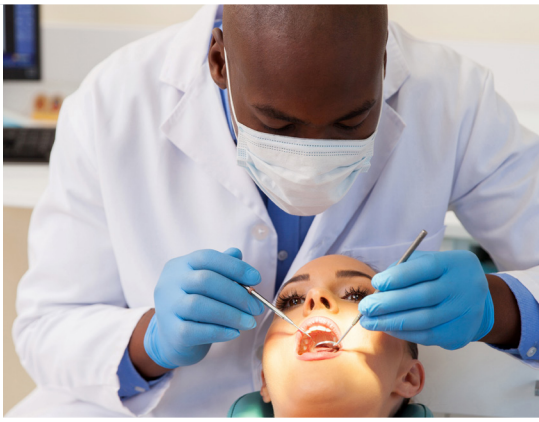
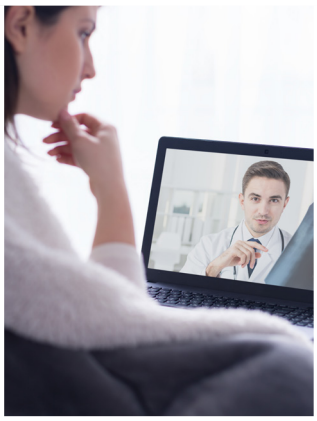
UNIFORM DATA SYSTEM

Reporting Instructions for 2017 Health Center Data





DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

HRSA
Health Center Program

Dear Health Center Program Participant:

On behalf of the Health Resources and Services Administration, thank you for your service and your support of the Health Center Program.

Your work makes a significant impact on the nation's health as you deliver care to our most vulnerable populations, including individuals experiencing homelessness, agricultural workers, veterans, and residents of public housing. Through new and ongoing investments, an increasing number of health centers are able to deliver oral health, mental health, substance abuse services, vision services, enabling services, upgrade facilities, and utilize health information technology, which increases access to affordable, quality health care and improves the health of our communities.

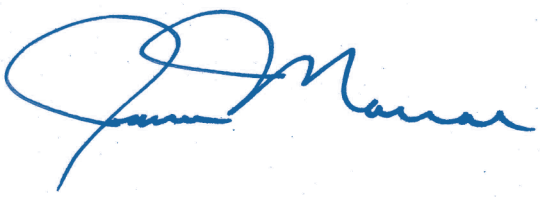
In response to the growing need for primary health care services, in 2016 the Health Center Program served nearly 26 million people through nearly 1,400 health centers operating approximately 10,400 service delivery sites in every U.S. state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In addition, 91% of health centers met or exceeded at least one Healthy People 2020 goal.

The data we receive through the Uniform Data System (UDS) is vital to understanding health centers' impact in expanding access, addressing health disparities, improving quality, and reducing the costs of health care. In response to your feedback through our satisfaction surveys, we have updated the 2017 UDS Manual to better align with national measures and reporting standards, and have included new appendices to more fully capture the changing landscape of health care delivery, as outlined in the Program Assistance Letter 2017-02. Changes include the clinical quality measures in Tables 6B and 7, which were revised to align with the Centers for Medicare & Medicaid Services electronic-specified Clinical Quality Measures (e-CQMs) and a new Appendix E to incorporate new information on telehealth use.

We are also modernizing the UDS reporting process to increase data standardization across national programs, reduce reporting burden, increase data quality, and expand data use to improve clinical care and operations as a result of the feedback you provided. You can read more about UDS modernization at https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html. Your continued feedback on both the manual and on the modernization efforts is critical to further advancing the Health Center Program.

I would like to extend my gratitude once again for your support of the Health Center Program. Your work on the frontlines of health care delivery is critical to the communities you serve and the health of the Nation.

Sincerely,



Jim Macrae
Associate Administrator, Bureau of Primary Health Care

UNIFORM DATA SYSTEM REPORTING INSTRUCTIONS

For Calendar Year 2017

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

Health Resources and Services Administration

Bureau of Primary Health Care

5600 Fishers Lane, Room 16W29, Rockville, Maryland 20857

2017 Uniform Data System Manual Contents

Introduction

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

In addition to detailed instructions, certain frequently asked questions are included. The instructions highlight changes to the tables that have been implemented for the current year. The Program Assistance Letter (PAL) 2017-02 provides an overview of changes that apply to the calendar year 2017 UDS report due February 15, 2018. There are eight appendices included:

- A list of personnel by category and identification of personnel by job title who may be able to produce countable "visits" for the UDS;
- Frequently asked questions (FAQs) by table;
- Information about addressing specific issues that affect multiple tables;
- Sampling methods for selecting patient charts for clinical reviews;
- Reporting instructions for the Health Center Health Information Technology (HIT) Capabilities and Quality Recognition form;
- Reporting instructions for the Other Data Elements form;
- A list of resources to assist health centers; and
- A glossary of terms.

About the UDS

The UDS is a standard data set that is reported annually and provides consistent information about health centers. It is a core set of information, including patient demographics, services provided, clinical processes and results, patients' use of services, costs, and revenues that document how health centers perform. HRSA routinely reports these data and related analyses, making them available to health centers in HRSA's Electronic Handbook (EHB) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website at http://bphc.hrsa.gov/datareporting/index.html.

A few health centers may have "dual status" by having both Health Center Program grantee sites and look-alike sites (or Health Center Program grantee sites and BHW sites). Dual status occurs when a health center receives Health Center Program grant funding for sites in the grant's approved scope of project and, at the same time, runs at least one other site under the scope of project of a look-alike (or BHW) designation. These sites must have separate scopes of project. These "dual status" health centers will complete both a grantee UDS Report and a look-alike (or BHW) UDS Report, covering the approved scope of each separately. Health centers should not use grant funds for sites and services included in the look-alike (or BHW) scope of project. However, health centers may allocate some costs — especially of corporate executives and other non-clinical support staff, their space, etc. — across the two reports. Patients who receive services at both grantee and look-alike (or BHW) sites may appear in both reports.

Note: *In this document, unless otherwise noted, the term "health center" refers to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, look-alike organizations which are recognized by BPHC as meeting all the Health Center Program requirements but do not receive Health Center Program grants, and primary care clinics funded under the BHW that receive funding through other HRSA programs.*

General Instructions

What to Submit

The UDS includes 12 tables and two appendices designed to yield consistent demographic, clinical, operational, and financial data. Health centers must complete each:

- ZIP Codes: Patients served reported by ZIP code and by primary third-party medical insurance source, if any
- Table 3A: Patients by age and by sex assigned at birth
- Table 3B: Patients by race, Hispanic/Latino ethnicity, language barriers, sexual orientation, and gender identity
- Table 4: Patients by income (by percentage of the federal poverty guidelines) and primary third-party medical insurance source; the number of "special population" patients receiving services; and managed care enrollment, if any
- Table 5: The annualized full-time equivalent (FTE) of program staff by position; visits by provider type; and patients by service type
- Table 5A: Tenure for selected health center staff
- Table 6A: Visits and patients for selected medical, mental health, substance abuse, vision, and dental diagnoses and services
- Table 6B: Clinical quality of care measures
- Table 7: Health outcome measures by race and ethnicity
- Table 8A: Direct and indirect expenses by service categories
- Table 9D: Full charges, collections, and allowances by payer type as well as sliding discounts and patient debt written off
- Table 9E: Other, non-patient service income
- Health Information Technology (HIT) Capabilities and Quality Recognition: Quality recognition and HIT capabilities, including the use of electronic health record (EHR) information
- Other Data Elements: Telehealth, medication-assisted treatment, and outreach and enrollment assists

  Note: Look-alikes and BHW primary care clinics are to follow the same reporting requirements provided in this manual for Health Center Program funded grantees. Sometimes, the reporting cell details for special populations and receipt of a BPHC grant will be visible, but gray areas will show where look-alikes and BHW primary care clinics do not enter data.

What to File

The UDS includes two parts that health centers submit through the EHB:

- The **Universal Report** that *all health centers use*. The Universal Report consists of each of the UDS tables, the HIT form, and the other data elements form, and provides data on patients, services, staffing, and financing *for the entire scope of services included in the grant or designation*. It is the source of unduplicated health center data for the reporting year within the scope of project supported by the grant/designation. If your health center brings services or sites into scope during

the calendar year, you must include data for the full year, not just for the period after the date of the scope change.

- *Health Center Program grantees that receive section 330 grants under multiple program funding authorities (i.e., sections 330(g), (h), and/or (i)) complete one or more* **Grant Reports**. Only Health Center Program grantees with multiple funding authorities complete Grant Reports. The Grant Report consists of one or more additional copies of Tables 3A, 3B, 4, 6A, and part of Table 5. The Grant Reports provide data comparable to the Universal Report, but only for that portion of the program that falls within the scope of a project *funded under a particular funding authority*. HRSA requires separate Grant Reports for each funding authority when grantees receive grant support under the Migrant Health Center (330(g)) program, Health Care for the Homeless (330(h)) program, and/or Public Housing Primary Care (330(i)) program, *unless* a grantee receives funding under only one of these program authorities. Grantees do not file a Grant Report for the scope of project supported under the Community Health Center (330(e)) program.

Health center patients can receive services through more than one BPHC funding authority, but health centers do not report all grants separately. Therefore, totaling numbers from a health center's Grant Reports will not produce a valid total. The number of patients in Grant Reports will not equal the total on the Universal Report. All patients reported on a Grant Report also appear in the Universal Report. Consequently, no cell in a Grant Report has a number larger than the same cell in the Universal Report. Report patients only once per section in each report filed.

Report all the data for a patient who receives services under *sections 330(g), (h), or (i)* funding authority in the proper Grant Report. For example, if a homeless patient receives medical services in the homeless medical van, and all dental services at the clinic, their dental services and diagnoses go on Tables 5 and 6A regardless of the dental funding source.

Health centers that receive funds under only one BPHC funding authority complete only the Universal Report, not Grant Reports. Health centers funded through multiple BPHC funding authorities complete a Universal Report for the combined projects and a separate Grant Report for each Migrant, Homeless, or Public Housing program grant. Examples include:

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

Note: *The EHB reporting system will automatically identify required reports and required sections within reports. Please tell BPHC about any errors by contacting the* ***UDS Support Center at 866-UDS-HELP or udshelp330@bphcdata.net.***

Tables Shown in Each Report

The table below shows which tables and data appear in the Universal Report and Grant Reports.

Table	Data Reported	Universal Report	Grant Reports
Service Area			
ZIP Code Table	Patients by ZIP Code	X	
Patient Profile			
Table 3A	Patients by Age and by Sex Assigned at Birth	X	X
Table 3B	Demographic Characteristics	X	X
Table 4	Selected Patient Characteristics	X	X
Staffing and Utilization			
Table 5	Staffing and Utilization	X	<partial>
Table 5A	Tenure for Health Center Staff	X	
Clinical			
Table 6A	Selected Diagnoses and Services Rendered	X	X
Table 6B	Quality of Care Measures	X	
Table 7	Health Outcomes and Disparities	X	
Financial			
Table 8A	Financial Costs	X	
Table 9D	Patient-related Revenue	X	
Table 9E	Other Revenue	X	
Other Form			
HIT Form	Health Information Technology (HIT) Capabilities and Quality Recognition	X	
Other Form	Other Data Elements	X	

Calendar Year Reporting Period

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

All health centers funded or designated in whole or in part before October 1 must report even if they did not draw down any grant funds during the calendar year. Health centers funded or designated for the first time on October 1 (or later) will not file a 2017 UDS report.

Health centers that had a look-alike designation only, and one or more look-alike sites received NAP funding before October, must exclude all the data related to those sites from the look-alike UDS report for 2017 AND report the data related to the sites in the grantee UDS report for 2017.

In Scope Reporting

All health centers must submit data that reflects activities in the HRSA-approved health center project, as defined in approved applications and reflected in Notice of Award/Designation.

Due Dates and Revisions to Reports

The period for submission of complete and accurate UDS Reports is January 1 through ***February 15, 2018***.

From February 15 through March 31, 2018, a HRSA UDS Reviewer will work with you, as needed, to correct potential data errors. Final, corrected submissions are due no later than March 31, 2018. **HRSA does not accept changes after this date.**

HRSA may grant an exemption under extraordinary circumstances such as the physical destruction of a health center. Health centers must request such exemptions directly from the BPHC Office of Quality Improvement through the UDS Support Center.

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

How and Where to Submit Data

Health centers report UDS data via a web-based system that is a part of the HRSA Electronic Handbook (EHB). Health center staff will use their user name and password to log into the EHB at https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to complete and submit their UDS Reports. The system supports the use of standard Web browsers.[1] It provides electronic forms that help to complete the reports.

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

Health center staff with EHB access can work on the forms in sections, saving interim or partial versions online as they work, and return to complete them later, as necessary. The system saves work in the EHB until the health center makes a formal submission. The Chief Executive Officer or project director usually does this, but may delegate the authority to someone else. Official UDS submission includes acknowledgement that the health center reviewed and verified the accuracy and validity of the data. Health centers may give data entry responsibility to several people, each using separate login and password credentials. However, health centers designate one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person explains all the tables during the review. Health center staff may receive "view" or "edit" privileges. These apply to the whole report, not just specific tables.

The EHB will check for potential inconsistencies or questionable data to ensure accuracy. Reports must be complete in order to submit into the EHB. The EHB will provide a summary of which tables are complete, as well as a list of mandatory audit questions. Audit questions are general and may not apply to some health centers' unique circumstances. Health center staff must address data audit findings. If staff believe the data is error-free, they should clearly explain any unique circumstances.

Please refer to Appendix F: Health Center Resources, for resources which may be helpful for completing the UDS Report. Support contacts and links are included, such as contact information for the UDS Support Center, web links to a complete set of the UDS tables, training opportunities, and other materials.

Instructions for Tables that Report Visits, Patients, and Providers

Visits

Visits determine who to count as a patient on the ZIP Code Table, Tables 3A, 3B, 4, 5, 6A, 6B, and 7; to report visits by type of provider on Table 5; and to report visits for selected diagnoses or selected services on Table 6A.

Countable visits are documented, face-to-face contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. Health centers count only visits that meet all these criteria.

To count visits, the services must be documented in a chart that stays in the possession of the health center (see further details below). Health center staff must be a provider for purposes of providing countable visits. ***Please Note:*** Not all health center staff who interact with patients qualify. Appendix A provides a list of health center personnel and the usual status of each as a provider or non-provider for UDS reporting purposes.

Visits provided by contractors and **paid for by the health center** are counted in the UDS if they meet all other criteria. These include Migrant Voucher visits or outpatient or inpatient specialty care associated with an at-risk managed care contract. In these instances, if the visit is not documented in the patient's medical record, a summary of the visit (rather than the complete record) must appear in the patient's medical record, including all appropriate CPT and ICD-10-CM codes. This ensures the health center can use their HIT, including their EHR, for UDS reporting.

Below are definitions and criteria for reporting visits. Table 5 provides further clarifications. (See Clinic Visits, Column B.)

Documentation

To meet the criterion for **documentation**, centers must record the service (and associated patient information) in written or electronic form in a system that permits ready retrieval of current data for the patient. The patient record does not have to be complete to meet this standard.

For example, a patient receiving documented emergency services counts even if some portions of the health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary discharge note showing activities for each of the visit dates.

Independent Professional Judgment

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

Independent judgment implies the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

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

Behavioral Health Group Visits

A behavioral health provider who services several patients simultaneously receive credit with a visit for each person only if the service appears in *each* person's health record.

Examples of "**group visits**" include family therapy or counseling sessions, group mental health counseling, and group substance abuse counseling where several people receive services that appear in each person's health record.

Other Considerations:

- The health center normally bills each patient, even if another grant or contract covers the costs.
- If only one person is billed (for example, where a relative participates in a patient's counseling session), count only the billed person as a patient, and count only that patient's visit.
- When a behavioral health provider conducts services via telemedicine/telehealth, the provider can be credited with a visit only if the service is noted in the patient's record. The session will normally be billed to the patient or a third-party.
- For medical visits, only individual services count.

Location of Services Provided

A visit must take place in the health center or at any other approved site or location.

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

Other Considerations:

- Visits also include contacts with existing hospitalized patients, where health center medical staff follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record. This applies when the health center pays medical staff and bills the patient either for the specific service or through a global fee.
- A reporting health center may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so.
- When a patient's first encounter is in a hospital, respite care, or a similar facility, *which is not specifically approved as a service delivery site under the scope of the grant/designation by BPHC,* none of the services for that patient go in the UDS.

Counting Multiple Visits by Category of Service

Multiple visits occur when a patient has more than one visit with the health center in a day. Limit the reported number of visits as follows. On any given day, a patient may have only one visit per service category, as described below.

Other Considerations:

- If multiple medical providers in a single category deliver multiple services on a single day (e.g., an Obstetrician/Gynecologist [Ob/Gyn] who provides prenatal care to a patient and an Internist who treats that same patient's hypertension) count only one visit even if third-party payers may recognize these as separate billable services.

  Health centers can count medical services provided by two *different* medical providers located at two *different* sites on the same day. This is the only exception (originally developed for homeless and agricultural worker programs) to this rule. This permits patients who are in challenging environments (e.g., in parks or migrant camps) to receive services from non-physician medical providers and to receive services again that day at the health center's fixed clinic site by a different, generally higher-level, provider.

- A provider receives credit for no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they occur.

Patient

Patients are people who have at least one reportable visit during the reporting year. The term "patient" applies to everyone who receives visits, not just medical or dental services.

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

- Report these patients and their visits on Tables 5 and 6A for each type of service (e.g., medical, dental, enabling) received during the year.
- On the ZIP Code Table, Tables 3A and 3B, and in each section of Tables 4 and 6A, count each patient once and only once. This applies even if they received more than one service (e.g., medical, dental, enabling) or received services supported by more than one program authority (i.e., section 330(g), section 330(h), section 330(i)).

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

For each **Grant Report**, patients reported are those who have at least one visit during the year within the scope of project activities supported by the specific section 330 program authority. Include a patient counted in any cell on a Grant Report in the same cell on the Universal Report.

Health centers see many people who are not reportable as patients on the UDS Report.

Services and Persons Not Reported on the UDS Report

Some services ***do not count as a visit for UDS reporting***.

Similarly, someone who receives only one of the services described below ***is not a patient for purposes of UDS reporting***.

These exceptions include:

Health screenings

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

Group visits

- Visits conducted in a group setting, *except for behavioral health group visits*
- The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition)

Tests and other ancillary services

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

Dispensing or administering medications

- Dispensing medications, including dispensing, from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as buprenorphine or Coumadin)
- Giving any injection (including vaccines, allergy shots, and family planning methods) regardless of education provided at the same time
- Providing narcotic agonists or antagonists or mixes of these, regardless of whether the patient is assessed at the time of the dispensing and

regardless of whether these medications are dispensed regularly

Telemedicine

- Telemedicine/telehealth, except for behavioral health telemedicine

Health status checks

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

Services under the Women, Infants, and Children (WIC) Program

- A person whose only contact with a health center is to receive services under a WIC program

Provider

A provider is someone who assumes primary responsibility for assessing the patient and documenting services in the patient's record.

