UDS TRAINING
November 9, 2015
Rochester, NY

Presenter:
Suz Friedrich

Today's Agenda

- Using the UDS for Program Monitoring and Improvement
- Table by Table Instructions
- State-based Specific Data Reporting
- Sample Data Scenarios
- Submission Instructions
- Available Assistance
- Discussion Forum

The UDS in Context

- What challenge is the health center program trying to address?
- What is our approach?
- How do we know if we are succeeding?
- How are we doing?

UDS
UNIFORM DATA SYSTEM

HRSA
Health Center Program

The UDS in Context

What is the challenge we are trying to address?

- Improve the health status of vulnerable and at risk populations.

HRSA Health Center Program

What is the challenge the health center program is trying to address?

What is our approach?

- Eliminate financial, linguistic and cultural barriers to access high quality, comprehensive health services.

HRSA Health Center Program

What is the challenge the health center program is trying to address?

What is our approach?

How do we know if we are succeeding?

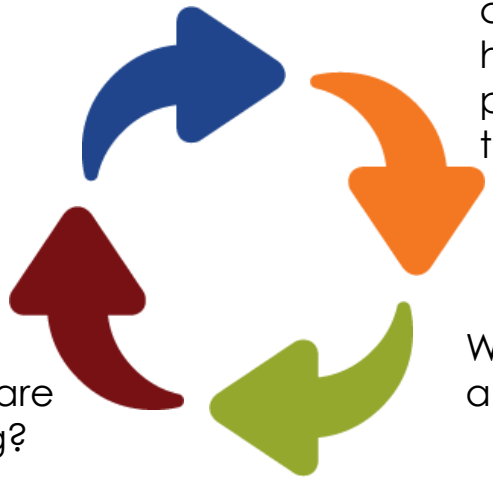
- UDS data.

HRSA Health Center Program

How are we doing?

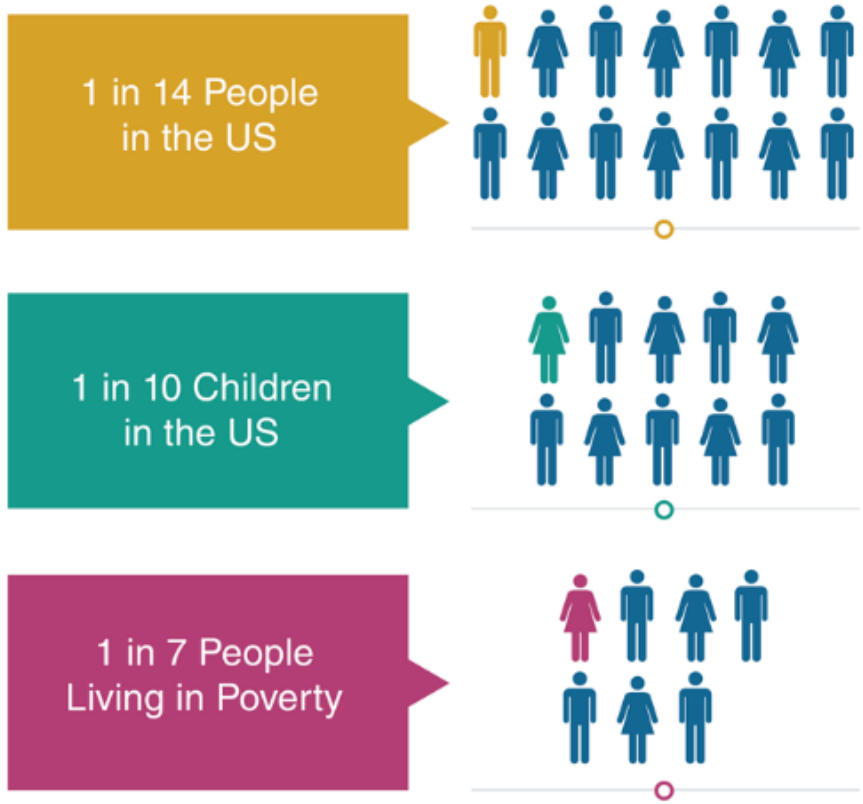
- UDS data trended over time and compared with national benchmarks answers the questions.

HRSA Health Center Program



Quick Facts

- How many patients are we serving?



Almost 23 million people receive primary medical, dental or behavioral health care from a health center

UDS answers the questions.

- **Patient profile:** Are you serving populations proposed in your application?
- **Quality of care:** Are you delivering high quality care according to your clinical performance measures?
- **Service Delivery:** What supports the delivery of services to patients?

- Are you serving populations proposed in your application?
- Are you delivering high quality care according to your clinical performance measures?
- What supports the delivery of services to patients?

Are you serving proposed patient populations?

- Are you serving BPHC priority patient populations?
  - Vulnerable and at-risk populations
  - Who lack access to care or
  - Experience barriers to care.

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Are you serving proposed patient populations?

Patient Profile

Are you serving your proposed population?

- Reach: Are you serving your proposed patient projections?
  - Projections included in health center applications
- Geographic origin: Are you serving your area?
  - Proposed vs. actual service area (Form 5B vs. ZIP code table)
- Demographic characteristics: Are you serving patients with access barriers?
  - Individuals with financial, cultural, racial/ethnic and linguistic barriers to care
  - Special populations

- Are you serving your proposed patient projections?
- Are you serving your area?
- Are you serving patients with access barriers?

Patient Profile Tables

- The same patients are reported in each table so totals must be equal!

Table	Description
ZIP code	Patients by ZIP code and insurance
3A	Patients by Age and Gender
3B	Patients by Race and Ethnicity
4	Patients by Income, Insurance and Special Populations

Total Patients: Who Counts?

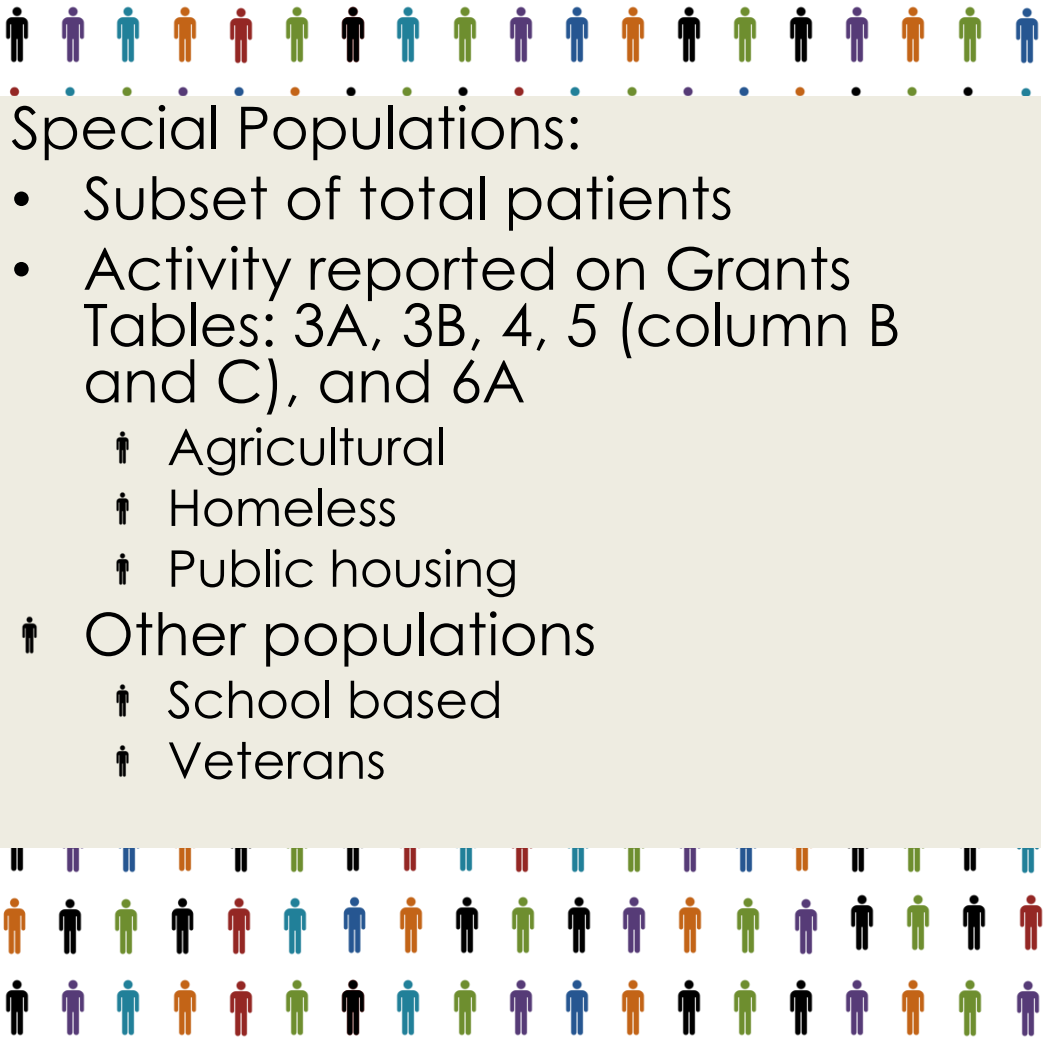
- Unduplicated count of individuals who receive at least one countable health service during reporting year.
- Countable services include medical, dental, mental health, substance abuse, vision, case management, health education.
  - A countable service is defined as a reportable visit during the year. We will learn more about what kinds of visits count when we get to Table 5.

Total Patients:

- Unduplicated count
  - At least 1 countable health service
  - i.e., medical, dental, mental health, substance abuse, vision, other professional, case management and health education

Special Population Patients: Who Counts?

- Subset of total patients
- **Agricultural:** Individuals employed in agriculture on a seasonable basis within last 24 months and their family members, and retired agricultural workers
- **Homeless:** Person known to be homeless at any time during reporting year
- **Public Housing:** Patients served in public housing clinics
- **Other Populations:**
  - School-based health center patients
  - Veterans



Special Populations:

- Subset of total patients
- Activity reported on Grants Tables: 3A, 3B, 4, 5 (column B and C), and 6A
  - Agricultural
  - Homeless
  - Public housing
- Other populations
  - School based
  - Veterans

Patients by ZIP Code and Insurance

- List all ZIP codes with 11 or more patients in column A
  - Aggregate all ZIP codes with 10 or fewer patients in "other"
- Report patients for each ZIP code by primary Medical Insurance
  - Totals by insurance must equal Table 4
  - Dually eligible are included with Medicare
- Special populations
  - Homeless with no address – use ZIP code of service location
  - Agricultural – use local address

PATIENTS BY ZIP CODE

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ S-CHIP/ Other Public (c)	Medicare (d)	Private (e)
Other ZIP Codes				
Unknown Residence				
TOTAL				

Combined ZIP totals by insurance = Table 4 totals by insurance

- Homeless ZIP = Service Location ZIP
- Agricultural ZIP = Local Address

3A: Patients by Age and Gender

- Age calculated as of June 30 (point in time).
- Transgender patients are reported by the patient's self-reported gender.

