants

Lines 1a through 1e

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

Total Health Center Cluster (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 major Health Center facility program as well as funds from the HRSA administered School Based Health Center capital grants program.

Total BPHC Grants (Line 1)

Enter the total of Lines 1g (Total Health Center Cluster), 1j (Capital Improvement Program Grants), and 1k (Capital Development Grants). Be sure that all BPHC section 330 grant funds drawn down during the year are included on Line 1. The amounts shown on the BPHC Grant Lines should reflect *direct funding only*. They should not include BPHC funds passed through to

you from another BPHC health center nor should they be reduced by money that you 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 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 OMH, IHS, HUD, and SAMHSA.)

Dually funded IHS/Health Center agencies 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, 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 Center agencies 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 of the associated charges, sliding discounts, and bad debt write-offs are reported on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 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 reported as income in column B on Table 9D.*

Local Government Grants and Contracts (Line 7)

Report the amount received from local governments during the reporting period that covers costs included in the scope of the 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. 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 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, Line 18. Also, *do not* show the proceeds of any loan received, either for operations or in the form of a mortgage. The receipt or recognition of "community benefit" from a third party is not to be reported here or anywhere else on the UDS unless it is received as a cash donation, and health centers may not recognize community benefit as an amount on the UDS.

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 full 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 of their 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, 2015 through December 31, 2015

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.	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 2–4a)	
Non-Federal Grants or Contracts		
6.	State Government Grants and Contracts (specify: _____)	
6a.	State/Local Indigent Care Programs (specify: _____)	
7.	Local Government Grants and Contracts (specify: _____)	
8.	Foundation/Private Grants and Contracts (specify: _____)	
9.	Total Non-Federal Grants and Contracts (Sum Lines 6 +6A + 7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify: _____)	
11.	Total Revenue (Lines 1+5+9+10)	

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. Note that a “provider” may also deliver services which are not counted as visits.

Personnel by Major Service Category	Provider	Non-Provider
PHYSICIANS		
Family Practitioners (Line 1)	X	
General Practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetrician/Gynecologists (Line 4)	X	
Pediatrician (Line 5)	X	
Licensed Medical Residents—line determined by specialty	X	
OTHER SPECIALIST PHYSICIANS (LINE 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other Specialists and Sub-Specialists	X	
NURSE PRACTITIONERS (Line 9a)	X	
PHYSICIANS ASSISTANTS (Line 9b)	X	
CERTIFIED NURSE MIDWIVES (Line 10)	X	
NURSES (Line 11)		
Clinical Nurse Specialists	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurse	X	
Licensed Practical Nurse/Licensed Vocational Nurse	X	
Nurse EMS / Nurse EMT	X	
OTHER MEDICAL PERSONNEL (Line 12)		
Nurse Aide/Assistant (Certified And Uncertified)		X
Clinic Aide / Medical Assistant / Community Health Worker (Certified and Uncertified Medical Technologists)		X
Quality Assurance/Quality Improvement and EHR design and operation staff		X
Unlicensed Interns and Residents		X
EMS/EMT Staff (not credentialed as a nurse)		X
LABORATORY PERSONNEL (Line 13)		
Pathologists		X
Medical Technologists		X
Laboratory Technicians		X
Laboratory Assistants		X
Phlebotomists		X
X-RAY PERSONNEL (Line 14)		
Radiologists		X
X-Ray Technologists		X

Personnel by Major Service Category	Provider	Non-Provider
X-Ray Technician		X
Radiology Assistants		X
DENTISTS (Line 16)		
General Practitioners	X	
Oral Surgeons	X	
Periodontists	X	
Endodontists	X	
OTHER DENTAL		
Dental Hygienists (Line 17)	X	
Dental Assistant (Line 18)		X
Dental Technician (Line 18)		X
Dental assistants, Advanced practice dental assistants		X
Dental Aide / Community Health Worker (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 Counselor (Line 20b or 21)	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
Audiologists	X	
Acupuncturists	X	
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 Assistant (Line 22c)		X
Ophthalmologist/Optometric Aide (Line 22c)		X
Ophthalmologist/Optometric Technician (Line 22c)		X