- Providers include only those who exercise independent judgment for services rendered to the patient during a visit.
- Only one provider who exercises independent judgment receives credit for the visit, even when two or more providers are present and participate.
    - For example, if two or more providers of the same type share the services for a patient (e.g., a family physician [FP] and a pediatrician both see a child or an ObGyn and an FP both see a pregnant woman for different purposes) only one provider receives credit for a visit.
    - In cases where a preceptor is following and supervising a licensed resident, the resident receives credit *(see Table 5 for further instruction on counting interns and residents)*.
    - When health center staff are following a patient in the hospital, the primary center staff person in attendance during the visit is the provider credited with a visit, even if other staff are present.
- Except for physicians, allocate staff time by function among the major service categories based on time dedicated to other roles (e.g., a nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split the 1.0 full-time equivalent (FTE) between a medical nurse and health educator).
- Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate visits for purposes of UDS reporting.
- Table 5 provides further clarifications to these definitions. See Instructions for Table 5: Staffing and Utilization.

Providers may be employees of the health center, contracted staff, or volunteers.

- Contract providers who the health center pays with grant funds or program income, who are part of the scope of the approved grant/designation, serve center patients, and document their services in the center's records, count as providers. (A discharge summary or similar document in the medical record will meet these criteria.)
- Contract providers paid for specific visits or services with grant funds or program income, who report patient visits to the direct recipient of

a BPHC or BHW grant or designation (e.g., under a Migrant Voucher program or homeless grantees with sub-grantees) are providers. The direct recipient of the BPHC or BHW grant/designation reports these providers' activities. Since such providers often have no time basis in their report, no FTE would be reported for them if time data were not collected.

- Count providers who volunteer to serve patients at the health center's sites under the supervision of the center's staff and document their services and time in the center's records.
- Individuals or groups who provide services under formal agreement or contract where the health center does not pay for the visit are not credited as providing a health center visit. This is the case even if they provide discharge summaries or report the service in the patient's medical chart, unless they are working at an approved site under the supervision of the appropriate health center staff, and credentialed by the health center.

Note: *These providers are generally noted in column III of the grant scope of project application Form 5A. See an example of Form 5A at http://bphc.hrsa.gov/programrequirements/scope.html.*

Instructions for ZIP Code Data

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

Patients by ZIP Code

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

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

- **Homeless Patients**: Although many patients who are homeless live doubled up or in shelters, transitional housing, or other fixed locations, others—especially those living on the street—do not know or will not share an exact location. When a ZIP code location is unavailable, or the location offered is questionable, health centers should use the service location ZIP code as a proxy. Similarly, if the patient has no other ZIP code and receives services in a mobile van, use the ZIP code of the van's location that day. Health centers might collect the address of a contact person to facilitate communication with the patient; however, while appropriate from a clinical and service delivery perspective, do not use this as the patient's address.
- **Migratory Agricultural Worker Patients**: Migratory agricultural workers may have both a temporary address that reflects where they live when they are working in the community, as well as a permanent or "downstream" address that may be far from the location of their current work and the site where they are receiving care. *For the purpose of the UDS report,* health centers are to report the ZIP code of where the patient lived when they received care from the health center. Note that migratory agricultural worker patients may *also* be seen by health center providers in their home, or "downstream" community. They still count as migratory agricultural workers. For patients where a precise ZIP code is unavailable (e.g., living in cars or on the land), the ZIP code for the location (fixed site or mobile camp outreach) where they received services should be used.
- **Foreign Nationals**: Report the current ZIP codes for people from other countries who reside in the United States either permanently or temporarily. Tourists and other people, who may have a permanent residence outside the country, are to be reported under "other ZIP code."

For the small number of patients for whom residence is not known or for whom a proxy is not available, residence should be reported as "unknown."

Although health centers report residence by ZIP code for all patients, some health centers may have many patients from numerous ZIP codes outside their service area. To ease the burden of reporting, report ZIP codes with ***ten or fewer*** *patients in the "other" category.*

Instructions for Source of Insurance

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

Insurance Categories

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

- Report patients who have both Medicare and Medicaid as Medicare patients because Medicare is billed before Medicaid. The exception to the Medicare first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.
- Report Medicaid and CHIP patients enrolled in a managed care program run by a private insurance company as "Medicaid / CHIP / Other Public." Report Medicare run by a private insurance company as Medicare.
- In rare instances, a patient may have an insurance that the health center cannot or does not bill. This may be a patient enrolled in Medicaid but assigned to another primary care provider or a patient with a private insurance where the health centers' providers have not been credentialed to bill that payer. In these instances, the health center *will report the patient as insured* and will report the type of insurance even if it did not bill this insurance.
- Section 330 grant funds to serve special populations (i.e., Migrant Health Center, Health Care for the Homeless, Public Housing Primary Care) are not a form of medical insurance. Report any third-party insurance that patients carry.
- Classify patients in correctional facilities as uninsured, whether seen in the correctional facility or at the health center and at the ZIP code of the jail or prison, unless Medicaid or other insurance covers them. Do not classify patients in residential drug programs, college dorms, military barracks, etc. as uninsured. In these instances, report the patient by type of insurance and record the ZIP code of the residential program, dorm, or barrack.
- Count patients who receive subsidized services through state or local government indigent care programs as uninsured. Examples include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.
- Affordable Care Act (ACA) subsidies do not affect insurance categories. Classify patients by their third-party insurer. Report patients who received insurance through the Health Insurance Marketplace as Private.

Additional information is available to clarify reporting**. View FAQs for the ZIP Code Table.**

Table Patients by ZIP Code

Reporting Period: January 1, 2017, through December 31, 2017

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

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

Instructions for Tables 3A and 3B

Tables 3A and 3B provide demographic data on patients who accessed services during the calendar year. This information is to be collected from patients at least once a year as part of the patient registration or intake process.

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

Report the *number* of patients by appropriate categories for age and sex assigned at birth:

- Use the individual's age on June 30 of the reporting period.
- Report patients according to their sex at birth or sex reported on a birth certificate. In states that permit this to be changed, the birth certificate sex may still be used.
- Note that on the non-prenatal and non-childhood immunization portions of *Tables 6B and 7*, age is defined as age as of January 1. Thus, the numbers on *Table 3A* will not be the same as those on *Tables 6B and 7* even if all the patients at a health center were medical patients, though they will usually be similar.

Table 3B: Demographic Characteristics

Report the number of patients by race, ethnicity, language, sexual orientation, and gender identity.

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

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

Hispanic or Latino Ethnicity

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

- Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification. Include those Hispanics/Latinos born in the United States. Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Column B (Non-Hispanic/Latino): Report the number of all other patients except those for whom there are neither racial nor Hispanic/Latino ethnicity data. If a patient has chosen a race (described below) but has not made a selection for the Hispanic /non-Hispanic question, presume that the patient is non-Hispanic/Latino.
- Column C (Unreported/Refused to Report): Only one cell is available in this column. Report on Line 7, Column C only those patients who left the entire race and Hispanic/Latino ethnicity part of the intake form blank.
- Patients who self-report as Hispanic/Latino but do not separately select a race must be reported on Line 7, Column A as Hispanic/Latino whose race is unreported or refused to report. Health centers may not default these patients to "White," "Native American," "more than one race," or any other category.

Race

All patients must be classified in one of the racial categories (including a category for patients with race "Unreported/Refused to Report" and Hispanic or Latino patients).

- Presume patients who self-report race, but do not separately indicate if they are Hispanic or Latino are non-Hispanic/Latino and report on the appropriate race line in Column B.
- Patients sometimes categorized as "Asian/Other Pacific Islander" in other systems are divided on the UDS into three separate categories:
    - **Line 1, Asian:** Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam
    - **Line 2a, Native Hawaiian:** Persons having origins to any of the original peoples of Hawai'i
    - **Line 2b, Other Pacific Islander:** Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Chuuk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other

Pacific Islands in Micronesia, Melanesia, or Polynesia

- **Line 4, American Indian/Alaska Native:** Persons who trace their origins to any of the original peoples of North and South America (including Central America) and who maintain Tribal affiliation or community attachment.
- **Line 6, More than one race:** "More than one race" should not appear as a selection option on your intake form. Use this line only if your system captures multiple races (but not a race and an ethnicity) and the patient has chosen two or more races. This is usually done with an intake form that lists the races and tells the patient to "check one or more" or "check all that apply."
    - Do not use "more than one race" for Hispanics/Latinos who do not check a separate race. Report on Line 7 (Unreported/ Refused to Report), as noted above.

***Note**: Report race and ethnicity for all patients. Some health centers' patient registration systems were originally configured to capture data for patients who were asked to report race or ethnicity. Health centers that are unable to distinguish a White Hispanic/Latino patient from a Black Hispanic/Latino patient (because their system only asks patients if they are White, Black, or Hispanic/Latino), are instructed to report these Hispanic/Latino patients on Line 7, Column A, as "unreported" race, but to include them in the count of those with Hispanic or Latino ethnicity. Health centers must take steps to enhance their registration system to permit the capture and reporting of these data in the future.*

Linguistic Barriers to Care (Line 12)

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

Report on Line 12 the number of patients who are best served in a language other than English, including those who are best served in sign language.

- Include those patients who were served in a second language by a bilingual provider and those who may have brought their own interpreter.
- Include patients residing in areas where a language other than English is the dominant language, such as Puerto Rico or the Pacific Islands.

Note**: Data reported on Line 12, Patients Served in a Language other than English, may be estimated if the health center does not maintain actual data in its Health Information Technology (HIT). If an estimate is required, the estimate should be based on a sample where possible. **This is the only place on the UDS where an estimate is accepted.

Patients by Sexual Orientation (Lines 13 – 19)

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

Health centers are encouraged to establish routine data collection systems to support patient-centered, high-quality care for LGBT individuals. As with all demographic data, this information is generally self-reported by patients or their caregivers if the patient cannot answer the questions themselves. Collection of sexual orientation data from patients less than 18 years of age is not mandated. Furthermore, patients have the choice not to disclose their sexual orientation. In the event that sexual orientation information is not available, the patient is to be reported on Table 3B as "don't know" on Line 17. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

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

Patients by Gender Identity (Lines 20 – 26)

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

As with all demographic data, this information is generally self-reported by patients or their caregivers if the patient cannot answer the questions themselves. Collection of gender identity data from patients less than 18 years of age is not mandated. Furthermore, patients have the choice not to disclose their gender identity. In the event that gender identity information is not available, the patient is to be reported on Table 3B as "other" on Line 24. **Do not use sex assigned at birth to identify the gender of patients.** The following descriptions

may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 20 – Male:** Report patients who identify themselves as a man/male.
- **Line 21 – Female:** Report patients who identify themselves as a woman/female.
- **Line 22 – Transgender Male / Female-to-Male:** Report transgender patients who describe their gender identity as man/male. (Some may just use the term man.)
- **Line 23 – Transgender Female / Male-to-Female:** Report transgender patients who describe their gender identity as woman/female. (Some may just use the term woman.)
- **Line 24 – Other:** Report patients who do not think that one of the four categories above adequately describes them. Include patients who identify themselves as genderqueer or non-binary. In addition, report patients where the health center does not know the patient's gender identity (i.e., health center did not have systems in place to routinely ask about gender identity).
- **Line 25 –Chose not to disclose:** Report patients who chose not to disclose their gender.
- **Line 26 – Total Patients:** Sum of Lines 20 + 21 + 22 + 23 + 24 + 25

Additional information is available to clarify reporting. **View FAQs for Tables 3A and 3B.**

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

Reporting Period: January 1, 2017, through December 31, 2017

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum Lines 1–38)		

Table 3B: Demographic Characteristics

Reporting Period: January 1, 2017, through December 31, 2017

Patients by Hispanic or Latino Ethnicity

Line	Patients By Race	Hispanic/ Latino (a)	Non-Hispanic/ Latino (b)	Unreported/ Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)				
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported/Refused to report race				
8.	**Total Patients** (Sum Lines 1+2 + 3 to 7)				

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

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

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

Instructions for Table 4: Selected Patient Characteristics

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

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

Collect income data on all patients once during the year. The report should include the most current information available.

- Family income is used. Children will always be classified in terms of their parent's income, except for minor-consent services.
- Report "unknown" income on Line 5 for patients when the information was not collected within a year of their last visit.
- Do not attempt to allocate patients with unknown income. Do not classify a patient who is homeless, is a migratory agricultural worker, or is on Medicaid as having income below the poverty guideline.
- Self-declaration of income from patients who are unable to document their income is acceptable, as long as it is consistent with Board-approved policies and procedures. This is particularly important for those patients whose wages are paid in cash who have no other means of proving their income. If documentation consistent with Board policy is lacking, report them as having "unknown" income.

Determine a patient's income relative to the Federal poverty guidelines. Use the Federal Poverty Guideline (FPL), which are revised annually.

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

This portion of the table provides data on patients classified by their age and the primary source of insurance for *medical* care. Note that there is no "unknown" insurance classification on this table—obtain medical insurance information from all patients to maximize third-party payments.

- Report the primary medical insurance the patient had at the time of their last visit *regardless of whether or not that insurance was billed for or paid for any or all of the visit services*. (Do not report other forms of insurance such as dental or vision coverage.)
- Patients are divided into two age groups: 0–17 (Column A) and age 18 and older (Column B) based on their age on June 30.
- Primary patient medical insurance is classified into seven types shown below.
- In rare instances, a patient may have insurance that the health center cannot or does not bill. In these instances, report the patient as being insured and report the type of insurance.
- ***Note:*** that states often rename federal programs, especially the State Children's Health Insurance Program [S-CHIP], Medicaid, Early Periodic Screening Detection and Treatment [EPSDT], Breast and Cervical Cancer Control program [BCCCP], and Title X [Title Ten].

Uninsured (Line 7)

Count patients who did not have *medical insurance* at the time of their last visit on Line 7. This may include patients whose visit was paid for by a third-party source that was not an insurance, such as EPSDT, BCCCP, Title X, or some state or local safety net or indigent care programs. *Do not count* patients as uninsured if their medical insurance did not *pay for* their visit. Some examples follow:

- Classify a patient with Medicare who was seen for a dental visit that was not paid for by Medicare as having Medicare for this table.
- Report a patient with Private insurance that has a $2,000 deductible who had not yet reached that deductible as a Private insurance patient.
- Classify a Medicaid patient who is assigned to another provider such that the health center cannot bill Medicaid for the visit as having Medicaid.
- Children seen in a school-based program who do not know their parent's health insurance status must obtain that information if they are to be included in the count of patients. *The only exception is for a student seeking minor-consent service permitted in the state, such as family planning or mental health services,* in which case record the minor child's status as uninsured if they do not have access to the parent's information. (Note that a minor receiving these same services with parental consent must be reported under the parent's insurance.)
- Presume a patient with Medicaid, Private, or Other Public dental insurance to have the same kind of medical insurance. If a patient does not have dental insurance, you *may not* assume that they are uninsured for medical care. Instead, obtain this information from the patient.
- Obtain the coverage information of patients in facilities such as residential drug programs, college dorms, and military barracks, (but not correctional facilities), and do not assume them to be uninsured.
- ***Note***: Patients served in correctional facilities may be classified as uninsured unless they have some form of insurance such as Medicaid or Medicare, whether seen in the correctional facility or at the health center.

Medicaid (Line 8a)

Report patients covered by state-run program operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act as Medicaid.

- Include Medicaid programs called by state-specific names (e.g., California's "Medi-Cal" program) and "state-only" programs covering individuals who are ineligible for Federal matching funds (e.g., general assistance recipients, children, pregnant women).
- Report patients enrolled in both Medicaid and Medicare as Medicare and Dually Eligible, on lines 9 and 9a, *not on Line 8a*.
- ***Note:*** Report patients who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the state Medicaid Agency as "Medicaid," *not* as privately insured.

CHIP-Medicaid (Line 8b)

Report patients covered by the Children's Health Insurance Program Reauthorization Act (CHIP-RA) and provided through the state's Medicaid program as CHIP-Medicaid.

- In states that make use of Medicaid to handle the CHIP program; it is sometimes difficult or even impossible to distinguish between "regular Medicaid" and "CHIP-Medicaid." In other states,

the distinction is readily apparent (e.g., they may have different appearing cards). Even where it is not obvious, CHIP patients may still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information from the state and/or county on their coding practice.

- *If there is no way to distinguish between regular Medicaid and CHIP Medicaid, classify all covered patients as "regular" Medicaid (Line 8a).*

Medicare (Line 9)

Report patients covered by the Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act) as Medicare.

- Report patients who have Medicare and Medicaid ("dually eligible") or Medicare and a private ("MediGap") insurance as Medicare on line 9.
- *In addition,* report those who have both Medicare and Medicaid (but *not* those with MediGap insurance) as Dually Eligible, on line 9a (see below).
- Count patients enrolled in "Medicare Advantage" products as Medicare on line 9, though they may have their services paid for by a private insurance company.
- A Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare will have an employer-based insurance plan, which is billed first.

Dually Eligible Medicare and Medicaid (Line 9a)

Report patients with both Medicare and Medicaid insurance as Dually Eligible on line 9a.

- This line is a subset of line 9 (Medicare) and patients who are dually eligible are to be reported on line 9a *and* included in the total on line 9, Medicare.
- Do not include MediGap enrollees on line 9a. Report them only on line 9.

Other Public Insurance (Line 10a)

Report state and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, which provide a broad set of benefits for eligible individuals and include public paid or subsidized private insurance not listed elsewhere on line 10a.

- Classify Medicaid expansion programs using Medicaid funds to help patients purchase their insurance through exchanges as Medicaid (line 8a) if it is possible to identify them. Otherwise, report them as Private (line 11).
- Do not include any CHIP, Medicaid, or Medicare patients on Line 10a.
- Do not include uninsured individuals whose visit may be covered by a public source with limited benefits, such as the Early Prevention, Screening, Detection, and Treatment (EPSDT) program, the Breast and Cervical Cancer Control Program (BCCCP), AIDS Drug Assistance Program (ADAP) providing pharmaceutical coverage for HIV patients, etc.
- In addition, do not include persons covered by workers' compensation here because this is not health insurance for the patient—it is liability insurance for the employer.

Other Public (CHIP) (Line 10b)

In those states where CHIP is contracted through a private third-party payer, classify participants as "other public-CHIP" (Line 10b), *not* as private.

- CHIP programs that are run through the private sector, are often covered through health maintenance organizations (HMOs). The coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and counted on Line 10b.
- Include CHIP patients who are on plans administered by Medicaid Coordinated Care Organizations here on Line 10b.
- Do not include patients who have insurance through the state insurance exchange here regardless of whether or not their premium cost is subsidized in whole or in part.

Private Insurance (Line 11)

Report patients with health insurance provided by commercial and not-for-profit companies as Private on line 11.

- Individuals may obtain insurance through employers or on their own.
- Include patients who purchase insurance through the federal or state exchanges here.
- In states making use of Medicaid expansion to support the purchase of insurance through exchanges, report patients covered under these plans as Medicaid, line 8a. Report patients who are not identifiable as Medicaid patients as Private on line 11.
- Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.

Managed Care Utilization, Lines 13a-13c

This part of table 4 provides data on managed care enrollment during the calendar year and specifically reports on patient member months in managed care plans.

- Do not report in this section enrollees in Primary Care Case Management (PCCM) programs or the Centers for Medicare and Medicaid Services (CMS) patient-centered medical home (PCMH) Demonstration grants or other third-party plans which pay a small monthly fee (usually $5 or less per member per month) to "manage" patient care.
- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical *and* dental, for example, is counted.

Member Months

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

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

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

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

Member Months for Managed Care (Capitated) (Line 13a): Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month.