TABLE 3A – PATIENTS BY AGE AND GENDER

	AGE GROUPS	MALE PATIENTS (a)	FEMALE PATIENTS (b)
1	Under age 1		
2	Age 1		
3	Ag		
4	Ag		
5	Ag		
6	Ag		
7	Ag		
8	Ag		
9	Ag		
10	Ag		
11	Ag		
12	Ag		
13	Ag		
14	Ag		
18	Ag		
19	Ag		
20	Ag		
21	Ag		
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)		

Transgender = patient's self-reported gender

3B: Race/Ethnicity and Language

- Ask all patients to self report ethnicity AND race
  - Patients can indicate multiple races (report on line 6)
  - If patient does not explicitly choose Hispanic / Latino, report in column B
  - If race is unreported, report on line 7
  - Only report patients who did not provide ethnicity or race in column C.
- Line 12 reports patients best served in a language other than English.
  - Can be estimated.

TABLE 3B – PATIENTS BY HISPANIC OR LATINO ETHNICITY/RACE/LANGUAGE

PATIENTS BY RACE		PATIENTS BY HISPANIC OR LATINO ETHNICITY			
		HISPANIC/ LATINO (a)	NOT 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.	**T**otal **H**awaiian/**O**ther **P**acific **I**slander (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)				

Patient Profile

4: Selected Patient Characteristics

- Table 4 records select patient characteristics
- Income must be updated annually
  - Report most recent income information
  - Income may be self-reported if permitted by your policy

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	Characteristic	Number of Patients
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	

- Report most recent
- Self-report, if permitted

Line				(c)		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
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)	

4: Patients by Medical Insurance

- Must report primary medical insurance information for all patients
  - Primary medical insurance is defined as the insurance plan/program that the health center would typically bill first for medical services.
  - Regardless of whether receive medical care.
  - Insurance is reported as of last visit.
  - Totals by age and insurance must match Tables 3A and ZIP code table.

Patient Profile

Table 4: Selected Patient Characteristics

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

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)		

PATIENTS BY ZIP CODE

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ S-CHIP/ Other Public (c)	Medicare (d)
Other ZIP Codes			
Unknown Residence			
TOTAL			

TABLE 3A – PATIENTS BY AGE AND GENDER

	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		

Patient Profile

4: Insurance Categories

- Line 7: None/No insurance
  - Uninsured may not be used for homeless, school based, etc.
- Line 8a: Regular Medicaid including managed care programs run by commercial insurers
- Lines 8b or 10b: CHIP
  - If provided through Medicaid it is reported on Line 8b (CHIP Medicaid)
  - If provided through a commercial carrier outside of Medicaid it is reported on Line 10b – do not report as Private Insurance

Table 4: Selected Patient Characteristics

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

Line	Principal Third Party Medical Insurance
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 8b: CHIP through Medicaid

Line 10b: CHIP through commercial carrier

STATE SPECIFIC REPORTING:
New York reports CHIP as Other Public, Line 10b.

Patient Profile

4: Insurance Categories

- NEW Line 9a: Report dually eligible on 9a and include on 9
  - Patients with Medicare and Medicaid insurance
- Line 9: Medicare, Medicare Advantage and Medi-Medi
- Line 10a: Other public insurance that covers broad set of benefits
  - Not single service programs – FP, EPSDT, BCCCP
- Line 11: Private commercial insurance
  - Not workers compensation

Table 4: Selected Patient Characteristics

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

Line	Principal Third Party Medical Insurance
7.	**None/Uninsured**
8a.	Regular [illegible] Title XIX)
8b.	CHIP [illegible]
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)

NEW

Line 10a: Other public insurance ≠ not single service programs

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STATE SPECIFIC REPORTING:

Family Health Plus – Medicaid line 8a.

SCHIP or Child Health Plus - Other Public 10b.

Healthy NY – Other Public 10a .

ADAP and NY Public Goods Pool – patient is uninsured, Line 7

4: Managed Care Utilization

- Completed only for capitated and/or fee-for-service (FFS) managed care (HMO) contracts
- Do not count Primary Care Case Management patients or patients capitated for non-medical services only (dental, mental health, etc.)
- Report the sum of monthly enrollment for 12 months; a member month = 1 member for 1 month.
  - For example, a member enrolled from March – July would be 5 member months.

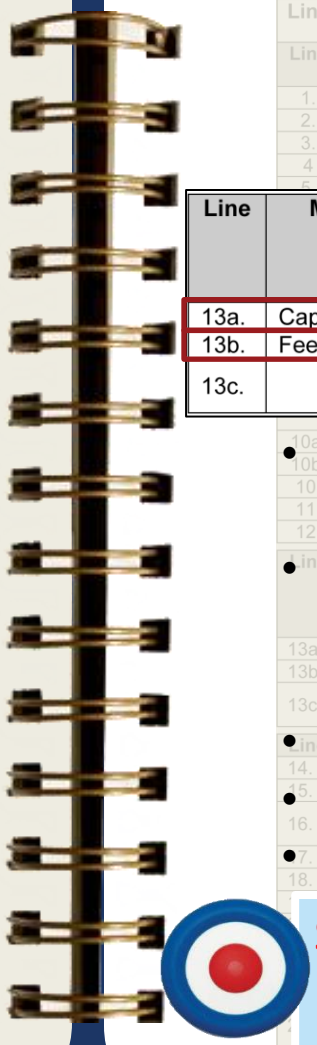

Table 4: Selected Patient Characteristics

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	

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)**					

- Do not include Primary Care Case Management as managed care
- Do not include single service non-medical capitation plans (e.g., dental, mental health, etc.)
- 1 member month = 1 member for 1 month.
- Must sum all 12 months enrollment.
- Table 4 managed care relates to Table 9D

STATE SPECIFIC REPORTING:
New York programs report capitated and/or FFS managed care enrollment in some or all insurance categories.

4: Special Populations

- Agricultural
  - Line 14: "Migratory" Workers who establish temporary home(s) for such employment.
  - Line 15: "Seasonal" Workers who do not live away from home.
  - Line 16: Migratory and seasonal workers, their families, and retired agricultural workers, regardless of migratory or seasonal status when they were working
- Homeless
  - Report where they are housed as of first visit in 2015.
  - If institutionalized, report where they will spend the night after release
- School-Based
  - Persons receiving services in designated school based health center (on or near school)
- Veteran
  - Persons who have completed service in Uniformed Services of U.S.; not active members
- Public Housing
  - Patients served at health center sites that meet statutory PHPC definition (located in or accessible to public housing)

Table 4: Selected Patient Characteristics

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

Line	Special Populations
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)

All health centers must report total number of special population patients (if any) on Lines 16, 23, 24, 25, and 26 even if they do not have targeted funding.

Patient Profile

2014 UDS Statistics

- Patient Profile
  - Comparison of national census data with health center patient profile for nation and state

Patient Profile Indicators	National (ACS 2009-2013, etc.)	2014 UDS Nation	NY
% Uninsured	15%	28%	19%
% Medicaid/ CHIP/Other Public	17%	48%	55%
% Low income (at or below <200% FPL)	34%	92%	86%
% Racial and/or ethnic minority	37%	62%	77%
% Hispanic or Latino	17%	35%	35%
% Best served in another language	9%	23%	26%
% Homeless	.2%	5%	5%
% Agricultural workers	.9%	4%	1%
% Public housing	.8%	2%	4%
% School-based health		2%	4%
% Veterans		1%	1%

Are you delivering high quality care according to your clinical performance measures?

- Achieve national benchmarks for routine and preventive, chronic care, prenatal care, and healthy behaviors.

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Are you delivering high quality care according to your clinical performance measures?

Quality of Care

Are you delivering high quality care according to your clinical performance measures?

- **Comprehensiveness:** What comprehensive services are you providing?
- **Continuity:** How are patients getting adequate access to care?
- **Prevalence :** How are you identifying all patients for indicated service?
- **Performance Measure Standard:** What measures meet or exceed performance standard?
- **Timeliness:** How are you ensuring that patients are being screened/treated in a timely manner?

- What comprehensive services are you providing?
- How are patients getting adequate access to care?
- How are you identifying all patients for indicated service?
- What measures meet or exceed performance standards?
- How are you ensuring that patients are being screened/treated in a timely manner?

Quality of Care Tables

- Patients reported on the clinical tables are related to other data including data on gender, age, race, and ethnicity.

Table	Description
6A	Diagnoses and Services
6B	Quality of Care Measures
7	Health Outcomes and Disparities

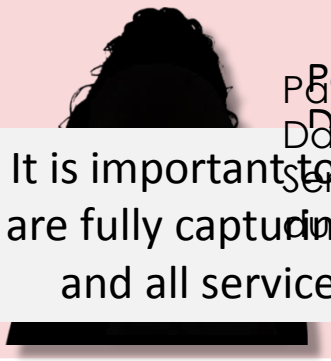
6A: Diagnoses and Services

- Table 6A has 2 parts: Selected Diagnoses and Selected Services
- For 2015, note that ICD-9 and ICD-10 codes are listed.
  - Careful attention is required to ensure patient activity is unduplicated
- Column A: Report number of visits with service or diagnosis
  - If patients have more than one reportable service/diagnosis during a visit, each is counted (e.g., Pap test and contraceptive services)
  - Do not report multiple services in same category (e.g., DPT and MMR at same visit)
- Column B: Report number of unduplicated patients receiving service or with diagnosis
  - Same patient can have multiple visits (e.g., 2) for same service – in which case 2 in column A and 1 in column B.
  - Can calculate visits per patient by dividing column A by column B. Check for reasonableness.

Quality of Care

Table 6A: Selected Services Rendered

NEW



Patient: Beryl S.
Date: 10/13/2015
Services: 2 Pap test
during the day

It is important to ensure health centers are fully capturing every diagnosis code and all services provided at visits.

		Applicable	Applicable ICD-10-CM	Nu	er of s
Servi					
Selec					
21.					
21a.					
21b.					
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	2 1	1
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	~~2~~	
24a.	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-	1	

6B: Quality of Care Measures

- Here are the measures included in Table 6B.
- Consists of "Process measures": If patients receive timely routine and preventive care, then we can expect improved health
  - e.g., if women receive timely routine pap tests, any cancer detected, it can be addressed earlier with a higher probability of a positive outcome.

Quality of Care

Table 6B: Quality of Care Measures

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

Timely Routine and Preventive Care

1	Trimester of entry into prenatal care
2	Childhood immunization
3	Cervical cancer screening
4	Weight assessment and counseling for children and adolescents
5	Adult Weight screening and follow-up
6	Tobacco use screening and cessation intervention
7	Asthma pharmacologic therapy
8	Coronary artery disease (CAD): Lipid therapy
9	Ischemic Vascular Disease (IVD): Aspirin or antithrombotic therapy
10	Colorectal cancer screening
11	HIV linkage to care
12	Patients screened for depression and follow-up
13	Dental sealants

		(a)	(b)	
11	MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

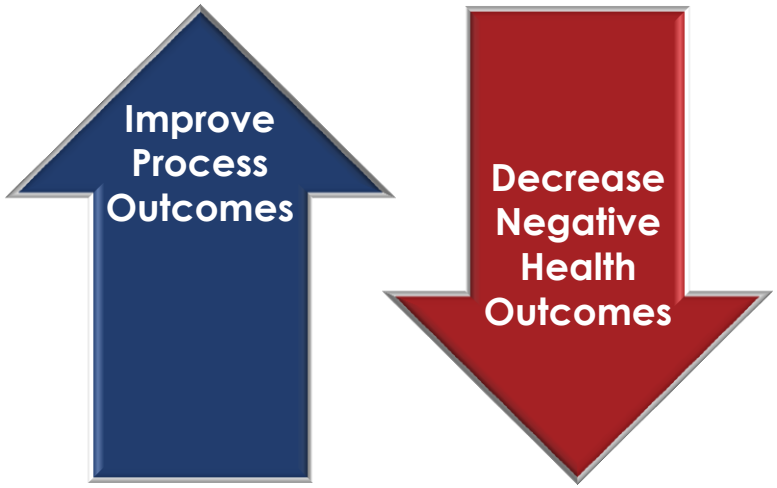
Section E - Weight Assessment and Counseling for Children and Adolescents

	Weight Assessment and	Total patients aged 3-17 on	Number Charts	Number of Patients with Counseling

7: Process Measures

- Table 7 focuses on three process measures : low birth weight, hypertension, and diabetes.
- If these measurable outcomes are improved, then later negative health outcomes will be less likely.
  - For example, hypertensive patients whose blood pressure is controlled, have reduced risk for future heart attack, stroke, coronary heart disease, heart failure, and kidney failure.