Personnel by Major Service Category	Provider	Non-Provider
PHARMACY PERSONNEL (Line 23)		
Pharmacist, Clinical Pharmacist		X
Pharmacy Technician		X
Pharmacist Assistant		X
Pharmacy Clerk		X
ENABLING SERVICES (Line 29)		
CASE MANAGERS (Line 24)		
Case Managers	X	
Care/Referral Coordinators	X	
Patient Advocates / Community Health Workers	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses	X	
HEALTH EDUCATORS		
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 Coordinator		X
Driver		X
ELIGIBILITY ASSISTANCE WORKERS (Line 27a)		
Benefits Assistance Workers		X
Pharmacy Assistance Program Eligibility Workers		X
Eligibility Workers		X
Patient Navigators		X
Patient Advocates		X
Registration Clerks		X
INTERPRETATION (Line 27b)		
Interpreters		X
Translators		X
OTHER ENABLING SERVICES PERSONNEL (Line 28)		X
OTHER 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

Personnel by Major Service Category	Provider	Non-Provider
Adult Day Health Care, Frail Elderly Support staff		X
MANAGEMENT AND SUPPORT STAFF (Line 30a)		
Project Director		X
Chief Executive Officer/Executive Director		X
Chief Financial Officer/Fiscal Officer)		X
Chief Information Officer		X
Chief Medical Officer		X
Secretary		X
Administrator		X
Director of Planning And Evaluation		X
Clerk Typist		X
Personnel Director		X
Receptionist		X
Director of Marketing		X
Marketing Representative		X
Enrollment/Service Representative		X
FISCAL AND BILLING STAFF		
Finance Director		X
Accountant		X
Bookkeeper		X
Billing Clerk		X
Cashier		X
Data Entry Clerk		X
IT STAFF (Line 30c)		
Director of Data Processing		X
Programmer		X
IT Help Desk Technician		X
Data Entry Clerk		X
FACILITY (Line 31)		
Janitor/Custodian		X
Security Guard		X
Groundskeeper		X
Equipment Maintenance Personnel		X
Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
Medical And Dental Team Clerks		X
Medical And Dental Team Secretaries		X
Medical And Dental Appointment Clerks		X
Medical And Dental Patient Records Clerks		X
Patient Records Supervisor		X
Patient Records Technician		X
Patient Records Clerk		X
Patient Records Transcriptionist		X
Registration Clerk		X
Appointments Clerk		X

Appendix B: Special Multi-Table Situations

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

- Contracted care (specialty, dental, mental health, etc.) which is paid for by the reporting 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

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 = 0.20 FTE). Providers are <i>not</i> counted if contract is for a service (e.g., \$X per visit or \$55 per RBRVU). Visits (Column B) are <i>always</i> 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, counts 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).

Tables Affected	Treatment
8A	<p>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.</p> <p>Column B: Facility and non-clinical support services—Health center will generally use a lower facility and non-clinical support services 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.</p>
9D	<p>Charge (Column A) is the health center’s usual, customary, and reasonable (UCR) charge if on-site; it is the contractor’s UCR charge if off site.</p> <p>Collection (Column B) is the amount received by <i>either</i> the health center <i>or</i> contractor from first or third parties.</p> <p>Allowance (Column D) is the amount disallowed by a third party for the charge (if on Lines 1–12)</p> <p>Sliding Discount (Column E) if applicable, is the amount written off for eligible patients per center’s fiscal policies (Line 13). Calculated as UCR charge minus amount collected from patient, minus amount owed by patient as their share of payment. Note that the payment by the health center is not considered here.</p>

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 can be included in the UDS report.