- A patient is in a capitated plan if the contract between the health center and the HMO, Accountable Care Organization (ACO), or other similar plans stipulates that for a flat payment per month, the health center will provide that patient all the services on a negotiated list. (Oregon programs should include enrollees in coordinated care organizations [CCOs] on this line.)
- This usually includes, at a minimum, all office visits.
- Payments are received (and reported on Table 9D) regardless of whether any service is rendered to the patient in that particular month. The capitated member months reported on Line 13a relate to the net capitated income reported on Table 9D on Lines 2a, 5a, 8a, and/or 11a.

Member Months for Managed Care (Fee-for-Service) (Line 13b): Enter the total fee-for-service member months by source of payment.

- A fee-for-service member month is defined as one patient being assigned to a health center or health center service delivery provider for one month, during which time the patient may receive basic primary care services only from the health center but for whom the services are paid on a fee-for-service basis.
- It is common for patients to have their primary care covered by capitation, but other services, such as behavioral health or pharmacy, are paid separately on a fee-for-service basis as a "carve out" in addition to the capitation. Do not include member months for individuals who receive "carved-out" services under a fee-for-service arrangement on line 13b if those individuals have already been counted for the same month as a capitated member on line 13a.
- There is a relationship between the fee-for-service member months reported on line 13b and the income reported on Table 9D on lines 2b, 5b, 8b, and/or 11b.

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

Targeted Special Populations, Lines 14-26

This section asks for a count of patients from targeted special populations, including persons who are homeless, migratory and seasonal agricultural

workers and their family members, patients who are served by school based health centers, patients served at or a health center located in or immediately accessible to a public housing site, and patients who are veterans. Grantees who receive targeted funding for section 330 (h) - Health Care for the Homeless (HCH) and section 330(g) - Migrant Health Center (MHC) must also provide additional information on their agricultural employment and/or housing characteristics.

- All health centers report these populations, regardless of whether or not they directly receive special population funding.
- Housing status must be collected by HCH grantees at the first visit of the year where the patient was identified to be homeless.
- Migratory or seasonal agricultural workers status must be verified at least every two years by MHC grantees.

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

Report either on line 16 or on lines 14 and 15 the number of patients seen during the reporting period who were either migratory or seasonal agricultural workers, family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B)). Only health centers that receive section 330(g) - Migrant Health Center funding, provide separate totals for migratory and for seasonal agricultural workers on lines 14 and 15. For section 330(g) grantees, Lines 14 + 15 = Line 16. All other health centers report on Line 16.

Instructions for Reporting Migratory and Seasonal Agricultural Workers:

- **Migratory Agricultural Workers, Line 14**: Report patients *whose principal employment is in agriculture* and who establish a temporary home for the purposes of such employment as a migratory agricultural worker, as defined by section 330(g) of the Public Health Service Act. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such work as their *principal employment* within 24 months of their last visit, as well as their *dependent* family members who have also used the center. The family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who *leave* a community to work elsewhere are classified as migratory workers in their home community, as are those who migrate *to* a community to work there.
    - Include **Aged and Disabled Former Migratory Agricultural Workers**, as defined in section 330 (g)(1)(B). Aged and disabled former agricultural workers includes those who were previously migratory agricultural workers but who no longer work in agriculture because of age or disability and family members.
- **Seasonal Agricultural Workers, Line 15**: Report patients *whose principal employment is in agriculture* on a seasonal basis (e.g., picking fruit during the limited months of a picking season) but who *do not* establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who have been so employed within 24 months of their last visit and their family members who may be patients of the health center.
- **Total Agricultural Workers or Dependents, Line 16:** Report the number of patients seen who were either migratory or seasonal agricultural workers, family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers.

For both categories of workers, report patients who meet the definition of agriculture farming in all its branches, as defined by the Office of Management and Budget (OMB) - developed North American Industry Classification System (NAICS), and include seasonal workers included in the following codes and all sub-codes within: 111, 112, 1151, and 1152.

Homeless Patients, Lines 17-23

All health centers are to report the total number of patients, known to have been homeless at the time of any service provided during the reporting period, on lines 17 – 22 or on line 23. Only health centers receiving section 330(h) - Homeless Health Center (HCH) funding provide separate totals for patients by housing location on lines 17 - 22.

Homeless: Report patients who lack housing (without regard to whether the individual is a member of a family) as homeless. Include patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and patients who reside in transitional housing or permanent supportive housing.

HCH grantees will provide separate totals for homeless patients by the type of shelter arrangement the patient had when they were *first encountered during the reporting year*. The following applies when categorizing patients for Lines 17 through 22:

- Report the patient's shelter arrangement as of the first visit during the reporting period. This is normally assumed to be where the person was housed the prior night.
- Report persons who spent the prior night incarcerated, in an institutional treatment program (mental health, substance abuse, etc.) or in a hospital based on where they intend to spend the night *after* their visit/release. If they do not know, report them on Line 20, Street.
- Patients currently residing in a jail or an institutional treatment program are not considered homeless until they are released to the street with no housing arrangement.
- **Line 17 – Shelter**: Report patients who are living in an organized shelter for homeless persons at the time of their first visit. Shelters that generally provide for meals as well as a place to sleep are seen as temporary and often have a limit on the number of days or the hours of the day that a resident may stay at the shelter.
- **Line 18 – Transitional Housing**: Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing stays – generally between six months and two years – in a service rich environment. Transitional housing provides a greater level of independence than traditional shelters and may require the resident to pay some or all the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. *Do not include those who are transitioning from jail, an institutional treatment program, the military, schools, or other institutions.*
- **Line 19 – Doubled Up**: Count patients who are living with others as 'doubled up'. The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time. Do not count the person who invites a homeless person to stay in their home for the night as homeless.
- **Line 20 – Street**: Include patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy in this category.

- **Line 21 – Other**: Report previously homeless patients who were housed when first seen, but who were still eligible for the program. HCH-funded programs may continue to serve patients who are no longer homeless as a result of becoming residents of permanent housing for 12 months after their last visit as homeless. Include them in this category. Classify patients who reside in single room occupancy (SRO) hotels or motels, patients who reside in other day-to-day paid housing, and residents of permanent supportive housing or other housing programs that are targeted to homeless populations as "other" on Line 21.
- **Line 22 – Unknown**: Report patients known to be homeless, but with no known housing arrangement in this category.
- **Line 23 – Total Homeless**: Report the total number of patients, known to have been homeless at the time of any service provided during the reporting period.

School-Based Health Center Patients, Line 24

All health centers that identified a school-based health center as a service delivery site in their scope of project (grant or designation) are to report the total number of patients who received primary health care services at the approved school service delivery site(s).

- Count patients served at in-scope school-based health centers located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services.
- Services are targeted to the students at the school, but may also be provided to their children, siblings, or parents and may occasionally include persons residing in the immediate vicinity of the school.
- Do not include students who receive screening services or mass treatment, such as vaccinations or fluoride treatments at a school, as patients.

Veterans, Line 25

All health centers report the total number of patients served who have been discharged from the uniformed services of the United States. This element is to be included in the patient information/intake form at each center.

- Report only those who affirmatively indicate they are veterans.
- Do not count persons who do not respond or who have no information, regardless of other indicators.
- Persons, who are still in the uniform services, including soldiers on leave and National Guard members not on active duty, are not considered veterans.
- Do not count veterans of other nations' military, even if they served in wars in which the United States was also involved.
- This category is not exclusive and an individual who is classified as a homeless patient (for example) can also be classified as a veteran.

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

All health centers are to report all patients seen at a *site* that is located in or immediately accessible to public housing, regardless of whether or not the patients are residents of public housing or the health center receives funding under section 330(i) - Public Housing Primary Care (PHPC).

- Count patients on this line if they are served at health center *sites* that meet the statutory definition of PHPC (located in or immediately

accessible to public housing) regardless of whether the health center *site* receives PHPC funding and regardless of whether or not the patient actually lives in public housing (location-based reporting).

- This is the only field in the UDS Report that requires you to **provide a count of all patients based on the health centers proximity to public housing**. This means that you are to report all patients seen at the health center site if it is located in or is immediately accessible to agency-developed, owned, or assisted low-income housing, including mixed finance projects.
    - Exclude from the count housing units with no public housing agency support other than section 8 housing vouchers.

For health centers that are multi-funded, including a Public Housing grant, on the Grant Report do not report a number greater than the count of patients served in that program.

Additional information is available to clarify reporting. View **FAQs for Table 4**.

Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2017, through December 31, 2017

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

Line	Principal Third Party Medical Insurance	0-17 years old (a)	18 and older (b)
7.	**None/Uninsured**		
8a.	Regular Medicaid (Title XIX)		
8b.	CHIP Medicaid		
8.	**Total Medicaid** (Line 8a + 8b)		
9a.	Dually Eligible (Medicare and Medicaid)		
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a.	Other Public Insurance Non-CHIP (specify:)		
10b.	Other Public Insurance CHIP		
10.	**Total Public Insurance (Line 10a + 10b)**		
11.	**Private Insurance**		
12.	**TOTAL** (Sum Lines 7 + 8 + 9 +10 +11)		

Line	Managed Care Utilization Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**Total Member months** (Sum Lines 13a + 13b)					

Table 4: Selected Patient Characteristics (continued)

Reporting Period: January 1, 2017, through December 31, 2017

Line	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	**Total Agricultural Workers or Dependents** (All Health Centers Report This Line)	
17.	Homeless Shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling Up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	**Total Homeless** (All Health Centers Report This Line)	
24.	**Total School-Based Health Center Patients** (All Health Centers Report This Line)	
25.	**Total Veterans** (All Health Centers Report This Line)	
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All Health Centers Report This Line)	

Instructions for Table 5: Staffing and Utilization

This table provides a profile of health center staff (Column A), the number of visits they render (Column B), and the number of patients served in each service category (Column C). Column C is designed to report the number of unduplicated patients *within each of seven service categories:*

- Medical
- Dental
- Mental health
- Substance abuse
- Vision
- Other professional
- Enabling

The patient count will often involve duplication *across* service categories, though it is unduplicated *within* service categories. This is unlike Tables 3A, 3B, and 4 where an unduplicated count of patients is reported.

The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial reporting while ensuring adequate detail on staff categories for program planning and evaluation purposes.

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

Staff Full-Time Equivalents (FTEs), Column A

Table 5 includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the project for all sites covered by the UDS. Report *all staff in terms of* ***annualized*** *FTEs.*

Staff may provide services on behalf of the health center under many different arrangements, including but not limited to salaried full-time, salaried part-time, hourly wages, National Health Service Corps assignment, under contract, or donated time.

FTEs reported on Table 5 Column A include paid staff, volunteers, contracted personnel (paid based on worked hours or FTE), interns, residents, and preceptors.

Do not count individuals who are paid by the health center on a fee-for-service basis only in the FTE

column, because there is no basis for determining their hours. Their visits are still reported in Column B and the patients who received services are reported in Column C.

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

- One full-time equivalent (FTE = 1.0) describes staff who individually or as a group worked the equivalent of full-time for one year. Each health center defines the number of hours for "full-time" work and may define it differently for different positions.
- The full-time equivalent is based on employment contracts for clinicians and other exempt employees. For example, a physician hired as a full-time employee who is only required to work nine four-hour sessions (36 hours) per week is full-time. Similarly, clinicians may routinely stay late in the clinic or see hospitalized patients before or after normal work days, but would still be considered to be 1.0 FTE.
- In some health centers, different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. For example, if physicians work 36 hours per week, 36 hours would be considered 1.0 FTE. An 18 hour per week physician would be considered as 0.5 FTE regardless of whether other employees work 40-hour weeks.
- For exempt staff working fewer than 40 hours a week, their FTE can often be determined by their benefits status. If they get full-time benefits (e.g., eight hours pay for New Year's Day), then they would be considered full-time. For non-exempt employees, an FTE is calculated based on paid hours. FTEs are adjusted for part-time work or for part-year employment. For example, in a health center that has a 40-hour work week (2,080 hours/year), a person who works 20 hours per week (i.e., 50 percent time) is reported as 0.5 FTE.
- An FTE is also based on the part of the year that the employee works. Report an employee who works full-time for four months out of the year as 0.33 FTE (4 months ÷ 12 months).

Allocate all staff time *by* **function** among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (nurses). If that nurse provided case management services during 10 dedicated hours per week and provided medical care services for the other 30 hours per week, the time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out the components of an interaction. The nurse who handles a referral after a visit as a part of that visit would not be allocated out of nursing. The nurse who collects vitals on a patient, who is then placed in the exam room, and later provides instructions on wound care, for example, would not have a portion of the time counted as health education – it is all a part of nursing.

Count an individual who is hired as a full-time clinician as 1.0 FTE regardless of the number of direct patient care or face-to-face hours they provide. Providers who have released time to compensate for on-call hours or who receive paid leave for continuing education or other reasons are still considered full-time if that is how they were hired. (Similarly, do not count providers who are routinely required to work more than 40 hours per week as more than 1.0 FTE.) Count the time spent by providers performing tasks in what could be considered non-clinical activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in quality improvement (QI) activities, supervising nurses, etc., as part of their overall

medical care services time and not in a non-clinical support category.

The one exception to this rule is when a Chief Medical Officer/Medical Director is engaged in non-clinical activities at the corporate level (e.g., attending Board of Directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), in which case time can be allocated to the non-clinical support services category. This does not, however, include non-clinical activities in the medical area, such as supervising the clinical staff, chairing or attending clinical meetings, or writing clinical protocols.

Staff by Major Service Category

Staff members are distributed into categories that reflect the types of services they provide as an independent provider. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a more detailed, though not exhaustive, list appears in Appendix A.

Medical Care Services (Lines 1-15)

- **Physicians (Lines 1–7)**: Report medical doctors (MDs) and doctors of osteopathic medicine (DOs), including licensed residents on lines 1-7. Do not report psychiatrists, ophthalmologists, pathologists, and radiologists here. They are separately reported on Lines 20a, 22a, 13, and 14, respectively. Report licensed interns and residents on the line designated for the specialty designation they are working toward and credited with their own visits. (Thus, count a family practice intern as a family physician on Line 1.) Do not count naturopaths, acupuncturists, community health aides/practitioners, and chiropractors on these lines. Report these providers on Line 22 as Other Professionals.
- **Nurse Practitioners (Line 9a)**: Report nurse practitioners (NPs) and advanced practice nurses (APNs) here. Do not include psychiatric nurse practitioners who are included on Line 20b, Other Licensed Mental Health Providers, and certified nurse midwives (CNMs) who are reported on line 10.
- **Physician Assistants (Line 9b)**
- **Certified Nurse Midwives (Line 10)**
- **Nurses (Line 11)**: Report registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
- **Other Medical Personnel (Line 12)**: Report medical assistants, nurses' aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with services provided by a physician, NP, PA, CNM, or nurse.

  Other medical personnel considerations:

  - Do not report staff dedicated to quality improvement or HIT/EHR informatics here. Report them on line 29b, Quality Improvement Staff.
  - Do not report medical records and patient support staff here. Report them on Line 32, Patient Support Staff.
- **Laboratory Personnel (Line 13)**: Report pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. Some or all of the time of licensed nurses may be in this category if they are delegated to this responsibility, but

none of the time of a physician should be included here.

- **X-ray Personnel (Line 14)**: Report radiologists, X-ray technologists, and X-ray technicians. Physician time would not be included here even if they were taking X-rays or performing sonograms.

Dental Services (Lines 16-19)

- **Dentists (Line 16)**: Report general practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration. ***Note***: Do not classify dental therapists here— report them on Line 17a, Dental Therapists.
- **Dental Hygienists (Line 17)**
- **Dental Therapists (Line 17a)**: Only some states license dental therapists. Classify staff to this line based on state licensing and function.
- **Other Dental Personnel (Line 18)**: Report dental assistants, aides, and technicians.

Behavioral Health Services

The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance abuse disorders. All visits, providers, and costs classified by health centers as "behavioral health" visits must be parsed out into mental health or substance abuse. Centers may choose to identify all services as Mental Health Services.

Mental Health Services

Mental health services include psychiatric, psychological, psychosocial or crisis intervention services.

- **Psychiatrists (Line 20a)**
- **Licensed Clinical Psychologists (Line 20a1)**
- **Licensed Clinical Social Workers (Line 20a2)**
- **Other Licensed Mental Health Providers (Line 20b)**: Report other licensed mental health providers, including psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Master's Degree-prepared clinicians.
- **Other Mental Health Staff (Line 20c)**: Report unlicensed individuals, including "certified" individuals, who provide counseling, treatment, or support to mental health providers.

Mental health service personnel considerations:

  - Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are counted on Line 20c, unless they possess a separate license that they are practicing under. (Thus, a licensed clinical social worker (LCSW) doing a psychology internship must be counted on the LCSW Line 20a2 until a license is received as a Psychologist.)

Substance Abuse Services (Line 21)

Report individuals who provide substance abuse services, including substance abuse workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, family therapists, and other individuals providing alcohol or drug abuse counseling and/or treatment services.

Substance abuse service personnel considerations:

  - Neither licenses nor credentials are required by the UDS – each center will

credential its own providers according to its own standards.

- Keep medical providers treating patients with substance use diagnoses on Lines 1 through 10.
- Do not include physicians, nurse practioners, or physician assistants who obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications (medication-assisted treatment [MAT]) specifically approved by the U.S. Food and Drug Administration (FDA) here. Include MAT on Lines 1-9b (if medical), Line 20a for psychiatrist, or Line 20b for psychiatric nurse practitioner.

Other Professional Health Services (Line 22)

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

Other professional health personnel considerations:

- These professionals are usually, but not always, licensed by some entity. They are also generally credentialed and privileged by the health center's governing board.
- Report WIC nutritionists and other professionals working in WIC programs on Line 29a, Other Programs and Services Staff.

Vision Services (Lines 22a-22d)

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

- **Ophthalmologists (Line 22a)**: Report medical doctors specializing in medical and surgical eye problems
- **Optometrists (Line 22b)**: Report optometrists (OD)
- **Other Vision Care Staff (Line 22c)**: Report ophthalmologist and optometric assistants, aides, and technicians.

Pharmacy Services (Line 23)

Report pharmacists (including clinical pharmacists), pharmacy technicians, pharmacist assistants, and others supporting pharmaceutical services.

Pharmacy services considerations:

- Do not report the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies (pharmacy assistance programs [PAP]) here. Report them under "Eligibility Assistance Workers," on Line 27a.

- Allocate an individual employee who works as a pharmacy assistant (for example) and also provides PAP enrollment assistance by time spent in each category.
- Report clinical pharmacists on Line 23. Do not allocate to other clinical or non-clinical lines.

Enabling Services (Lines 24-29)

- **Case Managers (Line 24)**: Report staff who assist patients in the management of their health and social needs, including assessment of patient medical and/or social service needs, establishment of service plans, and maintenance of referral, tracking, and follow-up systems. Case managers may, at times, provide health education and/or eligibility assistance in the course of their case management functions. Include individuals who are trained as, and specifically called, Case Managers, as well as individuals called Care Coordinators, Referral Coordinators, and other local titles.
- **Patient and Community Education Specialists (Line 25)**: Report health educators, with or without specific degrees in this area.
- **Outreach Workers (Line 26)**: Report individuals conducting case finding, education, or other services to identify potential patients or clients and/or facilitate access or referral of potential health center patients to available health center services.
- **Transportation Workers (Line 27)**: Report individuals who provide transportation for patients (van drivers) or arrange for transportation, including persons who provide for long distance transportation to major cities in some extremely remote clinic locations.
- **Eligibility Assistance Workers (Line 27a)**: Report staff who provide assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, Medicare, WIC, supplemental security income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Pharmacy Assistance Programs (PAPs), and related assistance programs, as well as staff hired under the HRSA Outreach and Enrollment grants.
- **Interpretation Staff (Line 27b)**: Report staff whose *full-time or dedicated time* is devoted to translation and/or interpretation services. *Do not include* that portion of the time of a nurse, medical assistant, or other support staff who provides interpretation or translation during the course of his/her other activities.
- **Community Health Workers (Line 27c)**: Report lay members of communities who work in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Staff may be called community health workers, community health advisors, lay health advocates, promotoras, community health representatives, peer health promoters, or peer health educators.