Measureable Process Outcomes
Low birth weight
Controlled hypertension
Poorly controlled diabetes



6B & 7: Prenatal and Birth Weight Reporting

- 6B: Report all patients, who received ANY prenatal care regardless of whether they delivered or transferred out during year
  - Age is as of June 30
- AND all patients who test positive for pregnancy and were referred for obstetrical care during the year
  - Do not include patients who only had tests, vitamins, assessments or education
- Check box to indicate if prenatal is provided by referral only

Table 6B: Quality of Care Measures

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

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

- Report all women who receive any prenatal care or are referred for care.

Prenatal care is provided by referral only

NEW

6B & 7: Prenatal and Birth Weight Reporting

- Report trimester women began care and whether entry was with the health center or another provider
- Trimester of entry into prenatal care
  - 1st: up through the end of the 13th week after conception
  - 2nd: start of the 14th week and the end of the 26th week after conception
- Entry into prenatal care occurs when the patient has a visit with a provider who initiates prenatal care with a complete physical exam (i.e., not a pregnancy test, nurse assessment, etc.)
- Women referred for all prenatal care by the health center report in column A
- Performance Standard: % of women who enter care in their first trimester

Table 6B: Quality of Care Measures

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

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		

- Report trimester women began care and whether it was with the health center or another provider
- Entry into prenatal care occurs when the patient has a visit with a provider who initiates prenatal care with a complete physical exam (i.e., not a pregnancy test, nurse assessment, etc.)
- Women who were referred by the health center for all their prenatal care are counted in Column A.
- Performance Standard: % of women who enter care in their first trimester (up through end of 13th week after conception)

6B & 7: Prenatal and Birth Weight Reporting

- Line "0" – report pregnant HIV patients seen in clinic whether or not they are the health center's (HC) prenatal patient
- Line 2: report deliveries performed by HC providers whether or not HC patients
- Report all prenatal patients from 6B that delivered during year
  - 1a: All known deliveries even if done by non-health center provider
- Report babies born
  - 1b-1d: Live births, by weight, born during the year to prenatal care patients and referred women, regardless of who performed the delivery
- Prenatal women ≠ Deliveries ≠ Birth outcomes
- 1a-1d: reported by race and ethnicity of mother and separately of infant
- Performance Measure: % of births below 2500 grams

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				

- Column 1a: Women known to have delivered (of prenatal patients on Table 6B, line 6)
  - Miscarriages are not counted as delivery, but the prenatal patient is reported on Table 6B
  - Stillbirths are, however, counted as a delivery for the mother (column 1a), but there are no birth outcomes reported in 1b, 1c, or 1d
- Column 1b-1d: Live births during year by birth weight (of patients on Table 7, column 1a)
  - Count twins as two births, triplets as three, etc.
  - Do not count still births
- Performance Measure: % of births below 2500 grams

Table 6B & 7: Overview

- All non-prenatal Table 6B measures follow the same format
  - Column A – universe
  - Column B – sample or universe (80% - 100%)
  - Column C = number in Column B that meets performance standard
- Calculation for each measure
  - Column C/Column B = % of patients meeting performance standard
- Table 7 non-prenatal measures follow same format
  - Column A = universe
  - Column B = sample or universe (80% - 100%)
  - Remaining columns report number of patients with result
  - Note unlike Table 6B, 7 is reported by race and ethnicity
- ICD-9 and 10 codes are included in the manual to help identify universes, exclusions, and measure standards

Table 6B

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 3rd birthday during measurement year (on or prior to December 31)			

Table 7

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			
	Subtotal Hispanic/Latino			

ICD-9 and 10 codes are included in the manual to help identify universes, exclusions, and measure standards

6B & 7: Universe (Column A)

- **For all clinical measures, you must report the universe**
- Each measure has a unique universe
- **Universe:** Includes all individuals who are eligible to be included in the measure
- **Universe is reported in column A of Tables 6B and 7**

Universe

Each measure has one!

Includes all individuals eligible to be included

6B & 7: Column A

Quality of Care

6B: Universe by Measure (Column A)

- Report universe in Column A
- Each measure has a unique universe defined by specific criteria
  - Requires that patient is a service patient *(directly or through paid referral under contract)* in the calendar year.
    - At least one medical visit for most measures
    - At least one dental visit for one measure
    - Seen during required period
  - Other criteria may include:
    - Age
    - Gender
    - Underlying health condition
    - Exclusions

Line	Childhood Immunization
10	MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to December 31)

Line	Cervical Cancer Screening
11	MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer

Line	Weight Assessment and Counseling for Children and Adolescents
12	MEASURE: Children and adolescents aged 3 until17 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

Childhood Immunization
- Children born between 1/1/11-12/31/11 (24 months old) as of 12/31/12
- At least one medical visit in reporting year before 2nd birthday

Cervical Cancer Screening
- Women born between 1/1/51-12/31/91 (21-64 years old) as of 12/31/12
- At least one medical visit in reporting year

Weight Assessment and Counseling for Children and Adolescents
- Children born between 1/1/95-12/31/12 (0-17 years old) as of 12/31/12
- At least one medical visit in reporting year
- First seen before 18th birthday
- Exclude pregnant women with adolescents hysterectomy

17% children and adolescents (2-19) are obese (2011-2012)

6B: Universe by Measure (Column A)

- Report universe in Column A
- Each measure has a unique universe defined by specific criteria
  - Requires that patient is a service patient *(directly or through paid referral under contract)* in the calendar year.
    - At least one medical visit for most measures
    - At least one dental visit for one measure
    - Seen during required period
  - Other criteria may include:
    - Age
    - Gender
    - Underlying health condition
    - Exclusions

Quality of Care

Line	Adult Weight Screening and Follow-Up
13	MEASURE: Patients aged 18 and older with (1) BMI charted *and* (2) follow-up plan documented *if* patients are overweight or underweight

Line	Tobacco Use Screening and Cessation Intervention
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 *and* (2) for those identified as tobacco user, counseling cessation

Line	Asthma Pharmacologic Therapy
16	MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan

4% of patients age 5 - 40 have persistent asthma

Adult Weight Screening and Follow-Up

- Patients aged 18 and older
- At least one medical visit in reporting year

Tobacco Use Screening and Cessation Intervention

- Patients born between 1/1/95-before 12/31/97 (18 and older)
- At least one medical visit in reporting year

Asthma Pharmacologic Therapy

- Patients born between 1/1/75-before 12/31/97 (18 and older)
- At least one medical visit in reporting year
- Seen after 18th birthday
- Exclude pregnant women and terminally ill patients
- Exclude patients with allergic

Seen at least twice over for medical visits

Diagnosed with persistent asthma

17.8% of adults 18+ smoke cigarettes

6B: Universe by Measure (Column A)

- Report universe in Column A
- Each measure has a unique universe defined by specific criteria
  - Requires that patient is a service patient *(directly or through paid referral under contract)* in the calendar year.
    - At least one medical visit for most measures
    - At least one dental visit for one measure
    - Seen during required period
  - Other criteria may include:
    - Age
    - Gender
    - Underlying health condition
    - Exclusions

Line	Coronary Artery Disease (CAD): Lipid Therapy
17	MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy

Line	Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy
18	MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI,CABG, or PTCA procedure with aspirin or another antithrombotic therapy

Line	Colorectal Cancer Screening
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

Coronary Artery Disease (CAD): Lipid Therapy

- Adults born before 12/31/97 (18 and older)
- At least one medical visit in reporting year
- **Active diagnosis of CAD or MI or had cardiac surgery**
- **Seen at least twice ever for medical visits**
- **Active diagnosis of IVD or discharged after AMI or CABG or PTCA in 2014**
- Excludes patients with LDL-C < 130 mg/dl or intolerance to LDL lowering medications

Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy

- Adults born before 12/31/97 (18 and older)
- At least one medical visit in reporting year
- **Active diagnosis of CAD or MI or had cardiac surgery**
- **Seen at least twice ever for medical visits**
- **Active diagnosis of IVD or discharged after AMI or CABG or PTCA in 2014**
- Excludes patients who have had colorectal cancer or colectomy

Colorectal Cancer Screening

- Adults born between 1/1/41-12/31/64 (51-74 years old)
- At least one medical visit in reporting year
- **Active diagnosis of CAD or MI or had cardiac surgery**
- **Seen at least twice ever for medical visits**
- Seen after 18th birthday
- Seen after 18th birthday
- Excludes patients with

Quality of Care

6B: Universe by Measure (Column A)

- Report universe in Column A
- Each measure has a unique universe defined by specific criteria
  - Requires that patient is a service patient *(directly or through paid referral under contract)* in the calendar year.
    - At least one medical visit for most measures
    - At least one dental visit for one measure
    - Seen during required period
  - Other criteria may include:
    - Age
    - Gender
    - Underlying health condition
    - Exclusions

Line	HIV Linkage to Care
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

Line	Patients Screened for Depression and Follow-Up
21	MEASURE: Patients aged 12 and older who were (1) screened for depression with a standardized tool and if screened positive, (2) had a follow-up plan documented

NEW

Line	Dental Sealants
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

HIV Linkage to Care

- Children born between 1/1/06 and 12/31/09 (6-9 years old)
- Dental patient with at least one oral evaluation within 10/1/14-9/30/15
- Excludes patients with active diagnosis of caries (defined by CDT codes)

Depression and Follow-Up

- regardless of age or gender
- Diagnosed for the first time with HIV between 10/1/14-9/30/15
- At least one medical visit during reporting year
- Were documented as having moderate to high risk for depression or bipolar disorder receiving recommended depression

8% of people age 12 and older with depression

Quality of Care

7: Universe by Measure (Column A)

- Report universe in Column A
  - By race and ethnicity
  - Note: must align with 3B
- Each measure has a unique universe defined by specific criteria
  - Requires the patient is a medical patient in the current year
    - At least two medical visits
    - Seen during required period
  - Other criteria may include:
    - Age
    - Gender
    - Underlying health condition
    - Exclusions

		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				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	*Total*				

32.5% adults age 20+ (2011-2012) are hypertensive

9.3% adults are diabetic (2014)

40a-40c

6B & 7: Reporting Options (Column B)

- **Universe:**
  - BPHC prefers reporting of universe
  - Assumes data can be extracted for all patients in the universe from EHR
  - No less than 80% of universe and *must not* be restricted by any variable related to the test measure
- **Sample:**
  - Random sample of 70 patients

6B & 7: Performance Standard (Column C)

- In general, Column C is the number of patients who meet the performance standard from Column B
- Exceptions:
  - Trimester of Entry and Low Birth Weight require all outcomes
  - Diabetes includes patients with poor control

What proportion of eligible patients have met the performance standard?