Tables Affected	Treatment
5	<p>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.</p> <p>Providers are not counted if their services are provided at their own offices.</p> <p>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.</p>
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	<p>Column A: Licensed interns and residents are counted in the category of credentialing that the provider is <i>working toward</i>. 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 <i>not</i> being paid). See volunteer providers, immediately above.</p> <p>Column B: Visits between a medical resident and a patient are recorded as visits <i>to that resident or intern</i>. 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.</p>
8A	<i>If the intern or resident is paid by the health center or his/her cost is being paid through a contract which <u>pays</u> a third party for the interns or residents, the cost is shown in column A on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the intern or resident is <i>not being paid by the health center</i> and the health center is not paying a third party, then the <i>value of the donated time</i> is reported on Line 18. Be sure to describe the nature of the donation on the table at this line.</i>

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 <i>are not counted as patients on any of these tables</i> . Do not count as patients because of nutritional, health education, or enabling services provided by WIC.
5	<p>Staff (Column A) is counted on Line 29a.</p> <p>Visits and patients (Columns B and C) are <i>never</i> reported.</p>

Tables Affected	Treatment
8A	<p>Column A: Net costs—Total cost of program included on Line 12 in Column A.</p> <p>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.</p>
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 <i>is</i> 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	<p>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.</p> <p>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.</p>

Tables Affected	Treatment
8A	<p>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 <i>not</i> reported here. The value of these donations <i>is</i> reported on Line 18 in Column C.</p> <p>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.</p> <p>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.</p> <p>Column B: Facility and Non-clinical Support Services—All facility and non-clinical support services costs associated with Line 8a and 8b are reported on Line 8a. While there may be some facility and non-clinical support services cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs.</p> <p>Column C, Line 18: Show the value of donated drugs [generally calculated at 340(b) rates] on this line <i>only</i>.</p>
9D	<p>Column A: Charge— is the health center’s full retail charge for the drugs dispensed.</p> <p>Column B: Collection— is the amount received from patients or other third parties / insurance companies.</p> <p>Column D: Allowance— is the amount disallowed by a third party for the charge (if on Lines 1–12).</p> <p>Column E: Sliding Discount— is the amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge minus amount collected from patient, minus amount owed by patient as his/her share of payment.</p>
9E	<p>The value of donated drugs is <i>not</i> 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.</p>

In-House Pharmacy for Community (i.e. for non-patients)

Many health centers which 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 all goes to enabling services on Line 27a: Eligibility Assistance Workers
8A	<p>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.</p> <p>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.</p> <p>If the pharmacy is reporting a flat amount for services including both pharmaceuticals and its services, <i>and there is no reasonable way to separate the amounts</i>, 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.</p> <p>If prepackaged drugs are being purchased, <i>and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs</i>, 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.</p>

Tables Affected	Treatment
9D	<p>Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed or the amount charged by the distributor/pre-packager if retail is not known.</p> <p>Collection (Column B) is the amount received from patients or insurance companies. (NOTE: most health centers do not have this sort of arrangement for their Medicaid patients.)</p> <p>Allowance (Column D) is the amount disallowed by a third party for the charge (if on Lines 1–12).</p> <p>Sliding Discount (Column E) is the amount written off for eligible patients per agency policies (Line 13). Calculated as retail charge (or pharmacy charge) minus amount collected from patient (by pharmacy or CHC), minus amount owed by patient as his/her share of payment.</p>
9E	No income would be reported on Table 9E. <i>Do not use Table 9E to show net income from Pharmacy.</i> Actual income must be reported on Table 9D.

Donated Drugs, Including Vaccines

Tables Affected	Treatment
8A	<i>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, 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.</i>
9D	If a dispensing fee is charged to the patient, show this amount (only) and its collection/write-off.
9E	Do not show any amount, even though GAAP might suggest another treatment for the value.

Clinical Dispensing of Drugs

Many pharmaceuticals, ranging from vaccines to allergy shots to family planning shots or pills, 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.