  Community health worker considerations:

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

- **Personnel Performing Other Enabling Service Activities (Line 28)**: Report all other staff performing enabling services not described above.

  Other enabling services considerations:

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

Other Programs and Related Services Staff (Line 29a)

Some health centers, especially "umbrella agencies," operate programs that although within their scope of service and often important to the overall health of their patients, are not directly a part of the listed medical, dental, behavioral, or other health services. Include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, childcare, frail elderly support programs, adult day health care programs, fitness or exercise programs, public/retail pharmacies, etc. Use the "specify" field to describe what these staff members are doing.

Quality Improvement Staff (Line 29b)

Although quality improvement (QI) is a part of virtually all clinical and administrative roles, some individuals have specific responsibility for the design and oversight of quality improvement systems. Report individuals that spend all or a substantial portion of their time dedicated to these activities. They may have clinical, IT, or research backgrounds, and may include QI nurses, data specialists, statisticians, and health information technologies (HIT), including electronic health records (EHR) and electronic medical records (EMR), designers.

Quality improvement staff considerations:

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

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

- **Management and Support Staff (Line 30a)**: Report management team including the Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Medical Officer, Chief Operations Officer, and Human Resources Director, as well as other non-clinical support staff and office support (secretaries, administrative assistants, file clerks, etc.). In the case of the Medical Director or other individuals whose time is split between clinical and non-clinical activities, report only that portion

of their FTE corresponding to the corporate management function. (See limits on non-clinical time above.)

- **Fiscal and Billing Staff (Line 30b)**: Report staff performing accounting and billing functions in support of health center operations for services performed within the scope of the program, *excluding the Chief Financial Officer* (who is reported on Line 30a).
- **IT Staff (Line 30c)**: Report technical information, technology, and information systems staff supporting the maintenance and operation of the computing systems that support functions performed within the scope of the program.

  Information technology (IT) staff considerations:

  - Report IT staff managing the hardware and software of an HIT (including EHR/EMR) system on Line 30c.
  - Report IT staff designing medical forms and conducting analysis of HIT data as part of the QI functions on Line 29b.
  - Include IT staff performing data entry as well as providing help-desk, training, and technical assistance functions as part of the other medical personnel or appropriate service category for which they perform these functions.
- **Facility Staff (Line 31)**: Report staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff. ***Note:*** If facility functions are contracted (e.g., janitorial services), do not attempt to create an FTE. Show the costs on the facility Line 14 on Table 8A.
- **Patient Services Support Staff (Line 32)**: Report intake staff, front desk staff, and medical/patient records.

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

Clinic Visits, Column B

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

Visits purchased from non-staff providers on a fee-for-service basis

Count these visits in this column, even though no corresponding FTEs are included in Column A. To count, the visit must meet the following criteria:

- The service was provided to a patient of the health center by a provider who is not part of the health center's staff (neither salaried, nor contracted on the basis of time worked but meeting the center's credentialing policies),
- The service was paid for in full by the health center, and
- The service otherwise meets the definition of a visit.

Do not include unpaid referrals, referrals where a third-party will make the payment (e.g., the patient's insurance company), or referrals where only nominal amounts are paid although the negotiated payment may be less than the provider's "usual, customary, and reasonable" rates.

Visit Considerations

Nurses, Line 11:

- Services may be provided under standing orders of a medical provider under specific instructions from a previous visit or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit. These services must meet the requirement of exercising independent professional judgment.
- Report nurse visits that meet all visit criteria. See Instructions for Visits.
- Report triage services provided by nurses and visiting nurse services when a nurse sees patients independently in the patients' homes to evaluate their condition.
- Count visits charged and generally coded as 99211 using Current Procedural Terminology.
- Most states prohibit a licensed vocational nurse (LVN) or a licensed practical nurse (LPN) from exercising independent judgment; do not count visits for them.

Other medical personnel, Line 12:

- Do not count services provided by medical assistants, aides, or other non-nursing personnel here or as nursing visits on Line 11.

Dentists, dental hygienists, and dental therapists, Lines 16, 17, and 17a:

- Report only one visit per patient per day, regardless of the number of clinicians who provide services or the volume of service (i.e., number of procedures) provided.
- Do not count the application of dental varnishes, fluoride treatments, and dental screenings, absent other comprehensive dental services as a visit.
- Do not credit services of dental students or anyone else other than a licensed dental provider with dental visits, even if these individuals are working under the supervision of a licensed dental provider.
- Exception: Count the visits of a supervising dentist's student (i.e., one who is overseeing dental students who are enrolled in a graduate education program leading to a license as a dentist) as long as the supervising dentist:
  - Has no other responsibilities, including the supervision of other personnel at the time services are furnished by the students,
  - Has primary responsibility for the patients,
  - Reviews the care furnished by the students during or immediately after each visit, and
  - Documents the extent of their

participation in the review and direction of the services furnished to each patient.

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

Other mental health, Line 20c:

- Credit these individuals with their own visits regardless of any billing practices at the center. No other person is to be credited with these visits.

Substance abuse, Line 21:

- In programs that include the regular use of narcotic agonists or antagonists or other medications on a regular (daily, every three days, weekly, etc.) basis, count the counseling services as visits but not the dispensing of the drugs, regardless of the level of oversight that occurs during that activity. Report counseling patients to determine or diagnose their medical needs, including medication-assistance, as medical or mental health visits based on the provider providing these services, not on Line 21 as substance abuse visits.

Other professional, Line 22:

- Describe all services in a clear detailed statement using the "specify" box.
- Check the reporting of such services with the UDS Support Center or their UDS Reviewer.

Vision services, Lines 22a-22d:

- Do not count the services of students or anyone other than a licensed vision service provider with vision services visits.
- Do not count retinography (imaging of the retina), whether performed by a licensed vision services provider or anyone else, as a vision visit absent of a comprehensive vision exam.
- Do not consider fitting glasses as a visit regardless of who performs the fitting.

Pharmacy, Line 23:

- Some states license clinical pharmacists whose scope of practice may include ordering labs and reviewing and altering medications or dosages. Despite this expanded scope of practice, do not record clinical pharmacist visits or interactions with patients.

Case managers, Line 24:

- Case managers often contact third-parties in the provision of their services. Do not count these contacts or interactions, though recognized as important.
- When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility) only count one visit, generally for an adult member of the family, regardless of documentation in other charts.
- Case management is rarely the only type of service provided to a patient.

Patient and community education, Line 25:

- Report only services provided one-on-one with the patient. Do not report group education classes or visits.
- Health education is provided to support the delivery of other health care services and is rarely the only type of service provided to a patient.

Do not record visits and patients for services provided by the following:

- Other Medical Personnel, Line 12
- Laboratory Personnel, Line 13
- X-ray Personnel, Line 14
- Other Dental Personnel, Line 18
- Other Vision Care Staff, Line 22c
- Pharmacy Personnel, Line 23
- Outreach Workers, Line 26
- Transportation Staff, Line 27
- Eligibility Assistance Workers, Line 27a
- Interpretation Staff, Line 27b
- Community Health Workers, Line 27c
- Other Enabling Services, Line 28
- Other Programs and Services, Line 29a
- Quality Improvement Staff, Line 29b
- Management and Support Staff, Line 30a
- Fiscal and Billing Staff, Line 30b
- IT Staff, Line 30c
- Facility Staff, Line 31
- Patient Support Staff, Line 32

Additionally, some interactions cannot be reported as visits. Please review the **Services and Persons Not Reported on the UDS Report** section above for specifics.

Patients, Column C

A patient is an individual who has at least one reportable visit during the reporting year. (See the Definitions of Visits, Providers, and Patients section, page 17, for further details.)

- Report an unduplicated patient count in Column C for any of the seven categories of services shown below at which the patient had visits reported in Column B during the reporting year.
- Report the total number of patients served for *each* of the seven separate services listed below.
    - Medical services (Line 15)
    - Dental services (Line 19)
    - Mental health services (Line 20)
    - Substance abuse services (Line 21)
    - Vision services (Line 22d)
    - Other professional services (Line 22)
    - Enabling services (Line 29)
- *Within each category, count an individual only once as a patient.*
- *Count a person who receives multiple types of services once (and only once) within each service category.*
- Because patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.
- Do not include individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, and outreach).

Relationship between Table 5 and Table 8A

The staffing on Table 5 is routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.

Additional information is available to clarify reporting. View **FAQs for Table 5**.

Table 5: Staffing and Utilization

Reporting Period: January 1, 2017, through December 31, 2017

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	**Total Physicians** (Lines 1–7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-ray Personnel			
15	**Total Medical** (Lines 8 + 10a through 14)			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services** (Lines 16–18)			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Total Mental Health** (Lines 20a–c)			
21	**Substance Abuse Services**			
22	**Other Professional Services** (specify___)			
22a	Ophthalmologists			

Table 5: Staffing and Utilization (continued)

Reporting Period: January 1, 2017, through December 31, 2017

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
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			
27c	Community Health Workers			
28	Other Enabling Services (specify___)			
29	**Total Enabling Services** (Lines 24–28)			
29a	**Other Programs/Services** (specify___)			
29b	**Quality Improvement Staff**			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
33	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)			
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)			

Instructions for Table 5A: Tenure for Health Center Staff

Table 5A provides information on the tenure of health center providers and key management staff who are employed or committed on the last day of the year to better assess workforce needs and improve efforts for workforce development and retention. They may be employed for all or a part of the year or by contract or retained as National Health Service Corps (NHSC) assignees. Report staff into one of two categories—(1) Full- and Part-Time staff and (2) Locums, On-call, and Others—as described below. The definitions for each line (category) on Table 5A is the same as those used on Table 5, and individuals reported on the selected lines on Table 5A are the same individuals that are reported on the comparable lines on Table 5. Line numbers on Table 5A correspond to those on Table 5. Not all Table 5 lines are reported. There are no lines for non-providers, other than key health center management staff, or for the providers of Other Professional and Enabling services.

Instructions

Persons (Columns A and C)

Include all individuals who are employed on the last day of the year or who are current employees/contractors who have that day off but are scheduled to return on a specific day. Table 5A is a census of staff as of the last workday of the year (i.e., December 31).

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

- Employed full-time
- Employed part-time on a regular basis with a regular schedule
- Is an NHSC clinician who is assigned to the health center
- Is contracted on a regular basis with a regular schedule
- Is an on-call, locum, resident, or volunteer provider who has worked and/or is scheduled to work a regular schedule for at least six months

Count individuals who are on leave on the census date, but intend to return to the health center. For example, count a physician who has been out for eight weeks on pregnancy leave but intends to return after the leave is over as one person even though she was not present on the census date.

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

Do not count persons who worked for part of the year, but resigned prior to the census date. For example, do not count a full-time physician who worked for the center for ages, but resigned prior to the census date.

Count residents in a program where they are present for six or more months (in Column C). Do not attempt to count residents who are present for a brief period during the year, even if they return in multiple years.

Note: *Staff reported on a given line on Table 5A must be reported on the same line on Table 5. However, it is possible that some part-time FTEs counted on Table 5 will not be included in the count on Table 5A.*

Full- and Part-Time Staff, Column A

Report full- and part-time staff who are considered regular employees of the health center who work in selected positions within the scope of the project for all programs covered by the UDS. They may be paid in any number of ways and may work different amounts of time. Future employment may be limited by the expiration of a contract or may be open-ended with no specific end date. Report the following full- and part-time staff in Column A with months in the current position in Column B:

Full-Time Staff

Include full-time staff employed by the health center, who receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the Internal Revenue Service (IRS) on a W2 form. Staff may or may not have a contract. Count staff as full-time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if full time employees get eight hours off for a holiday, these staff also receive eight hours off.) Include full-time staff with assigned work hours fewer than 40 per week and end up working more than the assigned hours. For example, count a full-time physician who was employed on the census date as one person.

Part-Time Staff

Include part-time staff employed by the health center, for fewer than 40 hours per week who receive benefits consistent with their FTE, who have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract. Count staff as part-time when they are so defined in their contract and/or when their benefits reflect this status. (For example, if a full-time employee receives eight hours off for a holiday, a 75 percent part time staff person would receive six hours off.) Include part-time staff that end up working more than their assigned hours. For example, count two half-time physicians who were employed on the census date (regardless of whether or not they actually worked that day) as two persons.

Part-Year Staff

Include persons employed or contracted full- or part-time for a specific period because of a recurring special need. This is especially common in centers that serve fishing fleets, agricultural workers, cannery workers, or recreation areas. Include persons employed by the health center on December 31 or under an agreement to return to the clinic the following year. Do not report an individual who works for part of the year and then leaves prior to the last working day of the year with no concrete plan to return. For example, count a part-time physician who works two months every summer during the migrant season, but was not present on the census date as one person.

Contract Staff

Report contract staff contracted by and working at the health center who work regular assigned hours every day, week, or month. They may or may not receive benefits appropriate to their FTE. They do not have withholding taxes deducted from their paychecks and they have their income reported to the IRS on a 1099 form. Do not include hospitalists or contract physicians who are paid by the visit to deliver services in their own offices.

National Health Service Corps (NHSC) Assignees

Report NHSC assignee members assigned by the Corps to the health center. Include members of the NHSC Loan Repayment Program. These individuals are employees of the U.S. government.

The health center may or may not have a contract with the NHSC to pay a specific amount to cover some or all of the cost of their assignment.

Locums, On-Call, and Other Service Providers or Consultants Column C

Report individuals other than their regular staff who provide services to your patients. They have many different names, though the difference between categories may be subtle or non-existent, and different centers may use the names differently. Report the following locums, on-call staff, etc. in Column C, with months in the current position in Column D:

Locum Tenens

Report locums who work at the health center on an as-needed basis. Include locums used to fill in for a part-time absence of another provider (e.g., on a day off or to cover for a vacation, sick leave, or the Family and Medical Leave Act [FMLA]), and locums used when the center is unable to hire a full- or part-time staff person for a position. Locums are uniquely identifiable because they work for an agency and the center pays the agency rather than the individual. They do not receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

On-call Providers

Report on-call providers who work at the health center on an as-needed basis and used to fill in for a part-time absence of another provider (e.g., on a day off or to cover for a provider who is on vacation, sick leave, or FMLA). Include on-call providers used for an extended period when the center is unable to hire a full- or part-time staff person for a position. Unlike locums, on-call providers are paid by the health center. They may or may not receive benefits and may or may not have payroll and income taxes withheld. Federal Tort Claims Act (FTCA) does not generally cover on-call providers, though they may be covered by the center's gap insurance.

Volunteers

Report volunteers with a regular schedule. Include both volunteers with a large number of hours and those with a few hours a month. They are generally scheduled by the session. Volunteer providers are not paid by the health center and do not receive benefits. They may be covered by FTCA or by the center's gap insurance.

Residents/Trainees

Report trainees providing services at the health center, under the supervision of a more senior person, when the health center participates in training programs. Many of these trainees (especially medical and dental residents) are licensed in their own right. Reporting considerations:

- Include medical residents on the line for which they are training for, so count a family practice resident on the family practice line, even though they have not yet passed the boards for that additional certification.
- Include mental health interns or residents who are licensed at a level other than that for which they are training on the line for which they are training. A Psychology resident may

be a Licensed Clinical Social Worker (LCSW), in which case they would be considered on the LCSW line.

- Do not count an individual who is not licensed. An LCSW trainee who holds no independent license would not be reported.

Off-site Contract Providers

Report providers contracted for services who work at a location that is not an in-scope site as defined in the application. This may be because the center does not have the critical mass to establish a service (e.g., a dental contract) or because it is serving a wider area than its existing sites can reach (especially in migrant voucher or homeless programs).

- Consider providers if they are contracted for a specific time (e.g., Monday and Wednesday afternoons or two days per week).
- Do not consider providers paid by the visit.

Non-Clinical Consultants

Count consultants used to fill administrative, non-clinical management positions because they are unable to recruit health center management staff or are unable to support a full-time person in that role - especially smaller and more remote health centers. Consider these consultants on Lines 30a1, 30a2, 30a3, and 30a4.

Total Months (Columns B and D)

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

- Report the number of months since they were hired for persons who have been continuously employed (contracted for) in their current position, regardless of whether or not the census day is a regular workday. For example:
  - Credit a full-time physician who has worked since January 1, 2014 with 48 months. (4 full years × 12 months)
  - Credit two half-time physicians who both began working on July 1, 2003 with 348 months. (14.5 years × 2 staff × 12 months)
  - Credit a part-time physician who has worked every summer during the agricultural season since July 1, 2006 with 138 months. (11.5 years × 12 months).
  - Credit a cardiologist who has worked the first and third Wednesday of every month since January 18, 2014 with 48 months.
- Report the number of months since they were *most recently* hired for persons who have been employed more than once and whose employment was terminated between the two (or more) periods.
- Report the number of months *since they began the position for which they are being counted* for persons who have served multiple positions in a health center (e.g., a long-term physician who was recently promoted to medical director). For example:
  - Credit a physician who has been (and remains) a pediatrician since January 1, 2014 and medical director since July 1, 2017 is credited with 48 months as a pediatrician and six months as a medical director.
- Report the number of continuous months they have been holding each position for persons who are currently working in two or more positions (e.g., a pediatrician/medical director or CEO/CFO). (So it might be 50 months as pediatrician and nine months as medical director.)

Additional information is available to clarify reporting. View **FAQs for Table 5A**.

Table 5A: Tenure for Health Center Staff

Reporting Period: January 1, 2017, through December 31, 2017

		Full and Part Time		Locum, On-Call, etc.	
Line	Health Center Staff	Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/ Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
11	Nurses				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer				
30a2	Chief Medical Officer				
30a3	Chief Financial Officer				
30a4	Chief Information Officer				

Instructions for Table 6A: Selected Diagnoses and Services Rendered

This table is designed to provide data on selected diagnosis and selected services rendered. The data source is data maintained for billing purposes and/or in HIT, including EHRs. Table 6A is not expected to reflect the full range of diagnoses and services rendered by a health center. The diagnoses and services selected represent those that are prevalent among Health Center Program patients, or that have been regarded as sentinel indicators of access to primary care or are of special interest to HRSA. *Report* diagnoses *on this table that were made by a medical, dental, mental health, substance abuse, or vision provider only*. For example, do not count a diagnosis for diabetes if a case manager or health educator sees a diabetic patient. However, if a physician shows the primary diagnosis as hypertension and the secondary diagnosis as diabetes, record the visit and the patient on both the line for hypertension and the line for diabetes.

Visits and Patients, Column A and B

Visits and Patients by Selected Diagnoses, Lines 1–20d

Lines 1 through 20d present the name and applicable International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Report on all visits and patients where the provider-assigned *diagnostic code* is included in the range/group of ICD-10-CM codes shown. Report all diagnoses for the visit (primary, secondary, tertiary, etc.) if they are included in the range of codes listed. All visits are entered into an HIT/EHR or a clinic practice management/billing systems, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc.