Quality of Care

6B: Performance Standard by Measure

- Report number of patients who meet the performance standard in Column C
  - Childhood Immunization
    - Vaccine list: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate
    - No exclusion for parental refusal or missed appointment
  - Cervical Cancer Screening
    - 2 options, depending on age of woman at time of test
  - Weight Assessment and Counseling for Children and Adolescents
    - Children must have both BMI percentile and counseling on nutrition and activity

Line	Childhood Immunization
10	MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to December 31)

Line	Cervical Cancer Screening
11	MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer

Line	Weight Assessment and Counseling for Children and Adolescents
12	MEASURE: Children and adolescents aged 3 until17 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

- Children who are fully immunized
- Cervical cancer screening
- Weight assessment and counseling for children and adolescents
  - Received one or more BMI percentile during 2013-2015 ***OR***
  - BMI percentile documented ***AND***
  - Counseling on nutrition (not just diet) and physical activity (not just exercise) provided during 2013-2015
- Date of vaccine required for documentation
- Good faith effort is not sufficient

6B: Performance Standard by Measure

- Report number of patients who meet the performance standard in Column C
  - Adult Weight Screening and Follow-up
    - Include patients with normal BMI in numerator
  - Tobacco Use Screening and Cessation Intervention
    - Include patients assessed and who are not tobacco users in numerator
  - Asthma Pharmacologic Therapy
    - Diagnosis of asthma (ICD-9 493.x) is not sufficient to define the universe – must report persistent asthma only

Quality of Care

Line	Adult Weight Screening and Follow-Up
13	MEASURE: Patients aged 18 and older with (1) BMI charted *and* (2) follow-up plan documented *if* patients are overweight or underweight

Line	Tobacco Use Screening and Cessation Intervention
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 *and* (2) for those found to be a tobacco user, received cessation counseling intervention or medication

Line	Asthma Pharmacologic Therapy
16	MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan

% of Adults Screened for Tobacco Use & Provided Cessation Service if Using

- Queried about their tobacco use one or more times within 24 months of their last visit ***AND***
- If found to be a tobacco user:
  - ➢ Received tobacco cessation services or
  - ➢ Received an order for a smoking cessation medication (prescription or OTC) or
  - ➢ Were found to be on (using) a smoking cessation agent

Quality of Care

6B: Performance Standard by Measure

- Report number of patients who meet the performance standard in Column C
  - Coronary Artery Disease (CAD): Lipid Therapy
    - Excludes patients whose cholesterol is controlled
    - Patients receiving a form of treatment other than pharmacologic treatment do not meet performance standard.
  - Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy
  - Colorectal Cancer Screening

Line	Coronary Artery Disease (CAD): Lipid Therapy
17	MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy

Line	Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy
18	MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI,CABG, or PTCA procedure with aspirin or another antithrombotic therapy

Line	Colorectal Cancer Screening
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

% Adults Screened for Colorectal Cancer

% CAD Patients on Lipid Therapy with Aspirin Therapy

- Patients who had a colonoscopy conducted during the reporting year or previous 4 years **OR**
- Patients who had a flexible sigmoidoscopy conducted during the reporting year or previous 4 years **OR**
- Fecal occult blood test (FOBT), or including the fecal immunochemical (FIT) test, during the reporting year

6B: Performance Standard by Measure

- Report number of patients who meet the performance standard in Column C
  - HIV Linkage to Care
    - Referral is not sufficient
    - Newly diagnosed (not all) HIV patents must be confirmed by a positive supplemental, not an initial, reactive test
  - Patients Screened for Depression and Follow-Up

    Include in numerator: 1) patients with a negative screening result ***AND*** 2) those with a positive screening who have a documented follow-up plan
  - Dental Sealants

Line	HIV Linkage to Care
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

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

NEW

Line	Dental Sealants
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

% Patients with Depression Screening & Follow-Up Care

% Newly Diagnosed HIV Patients Linked to Care

- With moderate to high risk for caries
- A medical visit with a health center provider **AND** initiates treatment for HIV
- If screening was positive, have a follow-up plan documented
- *A visit with* a referral resource who initiates treatment for HIV
- Care must be initiated to meet standard

7: Disparities

- Unlike Table 6B, Table 7 reports data by race and ethnicity
- Must be consistent with Table 3B and no racial/ethnic group can exceed totals on 3B
  - Check consistency across tables

Table 7

Line #	Race and Ethnicity
	Hispanic/Latino
1a	Asian
1b1	Native Hawaiian
1b2	Other Pacific Islander
1c	Black/African American
1d	American Indian/Alaska Native
1e	White
1f	More than One Race
1g	Unreported/Refused to Report Race
	Subtotal Hispanic/Latino
	Non-Hispanic/Latino
2a	Asian
2b1	Native Hawaiian
2b2	Other Pacific Islander
2c	Black/African American
2d	American Indian/Alaska Native
2e	White
2f	More than One Race
2g	Unreported/Refused to Report Race
	Subtotal Non-Hispanic/Latino
	Unreported/Refused to Report Ethnicity
h	Unreported/Refused to Report Race and Ethnicity
i	*Total*

Table 3B

Line	Patients By Race
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)

7: Performance Standard by Measure

- Report number of patients with
  - Controlled Hypertension
    - systolic BP < 140 mm Hg *and* diastolic BP < 90 mm Hg at the time of their last measurement
  - Poorly Controlled Diabetes
    - NEW: Table revised to report HbA1c < 8% and HbA1c > 9% or test not done
    - Removed column 3e – results will not equal 3b
    - Aligns with NQF, Meaningful Use and HP 2020

NEW

Total Patients with Diabetes	Charts Sampled or EHR Total	Patients with HbA1c <8%	~~Patients with 8% ≤ HbA1c ≤ 9%~~	Patients with HbA1c >9% or No Test During Year
(3a)	(3b)	(3d1)	(3e)	(3f)

% Hypertensive Patients with Controlled Blood Pressure

% Diabetes Patients with Uncontrolled Blood Sugar

- Column 3d1 and 3f: Report number of diabetic patients whose last HBA1c during the reporting year is in each range
  - No documented blood pressure in reporting year is reported in performance standard
  - No test in reporting year does not meet performance standard
- Column 2c: Include patients whose most recent blood pressure is less than 140/90

2014 UDS Statistics

- Quality of Care
  - Comparison of national benchmarks and HP 2020 with state and national health center performance

Quality of Care

Quality of Care Indicators	National (HP 2020, CDC etc.)	2014 UDS Nation	NY
% total patients receiving medical services		85%	84%
% total patients receiving dental services		21%	23%
Average medical visits/ medical patient (excl. nurses)		3.12	3.55
% Early access to prenatal care	74%	72%	75%
% Low birth weight	8%	7%	7%
% Childhood immunizations	80%	77%	75%
% Child and adolescent weight screening and counseling		57%	57%
% Tobacco use screening and cessation services		81%	84%
% Depression screening and follow-up		39%	54%
% Cervical cancer screening	93%	56%	59%
% Colorectal cancer screening	71%	35%	44%
% HIV linkage to care	85%	77%	81%
% Blood pressure control	61%	64%	68%
% Diabetes control	84%	69%	75%

What supports the delivery of services?

- Delivery of services aligns with your clinical and financial performance measures.
- Revenues are sufficient to cover operating costs.

UDS
UNIFORM DATA SYSTEM

HRSA
Health Center Program

What supports the delivery of services?

Are you meeting access and financial performance measure goals?

- Growth: Are you growing?
  - Consistent with NAPs and expansions?
  - Health Center Trend Report provides trends over a three-year period
- Financial Performance: Are you performing up to your financial performance measure goals?
  - Total cost per total patient (Formula: T8A_L17_CC/T5_L34_CB
  - Medical cost per medical visit (Formula: (T8A_L4_CC-T8A_L2_CC)/(T5_L15_CB-T5_L11_CB))

- Are you growing?
- Are you performing up to your financial performance measure goals?

What supports the delivery of services?

- **Capacity**: What staffing resources do you have to provide services? Do you have the necessary providers to deliver care?
- **Stability**: Are you retaining staff?
- **Access**: Do patients have access to comprehensive and continuous care?

- What staffing resources do you have to provide services?
- Are you retaining staff?
- Do patients have access to comprehensive and continuous care?

Service Delivery

- **Staffing:** What staffing support access to services?
- **Production:** Is production maximized?
- **Diversification of funding:** What are your funding sources?
- **Billing practices:** Do billing practices maximize revenues?
- **Cost-effectiveness:** Do costs support competitive pricing?
- **Profitability:** How do your expenses relate to revenues?

Table	Description
5	Staffing and Utilization
5A	Tenure
8A	Financial Costs
9D	Income from Patient Revenues
9E	Other Revenues

Service Delivery

5: Staffing and Utilization

- **Column A:** FTEs
- **Who:** All staff providing in-scope services
  - Include employees, contracted staff, residents, and volunteers
  - Do not include paid referral (fee-for-service (FFS) basis) provider FTEs

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			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 -**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NPs, PAs, and CNMs (Lines 9a - 1**			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	**Total Medical (Lines 8 + 10a through 1**			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	**Total Dental Services (Lines 16 - 1**			
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**			

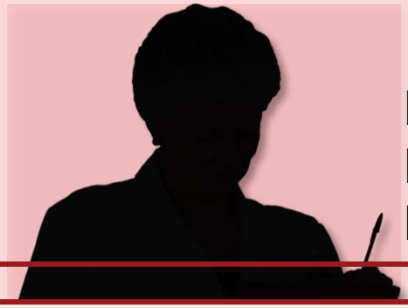
- Employees
- Contracted staff
- Residents
- Volunteers
- ~~Paid FFS referral visits~~

5: Staffing and Utilization

- Report based on work performed (see Appendix A of Manual)
  - Line 12: quality assurance, quality improvement, and EHR staff of medical activities
  - Line 22: other medical professionals (e.g., nutrition, podiatry, physical therapy)
  - Line 29a: other programs and services that address basic needs: housing, child care, job assistance
  - A single person can be allocated across categories.