Tables Affected	Treatment
6A	Because these are not visits, they are not counted on Table 6A.
8A	Drug costs are reported on Line 8b – pharmaceuticals (<i>not</i> 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 <i>not appropriate</i> to charge for a pharmaceutical that has been donated, though an administration and/or dispensing fee <i>is</i> 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 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 which are bundled together to form an ADHC service are <i>not</i> 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. 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. In most cases a significant portion of the total charge will transfer to Medicaid 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 <i>not</i> insurance programs. They pay for a service, but the patient is to be classified according to his/her 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 <i>is</i> an “other public” payer for the service. The clinic’s usual and customary charge for the service (<i>not</i> 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 <i>is not shown on Table 9E</i> . It is fully accounted for on Table 9D.

State or Local Safety Net Programs

These are programs which pay for a wide range of clinical services for uninsured patients, generally those under some income limit set by the program. They may pay based on a negotiated fee-for-service, or fee-per-visit. They may also pay “cents on the dollar” based on a cost report, in which case they are generally referred to as an “uncompensated care” program. 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 of the charge if there is no required co-payment) is reported as a sliding discount in Column E.
9E	The total amount received during the calendar year from the State or local indigent care program is reported on Line 6a.

Workers' Compensation

Tables Affected	Treatment
4	Workers' Compensation is a form of <i>liability insurance for employers</i> , not a <i>health insurance for employees</i> . 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 <i>any</i> 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	While there are many individuals whose insurance premium is paid for, in whole or in part by a government, ranging from military and dependents to school teachers to congressmen and HRSA staff, these are all considered to be private insurances. They are reported on Line 11 (Private), <i>not on Line 10a</i> .
9D	Charges, collections, and allowances are reported on Lines 10–12 (Private), <i>not on Lines 7–9</i> .

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	<p>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).</p> <p>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”.) <i>Family insurance must be reported. Except for confidential minor consent services, it is not acceptable to report the student as uninsured.</i></p>
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. <i>Do not report on Line 12 - “other related services.”</i>
9D	<i>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).</i>
9E	<i>Contract revenue is not reported on Table 9E.</i>

CHIP (CHIP-RA)

Tables Affected	Treatment
4	<p>Medicaid: If CHIP is handled through Medicaid and the enrolled patients are identifiable, they are reported on Line 8b. <i>If it is not possible to differentiate CHIP from regular Medicaid, the enrolled patients are reported on Line 8a with all other Medicaid patients.</i></p> <p>Non-Medicaid: CHIP enrolled patients in States which do not use Medicaid are reported as “Other Public CHIP” on Line 10b. Note that, even if the plan is administered through a commercial insurance plan, the enrollees are <i>not reported on Line 11.</i></p>
9D	<p>Medicaid: Report on Lines 1–3, as appropriate.</p> <p>Non-Medicaid: Report on Lines 7–9, as appropriate. <i>Do not report on Lines 10–12 even if the plan is administered by a commercial insurance company.</i></p>

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. <i>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.</i>
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). 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 his/her 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 <i>is not shown on Table 9E</i> . It is fully accounted for on Table 9D.

EHR Staff and Costs

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 the clinical program, though some aspects may be considered to be non-clinical support.

Tables Affected	Treatment
5	<p>The staff members dedicating some or all of their time to the operation of the EHR are reported as medical* on the appropriate line. This includes those involved in the design of medical forms, data entry, and analysis of EHR data, as well as help-desk, training and technical assistance functions. Staff managing the hardware and software of a PMS billing and collection system is reported as non-clinical support staff.</p> <p>*If the EHR also covers dental and/or mental health and/or vision, some portion of these staff (and costs) would be allocated to dental (line 18), mental health (line 20c) or vision (line 22c).</p>
8A	<p>Cost for staff noted above as being included in medical* staff are reported on Line 3, as are all costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the EHR; if the EHR covers dental and/or mental health, then some of costs will logically be allocated to these lines as well.</p> <p>*If the EHR also covers dental and/or mental health and/or vision, some portion of these staff (and costs) would be allocated to dental (line 5), mental health (line 6) or vision (line 9a).</p>