In Column A, report the total number of visits during the reporting period where the indicated diagnosis is listed in the HIT/EHR or visit/billing record. Do not report if a visit has a diagnosis that is among the many diagnoses not listed on Table 6A. Count each diagnosis made at a visit on Lines 1–20d regardless of the number of diagnoses listed for the visit. For example, count a patient visit with a primary diagnosis of hypertension once on Line 11 and a secondary diagnosis of diabetes once on Line 9.

In Column B, report each individual who had one or more visits during the year that was reported in the corresponding Column A. Count a patient only once on any given line, regardless of the number of visits made for that specific diagnosis or family of diagnoses. Report patients with multiple diagnoses in Column B only once for ***each*** diagnosis used during the year. For example, count a patient with one or more visits with a diagnosis of hypertension and one or more visits with a diagnosis of diabetes *once* as a patient in Column B on *both* Lines 9 and 11.

Visits and Patients by Selected Tests/Screenings, Lines 21–26d

Lines 21 through 26d present the name and applicable ICD-10-CM diagnostic and/or Current Procedural Terminology (CPT) procedure codes for selected tests, screenings, and preventive services that are particularly important to the populations served or are of particular interest to HRSA and are services performed by the health center or by contracted paid referral. On several lines, both CPT codes and ICD-10-CM codes are provided. Use ***either*** the CPT codes ***or*** the ICD-10-CM codes for any specific visit, ***but not both***. Report *all visits meeting the selection criteria*. A reported service may be in addition to another service and may be in addition to a reported diagnosis or may stem from a visit where there was no UDS-reportable diagnosis code.

> ***Note:*** *ICD-10-CM codes for mammography and Pap tests are listed to ensure capture of procedures that are done by the health center but coded with a different CPT code for state reimbursement under Title X or BCCCP. In some instances, payers (especially governmental payers) ask health centers to use different codes for services. In these instances, health centers should add these codes to the published list for reporting purposes.*

- Count a test paid for by a third-party only if the health center performed the test in its lab or collected the sample and transferred it to a reference lab.
- Do not report referrals or orders for tests or procedures, such as mammograms, X-rays, or tomography that are not performed by or paid for by the health center. (For example, do not count referral of a woman to the County Health Department for a mammogram.)
- Count mammograms performed by a health center but read by an outside radiologist who then bills a third-party.

In Column A, report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided. Note that codes for these services may either be diagnostic (ICD-10-CM) codes or procedure (CPT) codes. *During one visit, more than one test, screening, or preventive service may be provided. Count each* procedure or test on each applicable line. If they are on the same line, only count one visit.

In Column B, report patients who have had at least one visit during the reporting period where the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21–26d were provided.

- Count patients who receive more than one type of service during a single visit. For example, if a patient had a Pap test and contraceptive management during the same visit, this patient would be counted on both Lines 23 and 25.
- Count a patient only once per service, regardless of the number of times a patient receives a given service. For example, an infant who has an immunization at each of several well child visits in the year has each visit reported in Column A but is counted only once in Column B.

Some examples may illustrate these rules:

- When one visit involves more than one of the listed services, report each service. For example, if during a visit both a Pap test and an HIV test were provided, then report a visit on both line 21 (HIV test) and line 23 (Pap test).
- If a patient receives multiple immunizations at one visit, report only one visit on line 24.

- Report services *in addition to* diagnoses. For example, count a hypertensive patient who also receives an HIV test on line 11 (hypertension) and on line 21 (HIV test).
- Report services where no diagnosis is reported. For example, count a patient who comes in for annual physical and a flu shot. Report this patient on line 24a (flu shot), but not on any diagnostic line.

> ***Note**: Include follow-up services related to a countable visit. Thus, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit. Do not report an interaction with another person who is not a clinic patient who comes in just for a flu shot during a health center-run flu clinic and without a specific referral from a prior visit.*

Visits and Patients by Dental Services, Lines 27–34

Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services may be performed *only by a dental provider who is reported on Lines 16–17a on Table 5 or by an in-scope contractor paid by the health center.* Wherever appropriate, services have been grouped into code ranges. For these lines, the concept of a "primary" code is neither relevant nor used. *All* services are reported.

In Column A, report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or dental services were provided. Note that codes for these services are procedure (ADA) codes. *During one visit, more than one test, screening, or dental service may be provided. Count each* procedure, screening, or test on each applicable line. If they are on the same line, only count one visit. For example, if a patient had more than one tooth filled during a visit, report only one visit for restorative services (line 32), not one per tooth.

In Column B, report patients who had at least one visit with a dental professional during the reporting period for each of the selected dental services listed.

- Do not report services provided by persons other than a dentist, a dental hygienist, or a dental therapist.
- Count a patient only once if a patient had two teeth repaired and sealants applied during one visit on both lines 30 and 32.
- Report dental services provided directly by a licensed dental provider or an individual working under his/her direct supervision.
- Only report services that are provided at "countable" visits.

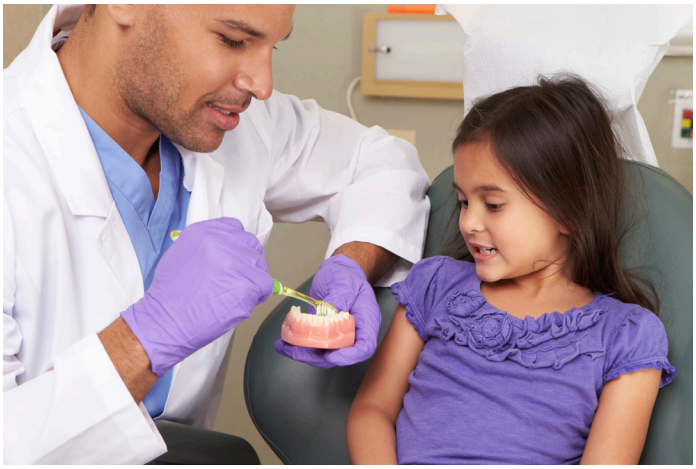
> ***Note**: Do not count fluoride treatments or varnishes that are applied outside of a comprehensive treatment plan, especially when provided as part of a community service at schools, on this table or as a visit on Table 5.*

Services provided by multiple entities:

Care must be taken when multiple entities are involved with a service. Use the following general examples to guide reporting:

- Count the service if the health center provider orders and performs the service. For example, count a rapid HbA1c test ordered by a physician and performed in the clinic lab.

- Do not report vaccinations performed by the health department when children are referred to a city or county health department and the health center does not pay for the service.
- If the health center provider orders a test (e.g., HIV tests) and the sample is collected at the health center and then sent to a reference lab for processing, count the test regardless of whether the test is paid for by the patient, the patient's insurance company,[2] a government entity, or the health center.
- Count a test that a provider asks the patient to get by a third-party that sends the results back to the provider to be acted on *and bills the health center that pays for it*. For example, count mammograms performed by a third-party provider that a health center contracts with and pays for the service.
- Do not count a test or service that a provider asks the patient to get from a third-party provider that *does not bill the health center*, even if the results are sent back to the provider to be acted on. For example, do not count mammograms performed by the county health department for which the county will follow up with the patient directly and the health center did not pay for the service. Do not count a test or service when a patient is referred (e.g., for an HIV test to a Ryan White program) where the receiving entity performs the service and follows up with the patient and the health center does not pay for the service. (These are generally noted in Column III: Formal Written Referral Arrangement [Health center does not pay] of Form 5A: Services Provided.)



Additional information is available to clarify reporting. View **FAQs for Table 6A.**

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

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2017, through December 31, 2017

Table 6A: Selected Diagnoses

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21		
3.	Tuberculosis	A15- through A19-		
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-		
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51		
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21		
	Selected Diseases of the Respiratory System			
5.	Asthma	J45-		
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-		
	Selected Other Medical Conditions			
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, N63-, R92-		
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820		
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-		

Table 6A: Selected Diagnoses (continued)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
11.	Hypertension	I10- through I16-		
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)		
13.	Dehydration	E86-		
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-		
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)		
	Selected Childhood Conditions (limited to ages 0 through 17)			
15.	Otitis media and Eustachian tube disorders	H65- through H69-		
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3		
	Selected Mental Health and Substance Abuse Conditions			
18.	Alcohol related disorders	F10-, G62.1		

Table 6A: Selected Diagnoses (continued)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a.	Tobacco use disorder	F17-		
20a.	Depression and other mood disorders	F30- through F39-		
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Table 6A: Selected Services Rendered

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/Preventive Services			
21.	HIV test	**CPT-4**: : 86689; 86701 through 86703; 87389 through 87391		
21a.	Hepatitis B test	**CPT-4**: 86704, 86706, 87515 through 87517		
21b.	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522		
22.	Mammogram	**CPT-4**: 77052, 77057, 77065, 77066, 77067 OR **ICD-10**: Z12.31		
23.	Pap test	**CPT-4**: 88141 through 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenzae B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4**: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748		
24a.	Seasonal Flu vaccine	**CPT-4**: 90654 through 90662, 90672, 90673, 90685 through 90688		
25.	Contraceptive management	**ICD-10**: Z30-		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393		
26a.	Childhood lead test screening (9 to 72 months)	**CPT-4**: 83655		

Table 6A: Selected Services Rendered (continued)

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS:** G0396, G0397, H0050		
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F		
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		
	Selected Dental Services			
27.	I. Emergency Services	**ADA:** D9110		
28.	II. Oral Exams	**ADA:** D0120, D0140, DO145, D0150, D0160, D0170, D0171, D0180		
29.	Prophylaxis – adult or child	**ADA:** D1110, D1120		
30.	Sealants	**ADA:** D1351		
31.	Fluoride treatment – adult or child	**ADA:** D1206, D1208		
32.	III. Restorative Services	**ADA:** D21xx through D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA:** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes:

- International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
- Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
- Current Dental Terminology (CDT), 2017 – Dental Procedure Codes. American Dental Association (ADA).

Note: *"X" in a code denotes any number including the absence of a number in that place. "–" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.*

Instructions for Table 6B: Quality of Care Measures

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

The quality of care measures reported are "process measures," which means that they document services that have been shown to be correlated with and serve as a proxy for good long-term health outcomes. We know that individuals who receive timely routine and preventive care are more likely to have an improved health status.

By increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, we can expect an improved health status of the patient population in the future. Specifically:

- **Early entry into prenatal care:** The probability of adverse birth outcome will be reduced, *if* women enter care in their first trimester.
- **Childhood immunization status**: Children will be less likely to contract vaccine preventable diseases or to suffer from the sequelae of these diseases, *if* they receive their vaccinations in a timely fashion.
- **Cervical cancer screening**: Early detection and treatment of abnormalities can occur and women will be less likely to suffer adverse outcomes from human papillomavirus (HPV) infection and cervical cancer, *if* women receive Pap tests as recommended.
- **Weight assessment and counseling for nutrition and physical activity for children and adolescents**: The likelihood of obesity and its sequelae will be reduced, *if* clinicians ensure their patients' body mass index (BMI) percentile is recorded, and *if* patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight).
- **Preventive care and screening: Body mass index (BMI) screening and follow-up plan**: The likelihood of the debilitating sequelae of serious weight problems can be reduced, *if* clinicians routinely calculate and record the BMI for their adult patients, and *if* they identify patients with weight problems and develop a follow-up plan for overweight and underweight patients.
- **Preventive care and screening: Tobacco use: Screening and cessation intervention**: Patients will be more likely to quit using tobacco and will therefore have a lower risk of cancer, asthma, emphysema, and other tobacco related illnesses, *if* patients are routinely queried about their tobacco use and are provided with effective cessation counseling and pharmacologic intervention if they are tobacco users.
- **Use of appropriate medications for asthma**: Patients will be less likely to have asthma attacks, will require fewer emergency room visits, and be less likely to develop complications related to asthma, including

death, *if* patients identified with persistent asthma are provided with appropriate pharmacological intervention.

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

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. Many of the UDS quality of care measures are now aligned with CMS e-CQMs for Eligible Professionals. TThe January 2017 Addendum eReporting update is used for the 2017 reporting period. (Although there are other updates available from CMS, they are not to be used for 2017 reporting.) The eReporting specifications can be found at the CMS' eCQI Resource Center at https://ecqi.healthit.gov/ep. E-CQM measure numbers and links are provided to assist you, where applicable. For clarification or interpretation of aligned CMS e-CQMs, please contact the measure steward. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/ is encouraged for health centers capable of appropriately using this resource as defined below to support the data reporting of these quality of care measures.

Column Logic Instructions

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

Report the total number of patients who fit the detailed criteria described for the specified measure. *Consider patients meeting the criteria in the health center's total patient population, including all sites, all programs, and by all providers.*

Because the initial patient population for each measure is defined in whole or in part in terms of age (or age and sex assigned at birth), comparisons to the numbers on Table 3A and Table 6B will be made when evaluating your submission. The numbers in Column A of Table 6B *will not be equal to* those which might be calculated on Table 3A for the following reasons:

(1) All patients seen for all reportable services are counted on Table 3A, but the clinical measures reported on Table 6B relate only to medical patients or dental patients (specific to one measure only) or to patients with specific conditions; and

(2) Table 3A measures age as of June 30 of the calendar year, but Table 6B defines specific time periods (e.g., as of January 1) to measure age.

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

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

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

* ***Note:*** To streamline the process for reporting on the clinical quality measures, and to encourage the use of health information technology (HIT) to report on the full universe of patients, health centers must use *all* of the records available in the HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient records are included in the HIT/EHR for any given measure and patients missing from the HIT/EHR are not related to any variable involved with any given measure. For example, if the patients from a pediatric site are missing in the HIT/EHR, it cannot be used for the childhood immunization measure.

If a sample is to be used, it *must* be a random sample of 70 patient charts and *must* be drawn from the entire patient population identified as the universe. Larger samples will not be accepted. Health centers *may not* choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms because this will result in over-sampling some group of patients.

Use a review of a sample of charts in lieu of full universe reporting from an HIT/EHR if:

- The HIT/EHR does *not include* a minimum of 80 percent of health center patients who meet the criteria described below for inclusion in the specific measure's universe,
- The HIT/EHR does *not exclude* every health center patient who meets one or more exclusion criteria described below for exclusion from the universe, or
- The look-back period data necessary for many of the UDS clinical quality measures (e.g., cervical cancer screening, colorectal cancer screening, and childhood immunizations) requires that the HIT/EHR be in place long enough to be able to find the data required in prior year's activities.
- The required data were not collected from the patient as part of the visit.

It is recommended that records for new patients be obtained from their former providers to document

prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR consistent with internal medical records policies, at which point they could be used in the calculated performance rate for the applicable measure.

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

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

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

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

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

Conditions may sometimes be listed as criteria and sometimes as exclusions because the UDS follows the structure developed for other quality reporting programs. Treat as described here to either constrain the universe of an HIT/EHR report or identify charts to be replaced in a chart review process.

In the information that follows, "conditions" or "criteria" are at times interchanged with "exclusions." This is partly because of the differing language and procedures in an HIT/EHR (or practice management system [PMS]) based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be able to be found in the HIT/EHR and must be in the HIT/EHR for each patient at the health center. To the extent that they cannot be found, they will distort the findings, and mean that the HIT/EHR must not be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the immunization of 2-year olds because you cannot limit the universe to medical patients.

> In a sample chart review process, items listed as "criteria" may be used as "exclusions." For example, if you are unable to use HIT/EHR, you are to randomly select 70 patient charts of all two year-old patients listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. In a computer search, include as a criterion that they must be medical patients for the child immunization measure.

And vs. Or

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

Detailed Instructions for Clinical Measures

The clinical measures reported in the UDS relate only to medical patients (or dental patients in the case of one measure only). Health centers are to

report each measure using the criteria outlined below. Each measure has been organized in the same way to assist you with data collection and reporting.

- **Measure Description**: Describes the quantifiable indicator to be evaluated
- **Denominator (Universe)**: Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated
- **Numerator**: Records (from the denominator) that meet the measurement standard for the specified measure
- **Exclusions/Exceptions**: Patients not to be considered and removed from the denominator
- **Specification Guidance**: CMS measure guidance that assists with understanding and implementation of e-CQMs
- **UDS Reporting Considerations**: BPHC best practices and guidance to be applied to the specific measure

Sections A and B: Demographic Characteristics of Prenatal Care Patients

Report on all patients who are either provided direct prenatal care or referred for prenatal care.

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

Prenatal Care by Referral Only (check box)

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

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

Report the total number of patients who received or were referred for prenatal care services at *any time during the reporting period* by age group. Include all women receiving any prenatal care during the reporting year, including the delivery of her child, regardless of when that care was initiated. Include women who:

- Receive all their prenatal care from the health center,
- Were referred by the health center to another provider for all their prenatal care,
- Began prenatal care with another provider but transferred to the health center at some point during their prenatal care,
- Began prenatal care with the health center but were transferred to another provider at some point during their prenatal care,
- Were provided with all their prenatal care by a health center provider, but were delivered by another provider.
- Began or were referred for prenatal care during the previous reporting period and continued into this reporting period,
- Began or were referred for care and delivered during the reporting year, or
- Began or were referred for their care in this reporting period, but will not/did not deliver until the next year.

To determine the appropriate age group, use the woman's age on June 30 of the reporting period.

Note: as many as half of all prenatal care patients reported will usually have been reported in the prior year or will be reported in the next year.

Section B: Early Entry into Prenatal Care (Lines 7–9), No e-CQM

Measure Description

- Percentage of prenatal care patients who entered prenatal care during their first trimester.

  Note: The measure itself is not dependent on which category of performance measurement achievement a woman might fall into.

Calculate as follows:

Denominator (Universe) (Line 7 + Line 8 + Line 9, Columns A + B)

- Women seen for prenatal care during the year

Numerator (Line 7, Columns A + B)

- Women beginning prenatal care at the health center, or with a referral provider (Column A), or with another prenatal provider (Column B), during their first trimester

Exclusions/Exceptions

- Denominator
  - Not applicable
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report on Lines 7-9, all women who received prenatal care, either directly or through a referral, including but not limited to the delivery of a baby during the reporting period.
  - **First Trimester (Line 7):** Report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after their last menstrual period.
  - **Second Trimester (Line 8):** Report women who were prenatal patients during the reporting period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.
  - **Third Trimester (Line 9):** Report women who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after their last menstrual period. **Note that it is unusual for the number in Column B to be very large or larger than that in Column A because it would require women to have begun care and then transferred in a very short period of time.**

Note: The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received prenatal care from the health center during the calendar year and *is equal to the number reported on Line 6.*

- Criteria used to identify how prenatal women are reported:
  - Determine the trimester by the trimester

of pregnancy that the woman was in *when she began prenatal care* either at one of the health center's service delivery locations or with another provider, including a referral provider. For example:

- If the woman began prenatal care during the first trimester at the health center's service delivery location or from a provider she was referred to by the health center, she is reported on Line 7 in Column A.
- If she received prenatal care from another provider during the first trimester before coming to the health center's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with the health center.

° Report a woman who begins her prenatal care with the health center or is referred by the health center to another provider only once in Column A.

° Report a woman who begins her prenatal care on her own with another provider and then transfers to the health center only once in Column B - *and not* in Column A.

° Prenatal care is considered to have begun at the time the patient has her first visit with a physician or NP, PA, or CNM provider who initiates prenatal care with a complete prenatal exam. Consider this the first prenatal care visit for UDS purposes. (Most women will have one or more interactions with the health center prior to that for their pregnancy, including pregnancy and other lab tests, dispensing vitamins, and/or taking a health history. Do not count these interactions as the start of prenatal care.)