Service Delivery

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			
6				
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	.5 FTE		



Donata S.
Nurse, Primary Care
HIV Case Manager

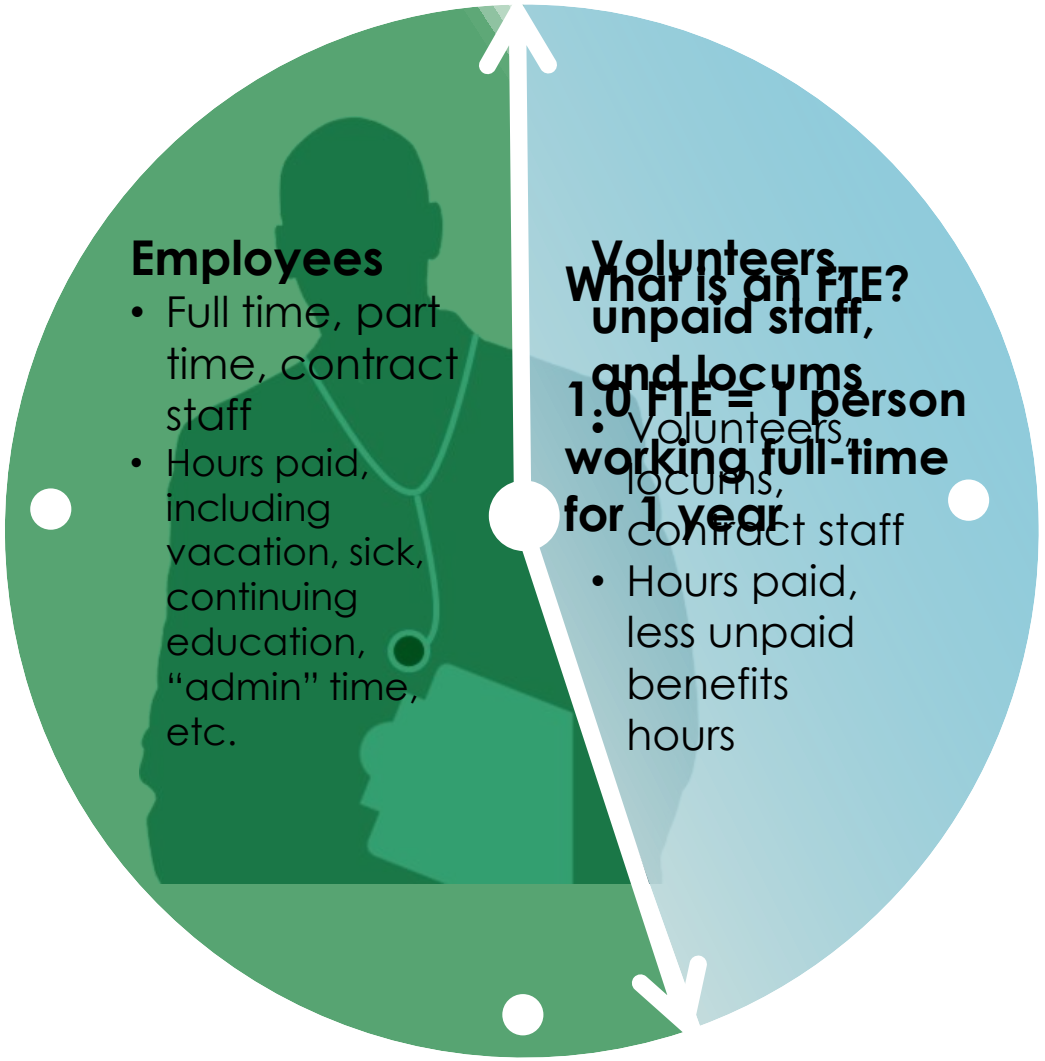
- Nutrition
- Podiatry
- Physical therapy, etc.

27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify)			
29a	**Other Programs/Services (specify)**			

- Housing
- WIC
- Child care
- Job assistance, etc.

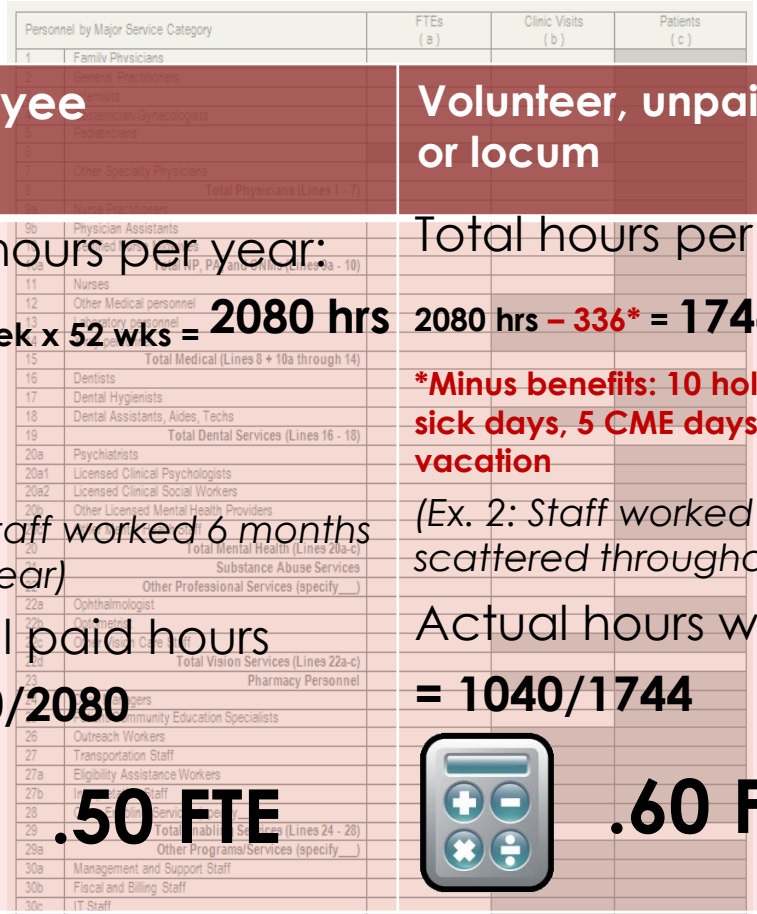
5: Staffing and Utilization

- What is an FTE?
  - 1.0 FTE is the equivalent of one person working full-time (as defined by health center) for one year
- Based on employment contracts
  - **Employees:** based on hours paid, including vacation, sick leave, continuing education, "admin" time, etc.
  - **Volunteers, unpaid staff, and locums:** total hours less unpaid benefits hours.



Calculating FTEs

- Calculate on whatever health center's base is for that position to determine full-time (1.0 FTE)
- Based on paid hours
  - Volunteers or other unpaid staff based on hours worked
- Not head count and not staff as of end of year
- 40-hour work week (2,080 hours/year)
- FTE also based on the part of the year that the employee works



Employee	Volunteer, unpaid staff, or locum
Total hours per year:	Total hours per year:
40 hr/week x 52 wks = **2080 hrs**	2080 hrs – 336* = **1744 hrs**
	***Minus benefits: 10 holidays, 12 sick days, 5 CME days, 3 weeks vacation**
(Ex. 1: Staff worked 6 months of the year)	*(Ex. 2: Staff worked 6 months scattered throughout year)*
Actual paid hours = 1040/2080	Actual hours worked = 1040/1744
.50 FTE	**.60 FTE**

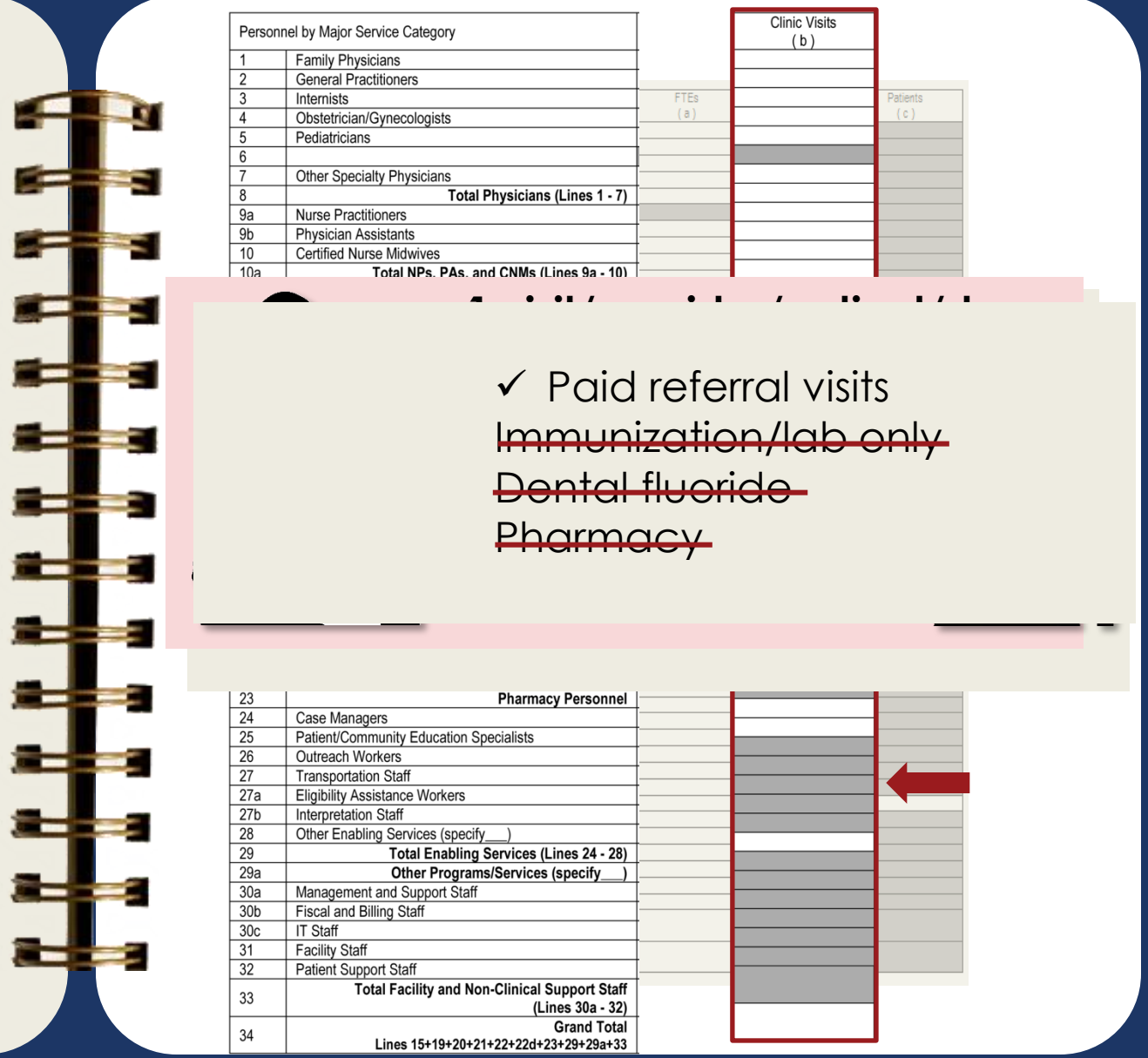
(Ex. 3: Staff employee worked all year, 30 hours per week)

Actual paid hours **= 1560/2080** **.75 FTE**

5: Staffing and Utilization

- Column B: Visits
- Not all staff can generate visits
- Provider must be appropriately credentialed/licensed
  - Face-to-face
  - Provided by paid and volunteer staff
  - Only 1:1 visits are counted except for group behavioral health
  - Service must be charted
- 1 visit/patient/ provider type/day (except if two sites)
- A provider may deliver many kinds of services but get credited for one visit (comprehensive care)
- Count paid referral visits
- Do not count as visits: immunization- / lab-only visits, dental fluoride, pharmacy

Service Delivery



5: Staffing and Utilization

- Column c:
  - Patients by service
  - Report number of unduplicated patients who received at least one countable visit for the service
  - Same patient may be counted in multiple service categories

    e.g., Patient had medical, vision, and case management visit during the year: she counts once on each of the three lines