(Migrant) Vouchers

Voucher Programs have traditionally been an exclusive part of the Agricultural worker program, though in recent years some Homeless and even other health center programs have made use of the mechanism. In this system, the center identifies services that are needed by its patients which cannot be provided by its in-house staff. Vouchers are written 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	<p>Patients are counted even if the only service that they receive is a paid vouchered service, provided that these services would make the patient eligible for inclusion if the center provided them. Thus a vouchered taxi ride would <i>not</i> make the patient "countable" because transportation services are not counted on Table 5, but a vouchered eye exam would count.</p>

Tables Affected	Treatment
5	<p>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 <i>at</i> the center, the FTE of <i>that</i> provider <i>is</i> counted. For example, the one-day-a-week family practitioner would be reported as 0.20 FTEs on Line 1. But the 125 vouchered visits to FPs would not result in an additional count on Line 1.</p> <p>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).</p>
6A, 6B, 7	<p>Diagnoses and Services: The Voucher Program is expected to receive from the provider a bill similar to a HCFA-1500 which lists the services and diagnoses. These are to be tracked by the center and reported on Table 6A, 6B, and 7, where appropriate.</p>
8A	<p>Cost of Vouchered Services: The costs are reported on the appropriate line. Medical vouchers are reported on Line 1, not Line 3. Report <i>only</i> those costs paid directly by the health center.</p> <p>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.” <i>While this is not required</i>, 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.</p>
9D	<p>Column A: Charges—Report the full charge that the provider shows on his/her HCFA-1500 as the charge on Line 13 – self-pay. Do not use the voucher amount as the full charge.</p> <p>Column B: Collections—If the patient paid the voucher program or the voucher provider a nominal or other fee, show this in Column B.</p> <p>Column E: Sliding Discounts—Show the difference between the full charge and the amount that the patient was <i>supposed to pay</i> 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.</p> <p>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.</p>

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 an Electronic Health Record must include a minimum of 80% of all medical (or dental for the sealants measure) patients from all service delivery sites and grant funded programs (e.g., CHC, HCH, MHC, PH) in the defined universe. In addition, the data source must cover the period of time to be reviewed (e.g., 3 to 5 years for pap tests, 4 years for immunizations) and include information to assess meeting the measurement standard with the clinical measure as well as to evaluate exclusions.

If all of these conditions can be met, reporting on the universe is more accurate because it reports on 80% 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% of the patients in the universe as long as the reason for using less than 100% 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% 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% of the universe (or if they choose not to use their 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 which are similar to outcomes reported for the universe of patients because the sample is “representative” of the universe.

Step by Step Process for Reporting Clinical Measures Using a Random Sample

For each measure, perform each of the following steps.

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

Define the universe for 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 (HCH, PHPC, MHC, CHC)
- 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-9 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 or not the patient had two medical visits during the year may be more difficult to add to a query. Others, such as whether a woman has ever had a hysterectomy, may not be available. When criteria cannot be used to 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, than 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 3 year old was first seen after his/her third birthday) may be used to exclude a record. Some specific criteria which may be used to exclude a record include:

- All measures – not a medical patient
- Childhood immunizations – none

- Cervical cancer screening – women who have had a hysterectomy
- Controlled hypertension – pregnant patients, end stage renal disease
- Controlled diabetes – patients with a diagnosis of polycystic ovaries that do not have two face-to-face visits with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year; gestational diabetes; or steroid-induced diabetes during the measurement year
- Child and Adolescent weight – pregnancy
- Adult weight – pregnancy or imminent demise
- Persistent Asthma – allergic response to asthma medication
- Tobacco use – patient is no longer a tobacco user
- CAD – LDL < 130mg/dL; or allergic response to LDL lowering medication
- IVD – none
- Colorectal cancer screening – patients who have or had colorectal cancer
- HIV linkage to care – none
- Depression screening – patient is actively involved in depression treatment
- Dental sealants – children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)