° In the event a woman is referred to another provider for care by a health center that does not have its own prenatal care program, count as the first visit the visit at which they receive a complete prenatal exam from the referral provider. Do not count when she first contacts the prenatal referral provider, when they do lab tests, or when she has psychosocial or nutritional assessments done if a prenatal exam was not conducted.

° Count a woman only once, regardless of the number of trimesters during which she receives care.

° In those rare instances where a woman receives prenatal care services for two separate pregnancies in the same calendar year, count her twice as a prenatal patient. For example, this can occur if a woman delivers in January and then becomes pregnant again in October.

Sections C through N: Other Quality of Care Measures

In these sections, report on the findings of your reviews of services provided to targeted populations.

- For Sections C through M, specifically assess the current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Do not include patients whose *only* visits were for dental, mental health, or something other than medical care in the universe for these measures.
- For Section N, assess current dental patients (i.e., patients who had a dental visit at least once during the reporting period). Do not include patients whose *only* visits were for medical, mental health, or something other than dental care in the universe for this measure.
- For these measures, base age on the patient's

age as of January 1st during the reporting year (or patient's age during the reporting year for the childhood immunization measure).

Note: In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2017 data.

Childhood Immunization Status (Line 10), CMS117v5

Measure Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenzae type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period

  Note: Include children born on or after January 1, 2015, and on or before December 31, 2015

Numerator (Column C)

- Children who have evidence showing they received recommended vaccines, had documented history of illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

Exclusions/Exceptions

- Denominator
  - Not applicable
- Numerator
  - Not applicable

Specification Guidance

- Include patients in the numerator in these situations:
  - MMR, hepatitis B, VZV and hepatitis A vaccines: evidence of receipt of the recommended vaccine; documented history of the illness; or, a seropositive test result for the antigen.
  - DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines: evidence of receipt of the recommended vaccine.
  - Include patients in the numerator for a particular antigen if they had an anaphylactic reaction to the vaccine.
  - DTaP vaccine: if they have encephalopathy.
  - IPV vaccine: if they have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin.
  - Influenza, MMR, or VZV vaccines: if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, have had an anaphylactic reaction to neomycin, have Immunodefiency, or have HIV.
  - Hepatitis B vaccine: if they have had an anaphylactic reaction to common baker's yeast.
- The measure allows a grace period by measuring compliance with these recommendations between birth and age two

UDS Reporting Considerations

- Include children seen during the year, regardless of their age at the time of the visit. For example, include patients who were seen for medical care during the year even if the visit was prior to them turning two during the measurement year.
- Include children in the universe if they came to the health center for well child[3] services or other medical services, including vaccinations or for treatment of an injury or illness.
- Include children in the universe for whom no vaccination information is available and/or who were first seen at a point when there was not enough time to fully immunize them prior to their second birthday.
- Do not include children here or anywhere on the UDS who only received a vaccination and never received other services.
- Include children who had a contraindication for a specific vaccine in the universe. Count them as being "compliant" for that specific vaccine, if the guidance (above) permits it, and then review for the administration of the rest of the vaccines.
- To count as meeting the measurement, a child must be documented as being compliant for each vaccine.
- Registries can be used to fill in any voids in the immunization record if the search is routinely done prior to or immediately after a visit. For example, you may use an immunization registry maintained by the state or other public entity that shows comparable information.
- Do not count as meeting the measurement standard charts that only state that the "patient is up-to-date" with all immunizations and that does not list the dates of all immunizations and the names of immunization agents.
- Do not count verbal assurance from a parent or other person that a vaccine has been given toward the measurement standard.
- Good faith efforts to get a child immunized that fail do not meet the measurement standard. Include the following:
    - Parental failure to bring in the patient,
    - Parents who refuse for personal or religious reasons, or
    - Parents who refuse because of beliefs about vaccines.

Cervical Cancer Screening (Line 11), **CMS124v5**

Measure Description

Percentage of women 23–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 23-64 who had cervical cytology performed every 3 years
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Women 23 through 64 years of age with a *medical* visit during the measurement period

  Note: Include women born on or after January 1, 1953, and on or before December 31, 1993

3 Health centers should add to their universe those patients whose only visits were well child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added as well.

Numerator (Column C)

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
    - Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test
    - Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test

Exclusions/Exceptions

- Denominator
    - Women who had a hysterectomy with no residual cervix
- Numerator
    - Not applicable

Specification Guidance

- To ensure the measure is only looking for a cervical cytology, test only after a woman turns 21 years of age. The youngest age in the initial population is 23

UDS Reporting Considerations

- Include documentation in the medical record of a test performed outside of the health center, which has the date the test was performed, who performed it, and the result of the finding or a copy of the lab test.
- Do not count as meeting the measurement standard charts that only provide a referral to a third-party but do not include a copy of the lab report or a report of some form from the clinician/clinic that provided the test.
- Do not count as meeting the measurement standard unsubstantiated statements from patients that cannot be backed up with third-party documentation.
- Do not count as compliant charts that note the refusal of the patient to have the test.
- If a system cannot determine exclusions, include them in the universe and later exclude and replace them from the sample, if identified.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Line 12), **CMS155v5**

Measure Description

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

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 3 through 17 years of age with at least one *medical* visit during the measurement period

  Note: Include children and adolescents who were born on or after January 1, 2000, and on or before December 31, 2013

Numerator (Column C)

- Children and adolescents who have had:
  - Their BMI percentile (not just BMI or height and weight) recorded during the measurement period ***and***
  - Counseling for nutrition during a visit that occurred during the measurement period ***and***
  - Counseling for physical activity during a visit that occurs during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients who have a diagnosis of pregnancy during the measurement period
- Numerator
  - Not applicable

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- Include medical visits performed by any medical provider. Note that this is different from the e-CQM which requires that the visit be performed by a primary care physician or an OB/Gyn. For example, include patients who had a medical visit with a nurse practitioner.
- The UDS numerator differs from the eCQM in that the eCQM requires the numerators to be reported separately, but for UDS purposes, the patients must have had all three numerator components completed in order to meet the measurement standard.
- Do not count as meeting the performance measure, charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), **CMS69v5**

Measure Description

Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous six months to that visit ***and*** when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of that visit

Note: Normal parameters: Age 18 years and older BMI greater than or equal to 18.5 and less than 25 kg/m^2

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age or older on the date of the visit with at least one *medical* visit during the measurement period

Note: Include patients who were born on or before December 31, 1998, ***and*** who were 18 years of age or older on the date of their last visit

Numerator (Column C)

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

      Note: Include in the numerator, patients with had their BMI documented **and** those with a follow-up plan if BMI is outside normal parameters.

Exclusions/Exceptions

- Denominator
    - Patients who are pregnant (18-64 only),
    - Patients receiving palliative care
    - Patients who refuse measurement of height and/or weight or refuse follow-up
    - Patients with a documented medical reason, including:
        - Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
            - Illness or physical disability
            - Mental illness, dementia, confusion
            - Nutritional deficiency, such as vitamin/mineral deficiency
        - Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Numerator
    - Not applicable

Specification Guidance

- Report this measure for all patients seen during the reporting period.
- An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate visits. Do not use self-reported values.
- BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center.
- If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.
- Document the follow-up plan based on the most recent documented BMI, outside of normal parameters.

UDS Reporting Considerations

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

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), **CMS138v5**

Measure Description

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

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients aged 18 years and older seen for at least two *medical* visits in the measurement year or at least one preventive *medical* visit during the measurement period

  Note: Include patients who were born on or before December 31, 1998

Numerator (Column C)

- Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period ***and***
- Who received tobacco cessation intervention if identified as a tobacco user

  Note: Include in the numerator, patients with a negative screening **and** those with a positive screening who had cessation intervention if a tobacco user.

Exclusions/Exceptions

- Denominator
  - Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
- Numerator
  - Not applicable

Clinical Guidance

- If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: counseling and/or pharmacotherapy.
- If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patient's not screened or when the patient is screened but does not provide a definitive answer.
- If the patient does not meet the screening component of the numerator but has an allowable medical exception, then remove the patient from the denominator.
- The medical reason exception only applies to the screening data element of the measure; once a patient has been screened; there are no allowable medical reason exceptions for not providing the intervention.
- If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.
- Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure.

UDS Reporting Considerations

- Include in the numerator records that demonstrate that the patient had been asked

about their use of any and all forms of tobacco within 24 months of the last visit

- Include patients who receive tobacco cessation intervention, including:
    - Received tobacco use cessation counseling services, ***or***
    - Received an order for (a prescription or a recommendation to purchase an over the counter [OTC] product) a tobacco use cessation medication, ***or***
    - Are on (using) a tobacco use cessation agent.

Use of Appropriate Medications for Asthma (Line 16), **CMS126v5**

Measure Description

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately ordered medication during the measurement period

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 5 through 64 years of age with persistent asthma with a *medical* visit during the measurement period

  Note: Include patients who were born on or after January 1, 1953, and on or before December 31, 2011

Numerator (Column C)

- Patients who were ordered at least one prescription for a preferred therapy during the measurement period

Exclusions/Exceptions

- Denominator
    - Patients with a diagnosis of emphysema, chronic obstructive pulmonary disease, obstructive chronic bronchitis, cystic fibrosis, or acute respiratory failure during or prior to the measurement period
- Numerator
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Do not include patients with mild or intermittent asthma in the universe
- Preferred therapy includes patients who:
    - Received a prescription for or were using an inhaled corticosteroid, ***or***
    - Received a prescription for or were using an acceptable pharmacological agent, specifically inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

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

Measure Description

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age and older with an active diagnosis of CAD on the date of the visit or diagnosed as having had a myocardial infarction (MI) or had cardiac surgery[4] in the past, with a *medical* visit during the measurement period and at least two medical visits ever

  Note: Include patients who were born on or before December 31, 1998

Numerator (Column C)

- Patients age 18 and older who received a prescription for or were provided or were taking lipid lowering medications during the measurement period

Exclusions/Exceptions

- Denominator:
  - Patients whose last low-density lipoprotein (LDL) lab test during the measurement year was less than 130 mg/dL
  - Patients with an allergy to, a history of adverse outcomes from, or intolerance to LDL lowering medications
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Include patients in the universe with no record of an LDL lab test; do not count toward the numerator
- Do not count for the measurement standard patients who received a form of treatment other than pharmacologic treatment. For example, patients involved in therapeutic lifestyle changes and/or control of non-lipid risk factors without concomitant pharmaceutical treatment do not met the measurement standard.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), **CMS164v5**

Measure Description

Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period *or* who had an *active* diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age and older with a *medical* visit during the measurement period who had an

4 A large number of surgical CPT codes relating to the performance of a CABG or PTCA are included in the specifications for cardiac surgery, however these may be difficult to find. Health centers should utilize HIT reporting capabilities to identify patients with a history of pertinent cardiac surgeries.

AMI, CABG, or PCI during the 12 months prior to the measurement year or who had an *active* diagnosis of IVD during the measurement year

Note: Include patients who were born on or before December 31, 1998

Numerator (Column C)

- Patients who had an active medication (use) of aspirin or another antiplatelet during the measurement period

Exclusions/Exceptions

- Denominator
    - Patients who had documentation of use of anticoagulant medications at some point in time during the measurement period
- Numerator
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug.

Colorectal Cancer Screening (Line 19), CMS130v5

Measure Description

Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 50 through 75 years of age with a *medical* visit during the measurement period

Note: Include patients born on or after January 1, 1942, and on or before December 31, 1966

Numerator (Column C)

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any *one* of the following criteria:
    - Fecal occult blood test (FOBT), including fecal immunochemical test (FIT), during the measurement period
    - Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
    - Colonoscopy during the measurement period or the nine years prior to the measurement period

Exclusions/Exceptions

- Denominator
    - Patients with a diagnosis of colorectal cancer or a past history of total colectomy
- Numerator
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the

immunochemical-based fecal occult blood test (iFOBT - commonly known as a FIT test).

- If tests were performed elsewhere; confirmation of this is required by having documented in the chart either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.
- FOBTs, including the fecal immunochemical test (FIT), can be used to document meeting the measurement standard. This test, if performed, is required each measurement year. For example, a patient who had an FOBT in November 2016 would still need one in 2017.
- Collect stool specimens for FOBT, including FIT, as recommended by the manufacturer.
- FOBT, including FIT, test kits can be mailed to patients during the year, but receipt, processing, and documentation of the test sample is required.

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

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis.[5]

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year and who had at least one *medical* visit during the measurement period or prior year

Note: Include patients who were diagnosed with HIV for the first time ever[6] by the health center between October 1, 2016, and September 30, 2017,[7] ***and*** had at least one medical visit during 2017 or 2016.

Numerator (Column C)

- Newly diagnosed HIV patients that received treatment within 90 days of diagnosis. Include patients who:
  - Were newly diagnosed by your health center providers, ***and***
  - Had a medical visit with your health center provider who initiates treatment for HIV, ***or***
  - Had a visit with a referral resource who initiates treatment for HIV.

Exclusions/Exceptions

- Denominator
  - Not applicable
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- *Treatment must be initiated* within 90 days of the HIV diagnosis, not just a referral made, education provided or retest at a referral site.
- Include patients in the numerator only if the patient received treatment for HIV care within 90 days of the diagnosis. If the treatment is by referral to another clinician/organization (such

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

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

7 Because the measure gives up to 90 days to complete the follow-up, you look back 90 days to find the entire universe of patients who should have had a follow-up during the measurement year.

as a Ryan White provider), the medical treatment at the referral source must begin and the referral loop must be closed during the 90-day period. Closing the referral loop means the referring provider received documented confirmation that the visit was complete from the provider whom the patient was referred to.

- Identification of patients for this measure crosses years and may include prior year patients.
- Reactive initial HIV tests and patients who self-identify as being HIV positive without documentation must be followed by a supplemental test to confirm diagnosis.
- Do not include patients who:
    - Were diagnosed elsewhere and can provide documentation of the positive test result;
    - Were diagnosed elsewhere, referred to you for treatment, and can provide documentation of the positive test result;
    - Had a positive reactive initial screening test but not a positive supplemental test;
    - Were positive on an initial screening test provided by you but were then sent to another provider for definitive testing and treatment.

Note: There are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. Either modify your HIT/EHR to record this information or keep track of the patients who are identified in a separate system.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), **CMS2v6**

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age appropriate standardized depression screening tool ***and*** if positive, a follow-up plan is documented on the date of the positive screen.

Calculated as follows:

Universe (Denominator) (Columns A and B)

- Patients aged 12 years and older with at least one *medical* visit during the measurement period

  Note: Include patients who were born on or before December 31, 2004

Numerator (Column C)

- Patients who:
    - Were screened for depression on the date of the visit using an age-appropriate standardized tool ***and***,
    - If screened positive for depression, a follow-up plan is documented on the date of the positive screen

      Note: Include in the numerator, patients with a negative screening **and** those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

- Denominator
    - Patients with an active diagnosis for

depression or a diagnosis of bipolar disorder

- Patients:
  - Who refuse to participate
  - Who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status
  - Whose functional capacity or motivation to improve may impact the accuracy of results

- Numerator
  - Not applicable

Specification Guidance

- The depression screening must be reviewed and addressed in the office of the provider on the date of the visit; they must occur on the same date.
- Standardized depression screening tools are normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record
- Examples of depression screening tools include, but are not limited to:
  - Adolescent Screening Tools (12-17 years)
    - Patient Health Questionnaire for Adolescents (PHQ-A)
    - Beck Depression Inventory-Primary Care Version (BDI-PC)
    - Mood Feeling Questionnaire (MFQ)
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - Patient Health Questionnaire (PHQ-9)
    - Pediatric Symptom Checklist (PSC-17)
    - PRIME MD-PHQ-2
  - Adult Screening Tools (18 years and older)
    - Patient Health Questionnaire (PHQ-9)
    - Beck Depression Inventory (BDI or BDI-II)
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - Depression Scale (DEPS)
    - Duke Anxiety-Depression Scale (DADS)
    - Geriatric Depression Scale (SDS)
    - Cornell Scale Screening
    - PRIME MD-PHQ-2
- The follow-up plan must be related to a positive depression screening.

UDS Reporting Considerations

- Not applicable

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

Measure Description

Percentage of children, age 6-9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation *dental* visit and are at moderate to high risk for caries in the measurement period

  Note: Include children who were born on or after January 1, 2008, and on or before December 31, 2010

Numerator (Column C)

- Children who received a sealant on a permanent first molar tooth during the measurement period

Exclusions/Exceptions

- Denominator
  - Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)
- Numerator
  - Not applicable

Specification Guidance

- The intent is to measure whether a child received a sealant on at least one of the four permanent first molars.
- "Elevated risk" is a finding at the patient- level, not a population-based factor such as low socio-economic status.
- Look for tooth level data for sealant placement.

Capture sealant application within buccal pits on a first permanent molar in the numerator.

UDS Reporting Considerations

- Include dental visits with the health center or with another dental provider who saw patients through a paid referral.

  Note: Although draft e-CQM reflects age 5 through 9 years of age, use age 6 through 9 as measure steward intended.

Additional information is available to clarify reporting. View **FAQs for Table 6B**.

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2017, through December 31, 2017

0	**Prenatal Care Provided by Referral Only (Check if Yes)**	

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

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	
5	Ages 45 and over	
6	Total Patients (Sum lines 1-5)	

Section B - Early Entry into Prenatal Care

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

Section C - Childhood Immunization Status

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

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age, who were screened for cervical cancer			

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

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

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

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

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

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

Section H – Use of Appropriate Medications for Asthma

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

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

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

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

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

Section K - Colorectal Cancer Screening

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

Section L - HIV Linkage to Care

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

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

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

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

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

Instructions for Table 7: Health Outcomes and Disparities

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

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

- **Low Birth Weight**: There will be fewer children who suffer the multiple negative sequelae of low birth weight, such as delayed or diminished intellectual and/or physical development, *if* fewer babies have low birth weight.
- **Controlling High Blood Pressure**: There will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life, *if* there is less uncontrolled hypertension.
- **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**: There will be fewer long-term complications such as amputations, blindness, and end-organ damage, *if* there is less poorly controlled diabetes.

The clinical health outcome and disparity measures described in this manual must be reported by all health centers using specifications detailed in the measure definitions below. Many of the UDS health outcome and disparity measures are now aligned with CMS e-CQMs for Eligible Professionals. The January 2017 Addendum eReporting update is used for the 2017 reporting period. (Although there are other updates available from CMS, *they are not to be used* for the 2017 reporting.) The eReporting specifications can be found at the CMS' eCQI Resource Center at https://ecqi.healthit.gov/ep. E-CQM measure numbers and links are provided to assist you, where applicable. For clarification or interpretation of aligned CMS e-CQMs, please contact the measure steward. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/ is encouraged for health centers capable of appropriately using this resource as defined below to support the data reporting of these health outcomes and disparity measures.

Column Logic Instructions

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

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

Report the total number of patients who fit the detailed criteria described for the specified measure. *Consider patients meeting the criteria in the health center's total patient population, including all sites, all programs, and by all providers.*

Because the initial patient population for two measures is defined in whole or in part in terms of age, comparisons to the numbers on Table 3A and Table 7 will be made when evaluating your submission. The numbers in column A of Table 7 will not be equal to those that might be calculated on Table 3A for the following reasons:

(1) All patients seen for all reportable services are counted on Table 3A, but the clinical measures reported on Table 7 relate only to medical patients with specific conditions; and

(2) Table 3A measures age as of June 30 of the calendar year, but Table 7 defines specific time periods (e.g., as of January 1) to measure age.