Service Delivery

Services during year:
1. Medical
2. Vision
3. Case management

Personnel by Major Service Category		Patients (c)
1	Family Physicians	
2	General Practitioners	
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)**	1
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)**	1
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)**	1
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**	

5A: Tenure

- Reports tenure for selected provider and management staff
- Include staff employed as of December 31 of the reporting year
  - Include those not working on last day of the year but have a scheduled commitment for the coming year
  - Exclude anyone who is not employed at end of year
- Count consecutive months person has been in position (since hire)
  - Position should align with Table 5
  - May pre-date health center grant or look-alike designation
- Person may appear on multiple lines
  - E.g., family physician (FP) who is <u>also</u> the chief medical officer (CMO)
  - Count 1 on FP line and 1 on CMO line.
  - As of 12/31 she has been working as FP for ten years (120 months) and promoted to CMO in October (3 months)

Table 5A: Tenure for Health Center Staff

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

Line	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc. Persons	Locum, On-Call, etc. Total Months
1	Family Physicians	1	120		
2					
3					
4	Obstetrician/Gyne				
5	Ped				
7	O				
9a	N				
9b	P				
10					
11					
16					
17					
20a					
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer				
30a2	Chief Medical Officer	1	3		
30a3	Chief Financial Officer				
30a4	Chief Information Officer				

31

MD, CMO

5A: Tenure

- Column A: Report number of health center individuals (not FTEs) who are regular employees or persons on regular contract who work for health center as of December 31.
- Column C: Report number of individuals who are volunteers, locums, on-call providers, residents, and off-site contract providers.
- Columns B and D: Tenure is reported as months of consecutive service in position regardless of full- or part-time/year status. **(Round up to a whole number.)**

Table 5A: Tenure for Health Center Staff

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

		Full and Part Time		Locum, On-Call, etc.	
Line	Health Center Staff	Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
11	Nurses				
16	Dentists				
17	Dental Hygienists				
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				

2014 UDS Statistics

- Service delivery indicators
  - Comparison of state and national performance with health center performance

Service Delivery Indicators	2014 UDS Nation	NY
% growth in total patients	5.3%	1.7%
Primary care physicians average years of tenure	5.3	5.55
Non Clinical/Facility/Service Support FTEs as % of Total FTEs	36%	37%
Medical cost per medical patient	$516	$630
Medical cost per medical visit	$165	$177
Dental cost per dental patient	$439	$430
Dental cost per dental visit	$176	$172

8A: Financial Costs

- Reports **accrued** costs
  - Includes depreciation
  - Excludes bad debt
- Requires allocation of facility and non-clinical services to other centers
- Note: Line 16, Column A = Sum of Column B
- Reports donated ("in-kind") costs on Line 18, only

TABLE 8A – FINANCIAL COSTS

		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 Through 3)			
Financial Costs for Other Clinical Services				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9.				
9a				
10				
Fin				
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)			

Includes depreciation
Excludes ~~bad debt~~

Financial Security

Table 5

Line	Personnel by Major Service Category
1	Family Physicians
2	General Practitioners
3	Internists
4	Obstetrician/Gynecologists
5	Pediatricians
7	Other Specialty Physicians
9b	Physician Assistants
10	Certified Nurse Midwives
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)
11	Nurses
12	Other Medical Personnel
15	**Total Medical** (Lines 8 + 10a through 14)
19	**Total Dental Services** (Lines 16–18)
20a	Psychiatrists
20a1	Licensed Clinical Psychologists
20c	Other Mental Health Staff
22d	**Total Vision Services** (Lines 22a
25	Patient/Community Education Specialists
26	Outreach Workers
27b	In
28	O
30a	M
32	Patient Support Staff

Lines 1-12 medical providers/support

Lines 13-14 lab/x-ray

Lines 16-18 dental

Lines 20a-20c mental health

Line 21 substance abuse

Line 22 other professional

Lines 22a-22c vision services

Line 23 pharmacy

Lines non-health related: e.g., WIC, job training, housing, child care

Line 2 security, maintenance, janitorial staff, etc.

Line 31 facility

Table 8A

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 THROUGH 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 RE	
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 TOT	
14.	Facility
15.	Non Clinical Support Services

8A Column A: Accrued Costs

- Lines 1-13: Direct expenses
  - Lines 1, 2, and 3 Medical costs: separate medical staff (including staff dedicated to EHR and QA) from medical lab/x-ray, and other direct
  - Line 8a and 8b Pharmacy costs: separate pharmaceuticals from other direct
    - 340b price of pharmacy is included on line 8b
  - All remaining lines report all direct expenses including personnel (hired and contracted), benefits, supplies & equipment together

		Accrued Cost (a)
Financial Costs for Medical Care		
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 Through 3)	
Financial Costs for Other Clinical Services		
5.	Dental	
6.	Mental Health	
7.	Substance Abuse	
9.	Other Professional (Specify _____)	
9a.	Vision	
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 Through 9A)	
Financial Costs of Enabling and Other Program Related Servic		
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	

8A Column A: Accrued Costs

- Line 14: All facility expenses
  - Rent or depreciation, mortgage interest payments, utilities, security, janitorial services, maintenance, etc.
- Line 15: Non-clinical support staff costs
  - Corporate administration, billing, collections, medical records, intake staff, and non-clinical staff supplies, equipment, depreciation, travel, etc.

		Accrued Cost (a)
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 Through 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 Service		
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	

8A Column B: Allocation

- Allocate Facility and Non-clinical support to each cost center
- Facility (Line 14)
  - Allocate each building separately
  - Captures differences in costs per building such as improvements, donated space, etc.
  - Allocate based on proportion of square footage utilized by each cost center
- Non-clinical support (Line 15)
  - Allocate based on actual use or straight line method (proportion of total costs)
  - Include allocation to "non-clinical support" for administration's facility costs

Fi

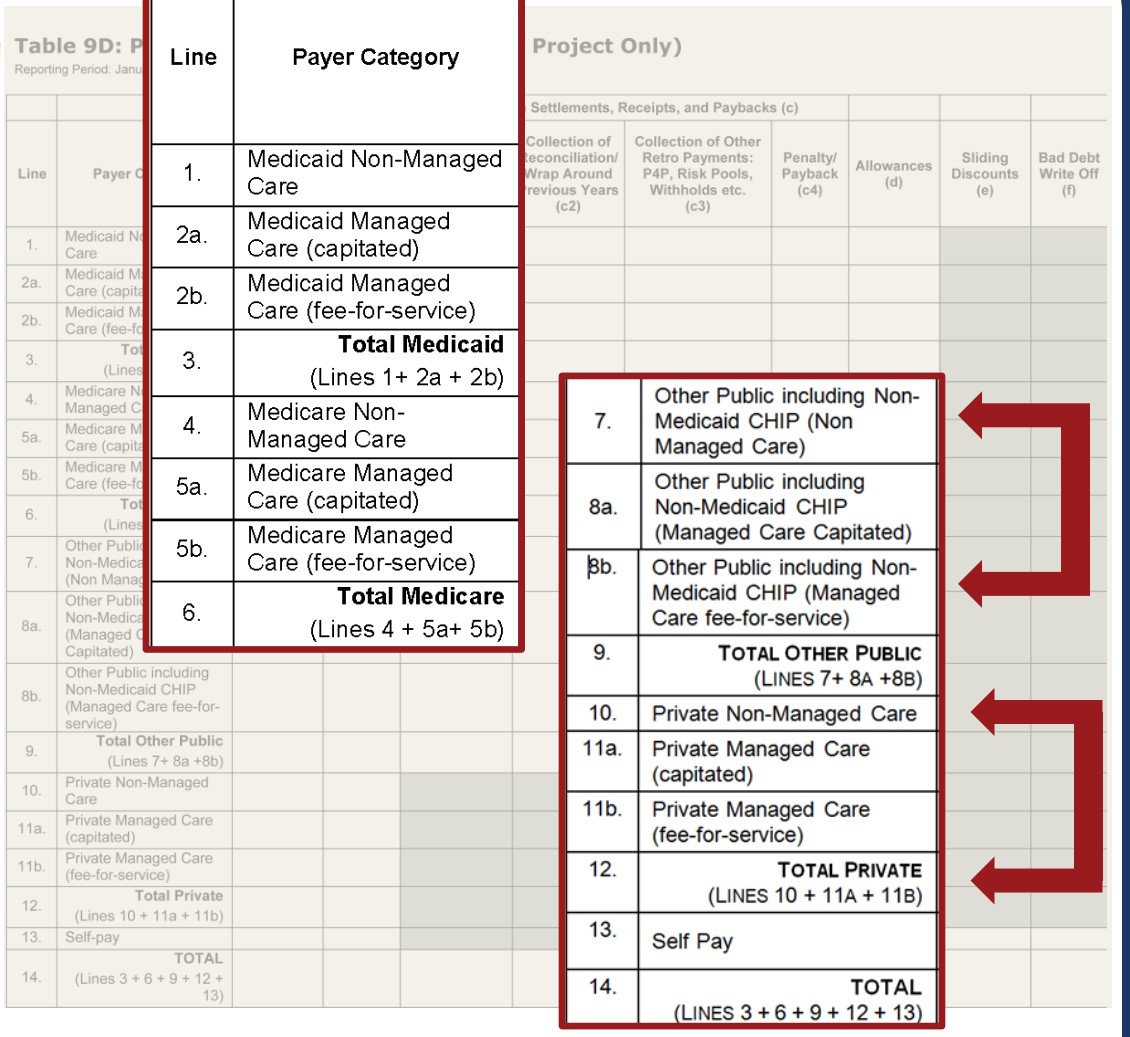
		Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)
Financial Costs for Medical Care			
1.	Medical Staff		
2.	Lab and X-ray		
3.	Medical/Other Direct		
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 Through 3)		
Financial Costs for Other Clinical Services			
5.	Dental		
6.	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		

9D: Patient Related Revenue

- Reported on a ***cash*** basis
- 2015 charges and cash income for patient services are reported by payer: Medicaid, Medicare, Other Public, Private and Self-Pay
  - Revenues are related to enrollment on Table 4
  - Exceptions:

    Include state-based programs which cover a specific service or disease (i.e., BCCCP Title X) as Other Public, Line 7-9

    Include revenues from contracts with schools, jails, head start, tribes, and workers compensation as Private, Line 10-12



9D: Payment Types Reported

- Each of the four third-party payer categories has three payment types:
  - **Fee-for-service**: Payment for each charge (or global fee) on the charge slip, encounter form, or bill.
  - **Managed care capitated**: Payments for each month the patient is enrolled in the program. In public programs, includes reconciliations to some prospective payment system (PPS) rates.
  - **Managed care fee-for-service**: Patient is assigned to doctor or clinic, but payment is only made when a charge is reported. Reconciliation to PPS rates occur in some public programs.

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): Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)									
3.	**Total Medicaid** (Lines 1+ 2a + 2b)									
4.	Medicare Non-Managed Care									
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**Total Medicare** (Lines 4 + 5a+ 5b)									
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)									
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public** (Lines 7+ 8a +8b)									
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care									

PAYOR CATEGORY	
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)
10.	Private Non-Managed Care
11a.	Private Managed Care (capitated)
11b.	Private Managed Care (fee-for-service)
12.	**TOTAL PRIVATE** (LINES 10 + 11A + 11B)

STATE SPECIFIC REPORTING: New York programs report capitated and/or FFS managed care enrollment in some or all payer categories.