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](http://www.randomizer.org/form.htm) at <http://www.randomizer.org/form.htm>. 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 1 list of 70 numbers.
2. Complete the “Number Range” by entering the 1 as the first number and the total number of patients in the universe for the particular measure under consideration as “n.” For example, if there are 628 children who turn 3 in the reporting year in the universe, enter 628 as N.
3. Then click on the button, “Randomize Now!” A list of randomly generated numbers will be created. These numbers correspond with the numbered list of patients in the

universe prepared in Step 1, above. (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:

Record #	Amount	
1	951456	
2	234951	← First record = #2 <i>selected at random from between 1 and 3</i>
3	492374	
4	157614	
5	736812	← Next records = #5 (2+3)
6	453764	
7	416145	
8	801784	← #8 (5+3)
9	481454	
10	487151	
11	158124	← #11 (8+3)
12	484504	
13	789415	
14	781763	← #14 (11+3)
15	745485	

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 Persistent Asthma Universe Where Codes Are Unavailable

Under certain situations, a larger number of records may need to be identified in order identify the necessary 70 random records. Because the “persistent asthma” measure does not have CPT or ICD-9 codes to identify the universe, alternative instructions for determining the size of the universe and measuring the performance standard are provided.

1. Identify all patients with any asthma diagnosis.
2. Review these records to find 70 records where the notes or other material demonstrate that the asthma is persistent (i.e., not intermittent).
3. *Estimate* the size of the universe by:
 - a. Dividing 70 by the number of records you had to review to find the 70
 - b. Multiplying the total number of asthma records found in step 1 by the ratio just calculated
4. Enter the estimated universe in Column a; “70” in Column b; and the number of those 70 who met the measure (pharmacologic treatment).

Appendix D: Health Center Electronic Health Record (EHR) Capabilities and Quality Recognition

Instructions

The Electronic Health Record (EHR) Capabilities and Quality Recognition Form includes a series of questions on health information technology (HIT) capabilities, including EHR interoperability and leverage for Meaningful Use. The EHR and Quality Recognition Form must be completed and submitted as part of the UDS submission. It includes questions about the health center's 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 PCMH).

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 EHR 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, 2015, 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 has 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, 2015, 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. While some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response "a." For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients and does not include administrative only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis.
- b. **At some sites or for some providers:** Select option b if one or more permanent 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, 2015, 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](#).) 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 center 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, 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 is 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
 - c. If yes, then 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 (AAHC)

Appendix E: Reporting for Health Center Program Look-Alikes

Health Center Program look-alikes are health centers that have been determined to meet Health Center Program requirements under section 330 of the PHS Act, although they do not receive section 330 grant funding.

Look-alikes are required to submit UDS data to HRSA through the EHB in the same manner as grantees. This allows HRSA to bring together data and information used to monitor look-alikes, record program changes, and track program performance in one centralized system.

Where an entire agency is designated as a look-alike, the look-alike reporting will cover the activities of the entire agency. However, when only a portion of an agency (e.g., only one of a number of sites) is designated, the look-alike report must accurately reflect this partial designation such that look-alike data represent only that portion of their agency that is designated as a look-alike. Special care should be taken in allocating only a part of the administrative and/or facility costs where these are shared between the look-alike and the overall corporation or agency.

Special care must also be taken by the limited number of “dual status” agencies. “Dual status” occurs when a health center receives grant funding under section 330 for sites in the grant’s approved scope of project and, at the same time, operates at least one other site under a look-alike designation. Dual status health centers must maintain separate and distinct scopes of project for the look-alike and grant scopes of project within their health center. Administrative costs must be allocated when reporting on both the grantee and look-alike UDS. Under no circumstances can the same cost be included in both the look-alike and grantee reports.