Pregnancy outcomes are compared to prenatal care patients on Table 6B.

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

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

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

* ***Note:*** To streamline the process for reporting on the clinical quality measures and encourage the use of HIT to report on the full universe of patients, health centers must use *all* of the records available in the HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient records are included in the HIT/EHR for any given measure and patients missing from the HIT/EHR are not related to any variable involved with any given measure. For example, if patients from a chronic care site are missing in the HIT/EHR, it cannot be used for the hypertension or diabetes measures.

If a sample is to be used it *must* be a random sample of 70 patient charts and *must* be drawn from the entire patient population identified as the universe. Larger samples will not be accepted. Health centers *may not* choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms because this will result in over-sampling some groups of patients.

Use a review of a sample of charts in lieu of full universe reporting from an HIT/EHR if:

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

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

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

Report the total number of records that meet the measurement standard as discussed for the specified measure. The number in Column 2C

(patients meeting the measurement standard) may never exceed the number in Column 2B (patient records reviewed).

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

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

Report the total number of records that do not meet the measurement standard as discussed for the specified measure. The number in Column 3F (patients not meeting the measurement standard) may never exceed the number in Column 3B (patient records reviewed).

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

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

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

In the information that follows, the "conditions" or "criteria" are at times interchanged with "exclusions." This is partly because of the differing language and procedures in an HIT/EHR (or practice management system [PMS]) based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be able to be found in the HIT/EHR and must be in the HIT/EHR for each patient at the health center. To the extent that they cannot be found, they will distort the findings, and mean that the HIT/EHR must not be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the diabetes measure because you cannot limit the universe to medical patients.

In a sample chart review process, items listed as "criteria" may be used as "exclusions." For example, if you are unable to use HIT/EHR, you are to randomly select 70 patient charts of all patients with diabetes listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. (In a computer search, you would include as criterion that they must be medical patients for the diabetes measure.)

And vs. Or

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

Race and Ethnicity Reporting

Table 7 reports health outcome data by race and Hispanic or Latino ethnicity to provide information on health centers' efforts to help to reduce health disparities. Race and Hispanic or Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. *Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to ensure race and ethnicity data across the systems are aligned.* **Do not report more Hispanic or Latino**

patients with hypertension or more patients with hypertension of any given race on Table 7 than are reported for that race or for the Hispanic or Latino ethnicity on Table 3B.

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

Health centers that report on a sample of patients – and even those who report on their entire universe of patients – are cautioned against using their data to evaluate disparities in their own systems given small sample sizes. On a national level, however, reported data permits HRSA to evaluate the impact of health center services on disparate outcomes for target populations.

Detailed Instructions for Clinical Measures

The clinical measures reported in the UDS relate only to medical patients (or dental patients in the case of one measure only). Health centers are to report each measure using the criteria outlined below. Each measure has been organized in the same way to assist you with data collection and reporting.

- **Measure Description**: Describes the quantifiable indicator to be evaluated
- **Denominator (Universe)**: Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated
- **Numerator**: Records (from the denominator) that meet the measurement standard for the specified measure
- **Exclusions/Exceptions**: Patients not to be considered and removed from the denominator
- **Specification Guidance**: CMS measure guidance that assists with understanding and implementation of e-CQMs
- **UDS Reporting Considerations**: BPHC best practices and guidance to be applied to the specific measure

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

Report the total number of HIV-positive pregnant women served by the health center on Line "0" *regardless of whether or not the health center provides prenatal care or HIV treatment for these women*.

Deliveries Performed by Health Center Provider (Line 2)

Report the total number of deliveries *performed by health center clinicians* during the reporting period on Line 2.

- On this line ONLY, include deliveries, regardless of outcome, of women who were either part of or not part of the health center's prenatal care program during the calendar year. Include such circumstances as:
    - the delivery of another doctor's patients when the health center provider participates in a call group and is on-call at the time of delivery;
    - emergency deliveries when the health center provider is on-call for the emergency room; and
- Deliveries of "undoctored" patients who are

assigned to the provider as a requirement for privileging at a hospital. Include as "health center providers" any clinician who is paid by the health center while doing the delivery, regardless of the method of compensation.

- Do not include deliveries where a clinic provider bills separately, receives, and retains payment for the delivery.

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

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

Report women (Column 1a) and babies (Columns 1b, 1c and 1d) separately by their race and ethnicity. Obtain race and ethnicity of mothers from the information on their patient registration forms. Obtain race and ethnicity of children from their registration forms, their birth certificates, or from their parent.

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

Report all health center prenatal care patients who delivered during the reporting period including those who health center staff cared for and delivered and those who had some or all care provided by a referral provider.

- Include all women who had deliveries, regardless of the outcome.
- Do not include deliveries where you have no documentation that the delivery occurred. For example, for women who may have moved out of the area and/or who were otherwise lost to follow-up.
- Do not include deliveries of women who had a miscarriage.
- This column collects data on "patients who delivered." Even if the delivery is of twins or triplets, or is a stillbirth, report only one woman as having delivered.

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

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

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

Measure Description

Percentage of babies of health center prenatal care patients born whose birth weight was *below* normal (less than 2,500 grams).

Note: The reporting of this measure captures all categories of performance, not only those that meet the performance measurement.

Calculate as follows:

Denominator (Universe) (Columns 1b + 1c + 1d)

- Babies born during the measurement period to prenatal care patients

Numerator (Columns 1b + 1c)

- Babies born with a birth weight below normal (under 2,500 grams)

Exclusions/Exceptions

- Denominator
  - Stillbirths or miscarriages
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period, according to the appropriate birth weight group (in grams):
  - **Very Low Birth Weight (Column 1b):** Weight at birth was less than 1,500 grams.
  - **Low Birth Weight (Column 1c):** Weight at birth was 1,500 grams through 2,499 grams.
  - **Normal Birth Weight (Column 1d):** Weight at birth was equal to or greater than 2,500 grams.

  Note: Be careful not to confuse pounds and ounces for grams when reporting these numbers.
- If the delivery is of multiple babies (i.e., twins or triplets), report the birth weight of each child separately.
- ***Note:*** *Report data regardless of whether the health center did the delivery, referred the delivery to another provider, or the woman transferred to another provider on her own. Follow-up on all patients is required.*
- In rare instances there may be no birth outcomes recorded although there may be evidence (i.e. records indicate delivery occurred) that the mother had delivered. Count the mother as having delivered with no birth outcomes.
- The number of deliveries reported in Column 1a will normally be different than the total number of infants reported in Columns 1b–1d because of multiple births and still births.

Note that this is a "negative" measure. For this measure, the higher the number of infants born below normal birth weight, the worse the performance on the measure.

Although data are provided for each racial and ethnicity category, the performance measure looks only at the totals.[8]

Sections B and C: Other Health Outcome and Disparity Measures

In these sections, report the findings of reviews of services provided to targeted populations. Sections B and C specifically assess the health centers current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Do not include patients whose *only* visits were for dental, mental health, or something other than medical care

Note: In this section, the term "measurement period" is the same as the term "reporting period," and is intended to capture calendar year 2017 data.

8 However, during the review of the UDS report, reviewers will question unusually high or low proportion of low birth weight babies for individual race or ethnicity categories.

Controlling High Blood Pressure (Columns 2a-2c), **CMS165v5**

Measure Description

Percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns 2a and 2b)

- Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period with a *medical* visit during the measurement period

  Note: Include patients who were born on or after January 1, 1932, and on or before December 31, 1998

Numerator (Column 2c)

- Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period
  - Patients with a diagnosis of pregnancy during the measurement period

  Numerator
  - Not Applicable

Specification Guidance

- Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." Count them in Columns 2a and 2b, but not in Column 2c.
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

UDS Reporting Considerations

- Do not include patients in the denominator with initial diagnosis of hypertension after June 30th of the measurement period.
- ***Note:*** Health centers that have I2I-Track, PCDEMS, PECS, or other supporting systems may use them to report the universe only if it can be limited to a the measurement period and only if it includes all required data elements (i.e., it includes data for the required time frame for all patients with hypertension from all service sites).

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (Columns 3a-3f), **CMS122v5**

Measure Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns 3a and 3b)

- Patients 18 through 75 years of age with diabetes with a *medical* visit during the measurement period

  Note: Include patients who were born on or after January 1, 1942, and on or before December 31,1998

Numerator (Column 3f)

- Patients whose most recent HbA1c level performed during the measurement year is greater than 9.0 percent *or* who had no test conducted during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients with a diagnosis of secondary diabetes due to another condition
- Numerator
  - Not applicable

Specification Guidance

- Include patients in the numerator whose most recent HbA1c level is greater 9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed or documented during the measurement period.
- Only include patients with an active diagnosis of Type 1 or Type 2 diabetes in the denominator of this measure.

UDS Reporting Considerations

- Report most recent HbA1c levels of patients, as follows:
  - **HbA1c <8% (Column 3d1):** HbA1c level was less than 8 percent
  - **HbA1c >9% or No Test During the Year (Column 3f):** HbA1c level was greater than 9 percent or who did not receive an HbA1c test during the reporting year or whose test result is missing
- Include patients with a diabetes diagnosis made anytime during the year. Do not limit diagnosis to those made through June 30th as is done to identify patients with hypertension.
- Even if the treatment of the patient's diabetes has been referred to a non-health center provider, the health center is expected to have the current lab test results in its records.
- Patients with diabetes may also be identified from pharmacy data (those dispensed insulin or oral hypoglycemic/antihyperglycemic).

Note that this is a "negative" measure. For this measure, the lower the number of adult patients with diabetes with poor diabetes control, the better the performance on the measure.

Although data are provided for each race and ethnicity category, the performance measure looks only at the totals.

Additional information is available to clarify reporting. View **FAQs for Table 7**.

Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2017, through December 31, 2017

Section A: Deliveries and Birth Weight

Line	Description	Patients
0	HIV Positive Pregnant Women	
2	Deliveries Performed by Health Center's Providers	

Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic/Latino				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	Total				

Section B: Controlling High Blood Pressure

Line #	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
	Hispanic/Latino			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic/Latino			
	Non-Hispanic/Latino			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic/Latino			
	Unreported/Refused to Report Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	*Total*			

Section C: Diabetes: Hemoglobin A1c Poor Control

Line #	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c <8% (3d1)	Patients with HbA1c >9% Or No Test During Year (3f)
	Hispanic/Latino				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	*Total*				

Instructions for Table 8A: Financial Costs

Table 8A reports the total cost of all activities that are within the scope of the project and covered by the program budget supported, in whole or in part, by (1) the Health Center Program grant covered by the UDS, ***or*** (2) the look-alike designation, ***or*** (3) the scope of the BHW primary care clinics. The same costs may be included in both a BHW clinic *and* a BPHC grantee or look-alike if they are included in the scope of both grants. The same costs cannot be reported under both a BPHC grant-and a look-alike designation.

Report all costs on Table 8A on an *accrual* basis. These are the costs attributable to the reporting period, including depreciation; regardless of when or if actual cash payments were made. (***Note:*** Only report depreciation for capital expenditures, including BPHC capital grants.) Do not report bad debts or the repayment of the principal of a loan, but do show interest on any such loans as an expense.

Direct Costs, Allocated Costs, and Costs After Allocation (Column Definitions)

Column A - Accrued Costs

In this column, report the accrued *direct costs* associated with each of the cost centers/services listed. See **Line Definitions** for costs to include in each category. In addition, report the total facility cost and the total cost of non-clinical support services (also referred to as administrative costs) separately on Lines 14 and 15.

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

In this column, report the allocation of facility and non-clinical support services costs (from Lines 14 and 15, Column A) to each of the direct cost centers. Use the following guidance to distribute these costs:

- Distribute the total of facility and non-clinical support services costs (reported in Column A, Lines 14 and 15) in Column B. The total for Column B will equal the amount reported on Line 16, Column A.
- Lines 1 and 3 both refer to aspects of the medical practice. It is acceptable to report the allocation of all medical facility and non-clinical support services on Line 1 if a more appropriate allocation between Lines 1 and 3 is not available.
- Allocate facility and non-clinical support services attributable to pharmacy to the non-supply line (Line 8a). Allocation for pharmaceutical supplies (Line 8b) is greyed out in the EHB. Any allocation of overhead that you choose to make for pharmaceuticals must be reported on Line 8a. This is true even if you did not report any direct pharmacy costs on Line 8a, Column A.

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

1. Allocate **Facility Costs** based on the amount of usable square footage utilized for each of the cost centers, including Medical, Medical Lab and X-ray, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, Vision, Enabling, Other Program Related Services, Quality Improvement, and Non-Clinical Support Services.

Square footage refers to the portion of the health center's facility space used in the operation of the organization, not including common spaces such as hallways, restrooms, and utility closets.

- Assign hallways and similar shared space *within a dedicated* area to that area. For example, the hallways inside the medical suite that connects the exam rooms and the doctor's offices and the medical supply closets are considered medical space, not "common space."
- Do not report the cost of the square footage associated with space owned by the health center and leased or rented to other parties on Line 14, or anywhere, if it is considered to be outside the scope of the project.
- Allocate leased or rented space to Other Program Related Services (Line 12) if it has been included inside the scope of project and include the rent received on Table 9E under Other Revenue (Line 10).
- An alternative allocation method that effectively distributes facility costs approved or used by your auditors may be used, but save back-up paperwork for review and explain the methods in the table note. Alternative methods often include the allocation of the cost of each building separately—especially when the square foot costs of multiple buildings vary dramatically—or recognizes substantial remodeling or renovation costs that affect only a portion of the program. For example, attribute the depreciation of a major remodeling of the medical exam rooms to medical costs only, rather than allocating them to all cost centers.
- Allocate a share of facility costs to non-clinical support services.

2. Allocate the **Non-Clinical Support Services Costs** to all other cost centers based on a straight-line allocation method.

    - Allocate non-clinical support services costs *after* its share of facility costs have been allocated to this cost center.
    - Allocate non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category. For example, if medical staff account for 50 percent of net cost (excluding facility and non-clinical support services costs) then allocate 50 percent of the non-clinical support services cost to medical staff on Line 1.
    - An alternative method that provides more accurate allocations may be used, but save back-up paperwork for review and explain the methods used in the table note. For example, it would be appropriate to allocate the cost of billing and collection activities exclusively to those cost centers that actually generate bills.
    - Reduce or eliminate the share of non-clinical support services allocated to pharmaceuticals where a very substantial cost is for pharmacy supplies, which requires only minimal administrative costs.

Column C – Total Cost After Allocation of Facility and Non-Clinical Support Services

This column shows the cost of each of the cost centers listed on Lines 1–13 after the allocation of facility and non-clinical support services. This cost is the sum of the direct cost, reported in Column A, plus the allocation of facility and non-clinical support services, reported in Column B. This calculation is done automatically in the EHB.

In addition, report in Column C, the value of any donated facilities, services, and supplies on Line 18. Report these *non-cash* donations as a positive number and do not include them in any of the lines above.

Note that this is the only place that the value of non-cash donations to the health center is shown. Do not report non-cash donations on Table 9E.

Line 19, Column C is the total cost including the value of donations.

Note: All UDS calculations that are based on "total cost" are calculated based on the costs shown on Line 17 and exclude the value of donated services, supplies, or facilities.

BPHC Major Service Categories (Line Definitions)

Medical Care Services (Lines 1-4)

Include in this category costs for medical care personnel, services provided under agreement, laboratory and x-ray, and other direct costs wholly attributable to medical care (e.g., staff recruitment, equipment depreciation, medical supplies, professional dues and subscriptions, continuing medical education [CME] and travel associated with CME).

Do not include costs associated with pharmacy including the in-clinic use of stock pharmaceuticals, dedicated quality improvement staff, or other non-medical service categories.

Do not count psychiatry and ophthalmology costs in the medical cost center. Report them on mental health (Line 6) and vision (Line 9a), respectively.

Show non-clinical support services and facility costs associated with the medical practice first on Lines 14 and 15, Column A, and then allocate them to medical in Column B, Lines 1-3.

Medical Staff Costs (Line 1)

Report all medical staff costs.

- Include salaries and fringe benefits for medical care personnel supported directly or under contract, including nurses, medical assistants, etc., *but specifically exclude* lab and x-ray staff.
- Dedicated QI, including HIT/EHR informatics staff costs, are excluded from medical and reported on Line 12a.
- Include the accrued cost (if any) of medical interns and residents who were paid or paid for, either directly or through a contract with their teaching institution.
- Include the cost for vouchered or contracted medical services here.
- In addition, include the cost of any medical visit paid for directly by the center, such as at-risk specialty care from a health maintenance organization (HMO) contract or other specialty care.
- The costs of intake, medical records, and billing and collections are considered non-clinical support costs. Report on Line 15, not here. Show amounts on this line if the health center opts to permit one or more providers to retain Meaningful Use EHR incentive payments, or transfers some or all of these payments to providers. Report the Meaningful Use EHR incentive payments received from Medicare or Medicaid on Table 9E on Line 3a.

Medical Lab and X-Ray Costs (Line 2)

Report all costs for medical lab and x-ray (including sonography, mammography, and any advanced forms of tomography).

- Include salaries and fringe benefits for lab and x-ray personnel supported directly or under contract, and all other direct costs, including but not limited to supplies, equipment depreciation, related travel, contracted or vouchered lab, and x-ray services.

Note: Report dental lab and x-ray costs as Dental, Line 5. If there are costs for retinography (most commonly for diabetic patients), report them in Vision Services, Line 9a.

Other Direct Medical Costs (Line 3)

Report all other direct costs for medical care, including but not limited to supplies, equipment depreciation, related travel, CME registration and travel, laundering of uniforms, recruitment, membership in professional societies, books, and journal subscriptions.

The cost of a medical HIT/EHR system is reported on Line 3, including but not limited to the depreciation on the software and hardware, training costs, and licensing fees. Allocate costs if the system covers over service categories (e.g., mental health, dental)

Total Medical (Line 4)

The sum of Lines 1 + 2 + 3.

Other Clinical Services (Lines 5-10)

This category includes staff and related costs for dental, mental health, substance abuse, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, podiatrists). Unlike medical, all costs are included on a single line.

Dental (Line 5)

Report all costs for the provision of dental services, including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, dental HIT/EHR, dental lab services, and dental x-ray.

Show non-clinical support services and facility costs associated with the dental practice first on Lines 14 and 15, Column A, and then allocate to dental in Column B.

Mental Health (Line 6)

Report all direct costs for the provision of mental health services, *other than substance abuse services,* including but not limited to staff, fringe benefits, supplies, equipment depreciation, mental health HIT/EHR, and related travel.

If a behavioral health program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology, but they must be consistent with Table 5 time allocations.

Show non-clinical support services and facility costs associated with the mental health practice first on Lines 14 and 15, Column A, and then allocate to mental health in Column B. (See also FAQs for Table 5.)

Substance Abuse (Line 7)

Report all direct costs for the provision of substance abuse services, including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel.

If a behavioral health program provides both mental health and substance abuse services, the cost should be allocated between the two programs, as should associated staff on Table 5. Allocations may be based on staffing or visits (from Table 5) or any other appropriate

methodology, but they must be consistent with the reporting on Table 5.

Show non-clinical support services and facility costs associated with the substance abuse program first on Lines 14 and 15, Column A, and then allocate to substance abuse in Column B. (In addition, see FAQ discussion for Table 5.)