9D Column A: Full Charges

- Undiscounted, unadjusted charges for services based on fee schedule; charges should cover costs
- Include all charges (medical, dental, pharmacy, mental health, contract 340b pharmacy, etc.).
- Do not include "charges" where no collection is attempted or expected, such as charges for enabling services, donated pharmaceuticals, or free vaccines.

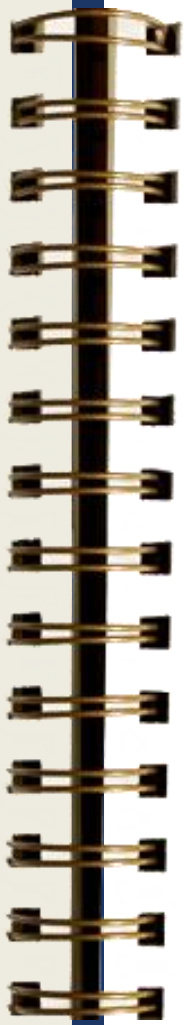


Table 9D: Patient Related Revenue (Scope of Project Only)

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)				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)			
1.	Medicaid 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)									
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)									

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)			

Full charges = undiscounted, unadjusted charges for services based on fee schedule

9D Column B: Collections

- Report all payments for health services including capitation payments, payments from patients, third party insurance, FQHC reconciliations, wrap-around payments, pay for performance, and other incentive payments, and contract payments, (e.g., payments from schools, jails) received during the year.
- Report by payer.
- Do not include "meaningful use" payments.

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): Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
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)									
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)									

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

Collections = All payments for services received during the year

Do not include meaningful use payments

9D Columns c1-c4: Adjustments – Retroactive Payments

Amounts reported in c1 – c4 are included in Column B, but do not equal Column B

- Columns (c1) and (c2): reconciliation payments for FQHC or CHIP-RA settlements (c1 from current year, c2 from prior year)
- Column (c3): "Other Retroactive Payments" including risk pools, incentives, pay for performance, withholds and court ordered payments
- Column (c4): amounts which are returned to third party (report as positive number)

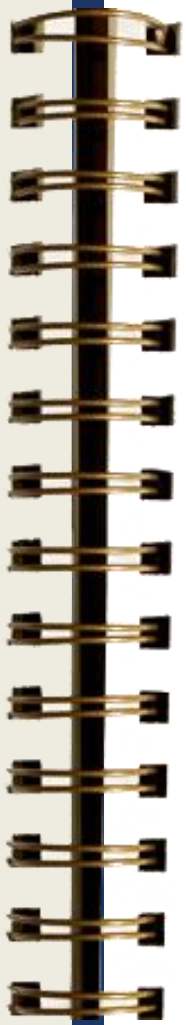


Table 9D: Patient Related Revenue (Scope of Project Only)

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): Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
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)									
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)									

Amounts reported in columns c1-c4 are included in column B, but do not equal column B

9D Column D: Allowances

- Reductions in payment by a third party based on a contract
- Allowances do not include disallowances:
  - non-payment for services that are not covered by the third party or that are rejected by the third party
  - deductibles or co-payments that are due from the patient and not paid by a third party
  - Disallowances need to be reclassified to secondary payer
- Because table is reported on cash basis - reduce allowances by any amounts of subsequent FQHC payments (reconciliations in Columns c1, c2 or c3)
- For capitated lines 2a, 5a, 8a, and 11a ONLY, Column D = Column A – Column B

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

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

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
2.	Medicaid Managed Care (capitated)									
2a.	Medicaid Managed Care (fee-for-service)									
3.	Total Medicaid (Lines 1 + 2a)									
4.	Medicare Non-Managed Care (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									
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	Total Other Public									
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)									

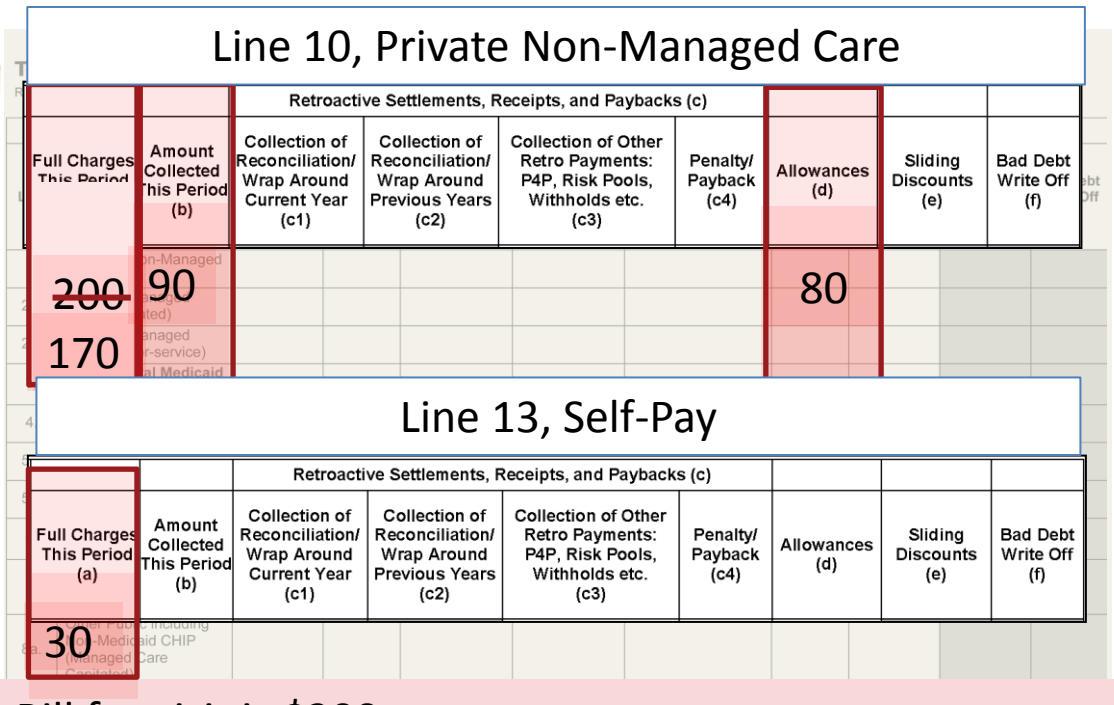
Allowances = Reductions in payment by a third party based on a contract

Reduce allowances (column D) by columns c1-c3

For capitated lines 2a, 5a, 8a and 11a ONLY, Column D = Column A – Column B

9D Insurance: Example with Reclassification

- Example for a patient with third party insurance
- The $30 that is the patient responsibility must be moved to the secondary payer – Self-pay
- It is essential to reclassify charges which are unpaid in whole or in part, not including allowances:
- This includes co-payments and deductibles as well as charges for non-covered services which are rejected by third parties
  - Deduct unpaid charges or portion of charge from original payer (Medicaid, Medicare, Private, or Other Public)
  - Add to charges on line for Self-pay or the secondary (tertiary, etc.) payer
  - Show collections of these amounts on the appropriate line



Bill for visit is $200
Insurance company takes contractual allowance of $80
Net = $120
Insurance company pays $90
Reclassified $30 to self-pay
Insurance charge changed from $200 to $170 to reflect reclassification
Self-Pay = $30 charge (25% copayment, $120 *.25 = $30)

9D Column E: Sliding Discounts

- Reported on Self-Pay, line 13 only
- A reduction in the amount charged (paid or owed) for services rendered which:
  - is based solely on the patient's documented income and family size at the time of service as it relates to the federal poverty level
  - may be applied to insured patients' co-payments, deductibles and non-covered services when the charge has been moved to self-pay if consistent with how uninsured patients are treated
  - may not be applied to past due amounts

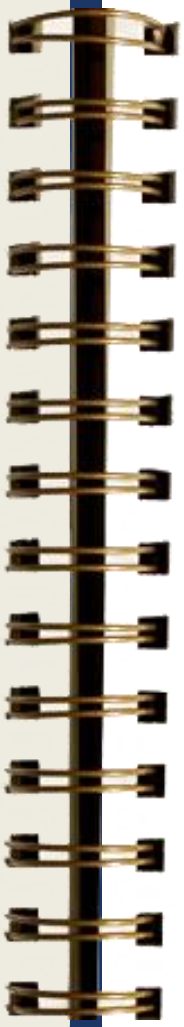


Table 9D: Patient Related Revenue (Scope of Project Only)

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): Collection of Reconciliation/ Wrap Around Current Year (c1)	Retroactive Settlements, Receipts, and Paybacks (c): Collection of Reconciliation/ Wrap Around Previous Years (c2)	Retroactive Settlements, Receipts, and Paybacks (c): Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
2.	Medicaid Managed Care (Capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**Total Medicare** (Lines 4 + 5a + 5b)									
7.	Non-Medicaid CHIP (Non-Managed Care)									
8a.	Non-Medicaid CHIP (Managed Care Capitated)									
	Other Public including Non-Medicaid CHIP (fee-for-service)									
9.	**Total Other Public**									
10.	Private Non-Managed Care									
	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)									

Sliding discount is reported for self-pay patients, only

Sliding Discounts = A reduction in the amount charged to patients for services based on income

9D Column F: Bad Debt

- Reported on Self-Pay, line 13 only. Do not report third party payer bad debt.
- Amounts owed by patients considered to be uncollectable and formally written off during 2015, regardless of when the service was provided
- Bad debt can never be changed to a sliding discount