Data will be reported by look-alikes using the definitions and rules in this manual. General exceptions to the reporting for look-alikes from the grantee reporting outlined in this manual are:

- Look-alikes complete only a Universal report. Discussion of grant tables is not applicable.
- Look-alikes report a modified version of BPHC grantee tables. Fields for data elements that do not apply or for which look-alikes are not required to report are grayed-out.

When reviewing UDS tables in this manual, look-alikes should note that they are the unmodified BPHC grantee tables. The look-alike UDS tables displayed in EHB will reflect the modifications described above and specified below.

Tables and Modifications

Service Area

Health Center Profile: Patients by Zip Code

Modification: None

Patient Profile

Table 3A: Patients by Age and Gender

Modification: None

Table 3B: Patients by Hispanic/Latino Ethnicity and Race; Patients Best Served in a Language Other Than English

Modification: None

Table 4: Selected Patient Characteristics

Modifications:

- Lines 14 and 15: No details are reported on agricultural patients
- Lines 17–22: No details are reported on homeless patients

Staffing and Utilization

Table 5: Staffing and Utilization

Modification: None

Table 5A: Tenure for Health Center Staff

Modification: None

Clinical

Table 6A: Selected Diagnoses and Services Rendered

Modification: None

Table 6B: Quality of Care Measures

Modification: None

Table 7: Health Outcomes and Disparities

Modification: None

Financial

Table 8A: Costs

Modification: None

Table 9D: Patient Related Revenue

Modification: None

Table 9E: Other Revenue

Modification: Data reported on BPHC 330 grants are not reported

Other Forms

Appendix D: EHR Capabilities and Quality Recognition

Modification: None

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/ehb/help.aspx	877-464-4772
EHB electronic reporting issues	BPHC Helpline	BPHC Helpline at http://www.hrsa.gov/about/contact/bphc.aspx	877-974-2742

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](http://bphc.hrsa.gov/datareporting/index.html) at <http://bphc.hrsa.gov/datareporting/index.html> or the [UDS Training Website](http://www.bphcdata.net/html/bphctraining.html) at <http://www.bphcdata.net/html/bphctraining.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	Julie Boden Schmidt; jschmidt@nachc.com	301-347-0467

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	215-731-7141
National Center for Health in Public Housing (NCHPH)	http://www.nchph.org	Karen Williams; Karen.williams@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	512-312-2700

Health Care for the Homeless Program

Organization	Website	Contact and Email	Phone
National Health Care for the Homeless Council (NHCHC)	http://www.nhchc.org	John Lozier; jlozier@nhchc.org	615-226-2292

Other Vulnerable Populations

Organization	Website	Contact and Email	Phone
Association of Asian Pacific Community Health Organizations (AAPCHO)	http://www.aapcho.org	Nina Agbayani; nagbayani@aapcho.org	510-272-9536 x102
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 centers can access their current year and prior year UDS reports, as well as several standard reports, through the [EHB Web-link](https://grants3.hrsa.gov/2010/WebEPSEExternal/Interface/common/accesscontrol/login.aspx) at <https://grants3.hrsa.gov/2010/WebEPSEExternal/Interface/common/accesscontrol/login.aspx>.

Reports and Their Availability

UDS Report Level	Timing	Description	Grantee*	Look-Alike*
<i>Health Center Trend Report</i>	July	Compares the Health Center's performance for 16 key performance measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3 year period.	HC, S, N	HC, N
<i>UDS Summary Report</i>	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
<i>UDS Rollup Report</i>	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

UDS Report Level	Timing	Description	Grantee*	Look-Alike*
<i>Performance Comparison Report</i>	September	Provides the summary and analysis on the Health Center's latest UDS data giving details at Grantee, State, National, Urban and Rural level 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