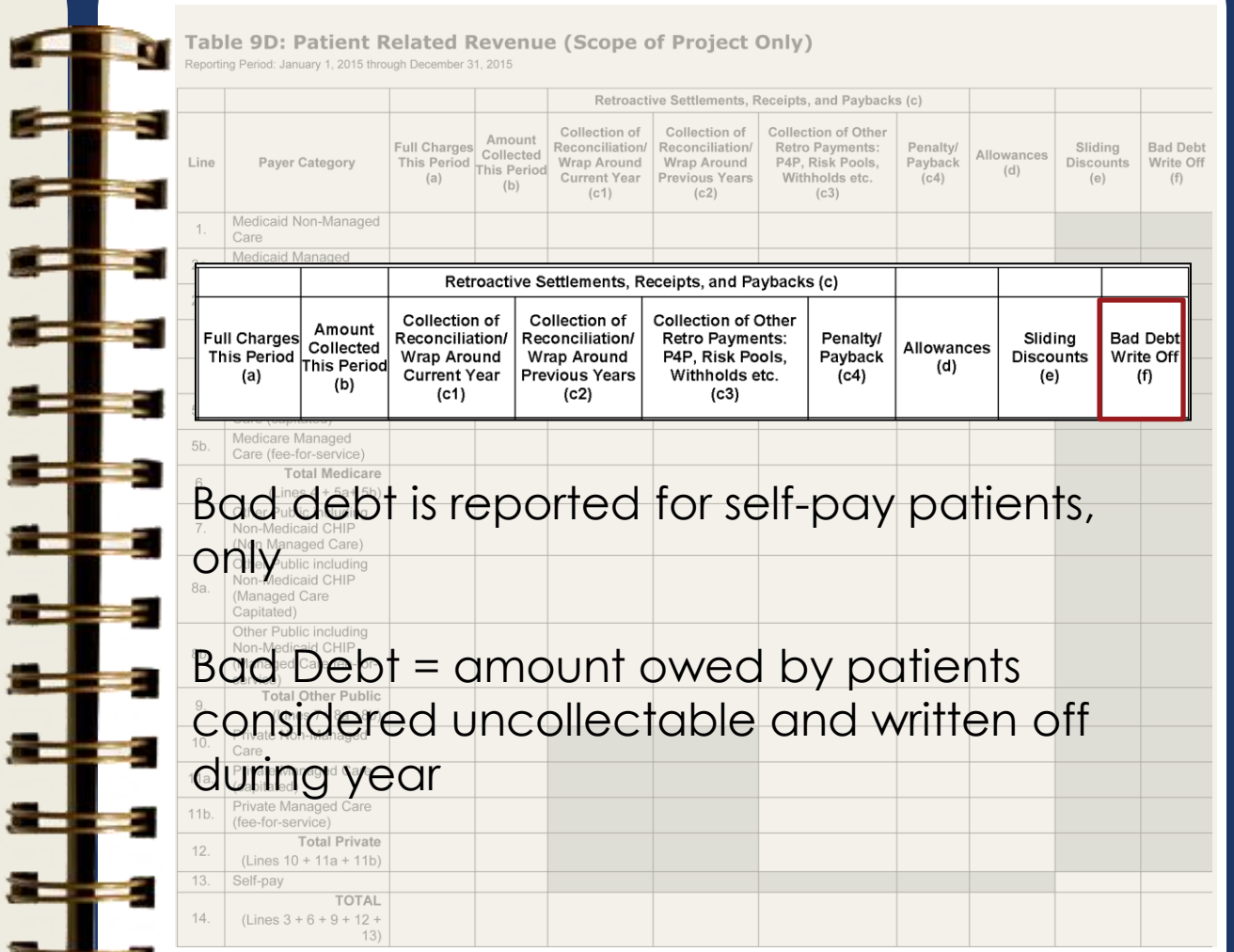


Table 9D: Patient Related Revenue (Scope of Project Only)

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): Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
1.	Medicaid Non-Managed Care									
2.	Medicaid Managed Care (Capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**Total Medicare** (Lines 4 + 5a + 5b)									
7.	Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)									
9.	**Total Other Public**									
10.	Private Non-Managed Care									
11.	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)									

Bad debt is reported for self-pay patients, only

Bad Debt = amount owed by patients considered uncollectable and written off during year

9D: Self-Pay Example

- Let's try an example for a self-pay patient service

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

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

Line 13, Self-Pay

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c): Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
13)	Self-Pay	150	6						140	4

Patient receives a $150 service and qualifies for a sliding fee discount.

The patient is charged a $10 nominal fee.

Patient pays $6 towards bill. Doesn't pay balance.

$4 was formally posted as bad debt

9E: Other Revenues

- Reported on a **cash** basis – amount received/drawn down during the year
- Report "last party" to handle funds before you received them
- Do not include:
  - Capital received as loan
  - Patient-related revenue, including pharmaceuticals
  - Value of donated services, supplies, or facilities
- Note: Most lines require the health center to specify the source of funds.

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	
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)	

- Amount received/drawn down
- "Last Party" to handle funds

~~Capital received as loan~~
~~Patient related revenue~~
~~Value of donated services~~
~~340b drugs~~

9E: Funds by Source

- Line 1: BPHC Grant Draw downs
  - Funds received directly from BPHC regardless of their end use
  - Include funds received from BPHC and passed through to another agency
- Ryan White Funds
  - Report Part C funds only on line 2
  - Usually, Part A is reported on line 7, Local
  - Usually, Part B is reported on line 6, State
- Line 3: Federal Grants
  - Other than BPHC
  - SPRANS, HUD, SAMHSA grants are reported on line 3, Other Federal

	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)	

9E: Funds by Source

- Line 3a: EHR Incentive
  - Meaningful use funds
  - Include funds paid to provider and returned to health center
- Lines 6: State & Line 7: Local Grants
  - Non health service delivery grants (WIC, prevention, outreach, etc.)
  - Do not include grant funds which pay for units of service (e.g., BCCCP, FP, TB)

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)	

9E: Indigent Care

- Line 6a: Indigent Care program
  - State and local programs that pay for health care in general and are based on a current or prior level of service, or on a flat fee per visit, but not fee-for-service
  - Not considered public insurance (Table 4)
  - Report full charges on Table 9D as self-pay charges and everything not due from the patient is written off as a sliding discount
  - Do not include state insurance plans
  - IHS PL 93-638 Compact funds allocated to the health center are reported here. Private contracts with tribes are to be reported as Private, on Table 9D.

Table 9E

6a.	State/Local Indigent Care Programs (specify:__

Table 4

Almost always counted on Line 7 as uninsured

Table 9D

13.	Self Pay

Column A: Usual charges to the patient
Column B: Patient discounted payment
Column F: Patient unpaid discounted payments written off as a bad-debt
Column E: The rest of the charge (or all of the charge if there is no required discounted payment owed)

STATE SPECIFIC REPORTING:
NY Public Goods Pool – still available?

Funds by Source

- Line 8: Foundation/ Private
  - Funds received from foundations or private organizations (including funds received from another health center)
- Line 10: Other
  - Contributions, fund raising income, rents, sales, patient record fees, pharmacy sales to the public (i.e., non-health center patients), etc.

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)	
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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)	

Submitting an Accurate UDS

- A few parting instructions

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Strategies for Success

Parting Instructions!

- **WHO**
  - Health center funded or designated prior to October 2015
- **WHAT**
  - "Scope of Project"
- **PERIOD**
  - January 1, 2015 - December 31, 2015
- **DUE DATE**
  - February 15, 2016
- **HOW**
  - Through Electronic Handbook (opens January 1, 2016)
- **REVIEW PERIOD**
  - February 15- March 31, 2016

- **Who?**
  Health center funded or designated prior to October 2015
- **What?**
  "Scope of Project"
- **Period?**
  January 1, 2015 - December 31, 2015
- **Due Date?**
  February 15, 2016
- **How?**
  Through Electronic Handbook (opens January 1, 2016)
- **Review Period**
  February 15- March 31, 2016

Strategies for Success

- Work as a team
  - Tables are inter-related
- Adhere to definitions and instructions
  - Refer to the manual, fact sheets, and other resources
- Check your data before submitting
  - Refer to last years reviewer's letter emailed to the UDS Preparer/Contact
  - Compare with benchmarks/trends
- Address edits in EHB by correcting or providing explanations that demonstrate your understanding.
  - "number is correct" is not sufficient
- Work with your reviewer

Available Assistance and Resources

- Lots of reference materials are available to help you report correctly. Use them!

- Regional in-person trainings
- On-line training modules, manual, fact sheets, webinars, other health center data and TA materials, including PALs available:
  - http://www.bphcdata.net
  - http://bphc.hrsa.gov/datareporting/index.html
    - PAL 2015-05: Approved Uniform Data System Changes for Calendar Year 2015 http://bphc.hrsa.gov/datareporting/reporting/udspals.html
  - *Proposed Changes for 2016 – Pending (see next two slides)*
- Telephone and email support line for reporting questions and use of UDS data
  - 866-UDS-HELP or udshelp330@bphcdata.net
- Technical support from a UDS Reviewer to review submission

Proposed Changes for 2016 - Pending

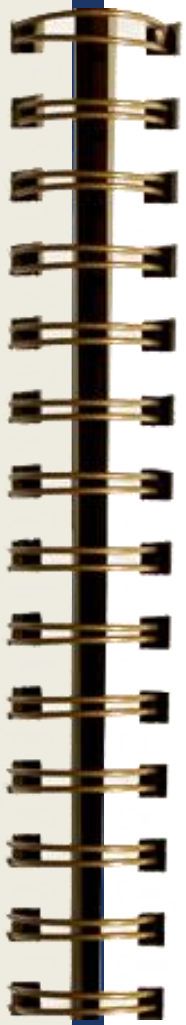
- Details are currently being developed
- OMB approval is pending

Proposed changes for 2016:

- Table 3A and 3B: Addition of sexual orientation and gender identity (SOGI) elements
  - In alignment with Office of the National Coordinator of Health IT (ONC)
- Table 5: Addition of new staffing information for:
  - community health workers (CHWs),
  - quality improvement (QI) staff and costs (Table 5 and 8A),
  - and dental therapists
- Appendix D - Health Center Electronic Health Record (EHR) Capabilities and Quality Recognition: Additions include:
  - Telehealth capacity and use,
  - Medication-Assisted Treatment (MAT) capacity and use

Proposed Changes for 2016 - Pending

- Details are currently being developed
- OMB approval is pending



Further proposed changes for 2016:

- Table 6B and 7: Revisions to clinical quality measures to fully align with CMS e-CQMs where possible, including:
  - Childhood immunization
  - Cervical cancer screening
  - Tobacco use screening and cessation intervention
  - Asthma pharmacologic therapy
  - Patients screened for depression and follow-up
  - Controlled hypertension
  - Poorly controlled diabetes

Available Assistance and Resources

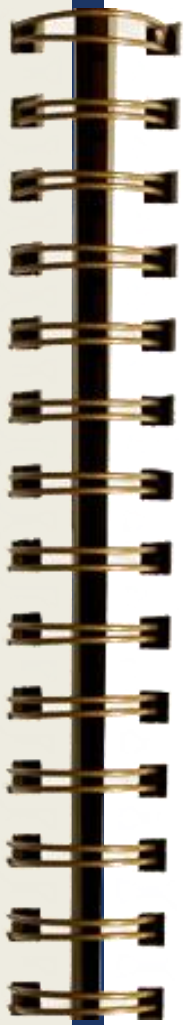
- EHB provides access to the UDS for submission and access to standard reports.
- Additional health center support and resources for are also available.

- EHB (UDS and Standard Report Access)
  - https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx
- National Cooperative Agreements
  http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html
- Primary Care Associations/Primary Care Offices
  http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html
- EHB Support (see handout)
  - HRSA Call Center for EHB access and roles: 877-464-4772 or http://www.hrsa.gov/about/contact/ehbhelp.aspx
  - BPHC Help Desk for EHB system issues: 301-443-7356

Strategies for Success

Available Assistance and Resources

- Performance measures references are available to review



- Million hearts for the HTN measure
  - http://millionhearts.hhs.gov/Docs/HTN_Change_Package.pdf
- National Quality Forum
  - http://www.qualityforum.org/QPS/QPSTool.aspx
- Clinical Quality Measures
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html
- United States Health Information Knowledgebase (USHIK)
  - https://ushik.org/QualityMeasuresListing?system=mu&stage=Stage%202&sortField=570&sortDirection=ascending&resultsPerPage=100&filter590=April+2014+EH&filter590=July+2014+EP&enableAsynchronousLoading=true
- Healthy People 2020
  - http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8
- US Preventive Services Task Force:
  - http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm
  - http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm
- State Tobacco statistics:
  - http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/map/index.htm
- State Diabetes statistics:
  - http://www.ncsl.org/issues-research/health/diabetes-state-rates.aspx
  - CDC National Center for Health Statistics State Facts: http://www.cdc.gov/nchs/fastats/map_page.htm
- SAMHSA-HRSA Center for Integrated Health Solutions (possible depression screening tools):
  - http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression

Discussion Forum

- What UDS-specific situations and questions have you encountered?

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State-Based Discussion Forum

Thank You!

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

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THANK YOU!