Pharmacy (Not Including Pharmaceuticals) (Line 8a)

Report all direct costs for the provision of pharmacy services, including but not limited to staff, fringe benefits, non-pharmaceutical supplies, equipment depreciation, related travel, contracted purchasing services, *but excluding the cost of pharmaceuticals*. The cost of all pharmacists is reported on this line, including clinical pharmacists.

Show all non-clinical support services and facility costs for both Lines 8a and 8b first on Lines 14 and 15, Column A, and then allocate to pharmacy *on Line 8a*, Column B.

Note: Report the cost of personnel engaged in assisting patients to become eligible for and/or receive free pharmaceuticals from manufacturers (often called Pharmacy Assistance Programs) on Line 11e – Eligibility Assistance, not here.

If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, show the *full* dispensing fee and any other service fees (such as share of profit, pharmacy benefit manager costs, inventory fees, ordering fees, or a charge of pharmacy computer services) on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

Pharmaceuticals (Line 8b)

Report all costs for the purchase of pharmaceuticals, including the cost of vaccines and other stock drugs that may be used (or directly dispensed) in the health center.

- Include all pharmaceuticals, such as Depo-Provera and buprenorphine.
- Do not include other supplies here – report on Line 8a, Pharmacy.
- Do not include the value of donated pharmaceutical supplies. (Report these on Line 18, Column C.)
- The cell for the allocation of facility and non-clinical support services costs associated with the purchase of pharmaceuticals is greyed out. To the extent that there are such costs (they would generally be limited to costs for purchasing and paying for the drugs), combine them with the allocation for pharmacy costs and report them on Line 8a, Column B.
- If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, show the full cost of these drugs on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

Other Professional (Line 9)

Report all direct costs for the provision of other professional and ancillary health care services, including but not limited to podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy. (A more complete list appears at Appendix A.) Include provider and support staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services in direct costs.

Show non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to "Other Professional" in Column B.

Note that there is a cell to "specify" the other professional costs reported on this line.

Vision (Line 9a)

Report all direct costs for the provision of vision services including optometry, ophthalmology, and vision support staff. Include staff, fringe benefits, supplies (including frames and lenses), equipment depreciation, related travel, and contracted services in direct costs.

Include costs for retinography (for example, for diabetic patients) here and any contract reading costs.

Show non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to vision in Column B.

Total Other Clinical (Line 10)

The sum of Lines 5 + 6 + 7 + 8a + 8b + 9a

Enabling, Other Program-Related Services, and Quality Improvement (Lines 11-13)

Report enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, community health workers, eligibility assistance—including pharmacy assistance program eligibility, environmental risk reduction, and other services that support and assist in the delivery of primary care and facilitate patient access to care. In addition, include the cost of staff and related costs for other program related services such as WIC, day care, adult day health care, job training, delinquency prevention, and other activities not included in other BPHC categories. Finally, include costs associated with HIT/EHR informatics and quality improvement.

Enabling (Line 11)

Enabling services include a wide range of services that support and assist primary care and facilitate patient access to care. Line 11 is calculated automatically as the total of the detail lines. Report all direct costs for the provision of enabling services, including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

Show non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to enabling in Column B, Line 11.

Use Lines 11a–11h to detail the cost of seven specific types of enabling services, and an "other" category for all other forms of enabling services. ***Note:*** Descriptions of the services and staff that belong in each of these categories is included in the Table 5 instructions.

- Case management (11a)
- Transportation (11b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (including pharmacy program eligibility and health insurance coverage options) (11e)

- Translation/Interpretation services (11f)
- Other (11g) - Specify the other forms of enabling services included on this line if used.
- Community health workers (11h)

Be consistent in the allocated costs detailed on each of these enabling categories with the staff and visits reported on Table 5. If they are not, (perhaps because of donated services, staff, or supplies) provide an explanation.

Other Program Related (Line 12)

Report all direct costs for the provision of services not included in any other category here. These are most frequently other programs that support the health of the center's patients and mission but are not traditionally considered health care programs. This includes services such as WIC, childcare centers, adult day health care centers, fitness centers, Head Start and Early Head Start, and employment training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. (Report staffs for these programs on Line 29a of Table 5.)

Show non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocated in Column B to other program related costs.

Include the estimated cost of something where part is program-related and part is not. Examples might include renting out space in the health center or providing retail pharmacy services to non-patient members of the community. Describe the program costs in the "specify" field provided.

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

Quality Improvement (Line 12a)

Report all direct costs for the quality improvement program, including all personnel who are dedicated in whole or in part to quality improvement (QI). Although most of these staff tend to work in service delivery (e.g., medical, dental, mental health) areas, they are accounted for separately here. QI is part of every aspect of the health center. No attempt should be made to carve out portions of the time of clinical or non-clinical support staff who attend meetings, participate in peer review, etc. Include in the direct costs staff dedicated to the QI program and/or HIT/EHR system development and analysis, their fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

Show non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to QI in Column B.

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

The sum of Lines 11 + 12 +12a

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

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

Facility Costs (Line 14)

Report facility costs, including all staff dedicated to facility services, their salaries, fringe benefits, and related travel, as well as rent and/or depreciation, facility mortgage interest payments, utilities, security, grounds keeping, facility

maintenance and repairs, janitorial services, and all other related costs.

Do not report space leased to others on this line. Instead, report it as Other Program Related costs on Line 12.

Report the depreciation of major renovations or capital equipment (e.g., building air conditioners), not the gross cost.

Non-Clinical Support Services Costs (Line 15)

Report non-clinical support services costs (sometimes referred to as administrative costs), including the cost of all non-clinical support services staff; billing and collections staff; medical records and intake staff; and the costs associated with them, including but not limited to salaries, fringe benefits, supplies, equipment depreciation, and travel.

Include senior administrative staff (CEO, CFO, COO, HR director, etc.) and their staff and supportive services in this category.

In addition, include other *corporate* costs (e.g., purchase of facility and liability insurance not including malpractice insurance, audits, legal fees, interest payments on non-facility loans, communication costs including phone and internet, Board of Directors' costs).

Include the cost of all patient support services (e.g., medical records and intake) - do not report as medical.

Note: Do not include the "cost" of bad debts here or show them on this table in any way. (Report bad debt as one of a number of adjustments to patient self-pay charges on Table 9D.)

Note: Some grant programs have limitations on the proportion of *grant funds* that may be used for non-clinical support services. **Do not consider limits on "administrative" costs for those programs when completing Lines 14 and 15.** The "non-clinical support services" and facility categories for this report include *all* such personnel working at the health center, whether or not that cost was identified as "administrative" in any other grant application.

Total Facility and Non-Clinical Support Services (Line 16)

The sum of lines 14 + 15

Total Accrued Cost (Line 17)[9]

The sum of Lines 4 + 10 + 13 + 16

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

Include the total imputed value of all in-kind and donated services, facilities, and supplies (including donated pharmaceuticals) applicable to the reporting period that are within your scope of project, using the methodology discussed below. In-kind services and donations include all services (generally volunteers, but sometimes paid staff donated to the health center by another organization), supplies, equipment, space, etc., that are necessary and prudent to the operation of your program that you do not pay for directly. Report on

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

Line 18 the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment.

Do not include the value of these services in Column A on the lines above.

Calculate the estimated reasonable acquisition cost according to the cost that would be required to obtain similar services, supplies, equipment, or facilities within the immediate area at the time of the donation. For example, show donated pharmaceuticals (including vaccines) at the price that would be paid under the Federal Section 340(b) drug pricing program, not the manufacturer's suggested retail price. Evaluate donated clinical staff at the cost of hiring comparable staff, net fringe benefits. *Do not* use the usual and customary charge for the services they provide.

Only recognize donated value when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the health center's operation.

If the health center is not paying NHSC for assignees, include the full market value of "HSC Federal assignee(s), including ready responders." Capitalize NHSC-furnished equipment, including a dental operatory, at the amount shown on the NHSC Equipment Inventory Document, and show the appropriate depreciation expense for the reporting period.

Describe the donated items in detail using the "specify" field provided.

Total with Donations (Line 19)

The sum of Lines 17 and 18, Column C

Relationship between Table 5 and Table 8A

The staffing on Table 5 is routinely compared to the costs on Table 8A since staff makes up 70 percent plus of the cost of most health centers. See the crosswalk of comparable fields on in Appendix B.

Additional information is available to clarify reporting. View **FAQs for Table 8A**.

Table 8A: Financial Costs

Reporting Period: January 1, 2017, through December 31, 2017

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**Total Medical Care Services** (Sum Lines 1- 3)			
	Financial Costs of Other Clinical Services			
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify: _____)			
9a.	Vision			
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)			

Table 8A: Financial Costs (continued)

Reporting Period: January 1, 2017, through December 31, 2017

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Enabling and Other Services			
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11f.	Interpretation Services			
11g.	Other Enabling Services (Specify: _____)			
11h.	Community Health Workers			
11.	Total Enabling Services Cost (Sum Lines 11a through 11h)			
12.	Other Related Services (Specify:_____)			
12a.	Quality Improvement			
13.	**Total Enabling and Other Services** (Sum Lines 11, 12, and 12a)			

Table 8A: Financial Costs (continued)

Reporting Period: January 1, 2017, through December 31, 2017

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14.	Facility			
15.	Non-Clinical Support Services			
16.	**Total Facility and Non-Clinical Support Services** (Sum Lines 14 and 15)			
17.	**Total Accrued Costs** (Sum Lines 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services, and Supplies (specify: _____)			
19.	**Total With Donations** (Sum Lines 17 and 18)			

Instructions for Table 9D: Patient-Related Revenue

This table collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off. The statute requires that *all* health centers have a fee schedule and that they charge patients and/or their third-party payers. This does not preclude the center from discounting these fees (see discussion regarding sliding discounts below) but there must be charges. Note that, unlike Table 8A, Table 9D is a ***cash basis***.

Rows: Payer Categories and Form of Payment

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

Form of Payment

Fee-for-Service

Report charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes (for medical) and the charge associated with each of these services. Other services (dental, mental health, pharmacy, etc.) have similar fee schedules. Third-party payers pay some or the entire bill, generally based on agreed upon maximums or discounts.

Managed Care – Capitated

Report charges billed to a managed care payer who lists each of the services provided and the associated fee; the HMO pays the health center a monthly capitation fee *regardless of whether or not any services were rendered during the month*.

If the billed services are on a list of covered services in the agreement between the health center and the HMO, no further payment is provided by the HMO (although an FQHC wrap-around payment may be paid for Medicaid, Medicare, or CHIP services to adjust total payment to FQHC prospective payment system (PPS) rates).

If the service is "carved out" of the listed services, reflect the additional amount as a fee-for-service managed care service.

Report the capitation (monthly payment) as a collection, not as an additional charge.

Managed Care – Fee-for-Service

Report charges for services provided to patients who are assigned to the health center and must receive their primary care from the health center – hence the managed care inclusion — but for whom no monthly fee is paid. Instead, the HMO pays some or the entire bill, generally based on agreed upon maximums or discounts for services.

A supplemental wrap-around payment may also be paid. In addition to basic services to fee-for-service managed care patients, reflect carved out charges and collections for capitated patients on these lines.

Payer Categories

Medicaid (Lines 1–3)

Report all services billed to and paid for by Medicaid (Title XIX), regardless of whether payment comes directly or through a fiscal intermediary or an HMO. For example, in states

with a capitated Medicaid program, where the health center has a contract with a private plan like Blue Cross, the payer would be Medicaid, even though the actual payment may have come from Blue Cross.

- ***Note:*** Include EPSDT (the childhood Early and Periodic Screening, Diagnosis, and Treatment program), which has various names in different states and is a part of Title XIX. The EPSDT program includes some children who are eligible for the screening services *only* and are not included in the rest of the Medicaid program. Always report their charges on Line 1.
- CHIP (or CHIP-RA), which also has many different names in different states, is sometimes paid through Medicaid. If this is the case, include it in the numbers here.
- Note that some states are experimenting with the Medicaid expansion program by providing funds for eligible individuals to purchase their own insurance. *Classify these payers as Medicaid, not as private.*
- In addition, include here a portion of the charges for dually eligible patients that are reclassified to Medicaid after being initially submitted to Medicare.
- In a small number of cases, Medicaid patients are enrolled in a "share of cost" program where they pay some portion of the fee as a co-payment or a deductible. In this case, reclassify the patient's share of the cost to self-pay.
- Recognize charges and collections for patients enrolled in Adult Day Health Care or Program of All-Inclusive Care for the Elderly (PACE) programs under the appropriate payer. Treat as discussed in Appendix B, page 168.

Medicare (Lines 4–6)

Report all services billed to and paid for by Medicare (Title XVIII), regardless of whether they are paid directly or through a fiscal intermediary or an HMO.

- Specifically, for patients enrolled in a capitated Medicare program, including Medicare Advantage, where the health center has a contract with a private plan like Blue Cross, consider the payer to be Medicare, even though the actual payment may come from Blue Cross.
- If a patient is covered by both Medicare and Medicaid, or by Medicare and a private payer, reclassify the portion of the charge owed to these other payment sources.
- Reclassify patient co-payments to "self-pay" after the initial Medicare payment is received.
- Recognize charges and collections for patients enrolled in Adult Day Health Care or PACE programs under the appropriate payer. Treat as discussed in Appendix B, page 168.

Other Public (Lines 7–9)

Report all services billed to and paid for by state or local governments programs *other than indigent care programs.*

- The most common of these would be the Children's Health Insurance Program (CHIP) *when paid for through commercial carriers.* (See above, if CHIP is paid through Medicaid.)
- Include family planning programs including, including but not limited to, Title X programs, BCCCP (Breast and Cervical Cancer Control Programs with various state

names), and other dedicated state or local programs.

- In addition, include state-run insurance plans, such as the Massachusetts' Commonwealth Plan.
- ***Do not include state or local indigent care programs***. Report patients whose only payment source is one of these state or local indigent care programs as "uninsured" on Table 4 and their charges, and any associated self-pay collections, etc., on the self-pay line, Line 13, as described below.
- Do not report third-party coverage purchased through state or federal exchanges which may be subsidized here. Report as Private unless you can identify them as being enrolled through purchased subsidies from a Medicaid Expansion program, which you report as Medicaid.

Private (Lines 10-12)

Report all services billed to and paid for by commercial insurance companies or by other third-party payers as Private. Do not include any services that fall into one of the other categories.

- As noted above, classify elsewhere services covered by Medicaid, Medicare, and CHIP programs that use commercial programs as intermediaries.
- *Include* insurance purchased for public employees or retirees such as Tricare, Trigon, and the Federal Employees Insurance Program, as well as Workers' Compensation.
- Report charges and collections associated with insurance purchased through state exchanges here unless you can identify them as being enrolled through purchased subsidies from a Medicaid Expansion program.
- Include contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis, such as a Head Start program that pays for annual physical exams at a contracted rate, or a school, jail, or large company that pays for provision of medical care at a per-session or negotiated rate.

Self-Pay (Line 13)

Report all charges and collections where the patient is responsible as "self-pay", *including charges for indigent care programs as described below.*

- ***Note:*** *Include the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals that become the patient's personal responsibility.*

State or Local Indigent Care Programs:

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

- Report *all charges* for these services and collections from patients on the "self-pay" line (Line 13, Columns A and B);
- Report *all amounts not collected or due from the patients as sliding discounts or bad debt write-off*, as appropriate, on Line 13, Columns E and F; and
- Report *collections* from the associated state and local indigent care programs on *Table 9E* on Line 6a, and specify the name of the program paying for the services.
- Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program, with your UDS Reviewer, or with the UDS Support Center.

Columns: Charges, Payments, and Adjustments Related to Services Delivered (Reported on a Cash Basis)

Column A – Full Charges this Period

Report in Column A the total charges for each payer source. This will initially reflect the total full charges (per the fee schedule) for services rendered to patients in that payer category during the calendar year. Record charges for services that are billed to ***and*** covered in whole or in part by a payer, or the patient, even if some or all of them are written off as contractual allowances, sliding discounts, or bad debts. Always report full gross charges.

Do not record "contractual allowances" as a charge. Instead, report the difference between gross charges and contracted payments from third-parties as described below in Allowances.

Some patients have more than one source of payment for their services. In these instances, a charge goes to one carrier, who may deny some or all of the charge. Move the unpaid portion of charges to the secondary payer and to a tertiary payer if one exists and, eventually, to the patient as a self-pay charge. Only report the amount owed by payer, after reclassifying charges to the appropriate payer.

Do not include charges that are generally not billable to or covered by traditional third-party payers. For example, a charge for parking or for job training would not normally be included. WIC services are not billable charges. Charges for transportation and similar enabling services would not generally be included in Column A, except where the payer (e.g., Medicaid) accepts billing and *pays for* these services.

Include charges for eyeglasses, pharmaceuticals, durable medical equipment, and other similar supply items. Do not include charges for *pharmaceuticals, including vaccines, donated* to the health center or directly to a patient through the health center, since the clinic may not legally charge for these drugs. Include charges for dispensing or injecting these pharmaceuticals if they appear on bills and are collected from first and third-parties.

Report pharmaceuticals dispensed through a (340(b)) contract pharmacy at the pharmacy's usual, customary, and reasonable (UCR) gross charge even though they are sold at a discount to clinic patients.

Note: *Under no circumstances should the actual amount paid by Medicaid or Medicare (such as FQHC rates) or the amount paid by any other payer be used as the actual charges. Charges must come from the health center's CPT-based fee schedule.*

Reclassifying Charges

Reduce amounts for which another third-party or a private individual can be billed (e.g. amounts due from patients or "Medigap" payers for co-payments) from the initial charges to the primary payer and record or reclassify as charges due from the secondary source of payment.

Charges rejected by a payer that need reclassification (including deductibles and co-insurance) should be reversed as negative charges if your management information system (MIS) system does not reclassify them automatically.

Reclassifying these charges by utilizing an adjustment and rebilling to another category is an incorrect procedure, since it will result in an overstatement of total gross charges by including the charges twice, as well as the adjustments and payments.

Column B – Amount Collected This Period

Report in Column B the gross receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered. *Include FQHC reconciliations, managed care pool distributions, pay for performance (P4P) payments, quality*

bonuses, court settlements, and other payments. Report these additional payments in Column B and in Columns c1, c2, c3, and/or c4.

When a pharmacy is dispensing 340(b) drugs on behalf of the health center, report *the gross payments to the pharmacies* by patients and third-parties in Column B.

Note: Record charges and collections for deductibles and co-payments that are charged to, paid by, and/or due from patients as "self-pay" on Line 13.

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

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

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

Enter FQHC cash receipts from *reconciliations* (lump sum retroactive adjustments based on the filing of a cost report) and *wrap-around payments* (additional amounts for each visit to bring payment up to FQHC level) from Medicare, Medicaid, or Other Public payers that are for *services provided during the* ***current reporting period****. Include the current-year component, if any, of multi-year settlements here.*

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

Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level) from Medicare, Medicaid, or Other Public payers that are for *services provided during* ***previous reporting periods****. Include the prior-year component of multi-year settlements here.*

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

Column C3 – Collection of Other Payments Including Pay for Performance, Quality Bonuses, Risk Pools, and Incentives

Enter other cash payments including managed care risk pool redistribution, incentives including "pay for performance" incentives, and quality bonuses from any payer.

CMS patient-centered medical home (PCMH) demonstration funds may include payment for a person being enrolled in the grant. Include these payments here, regardless of whether or not there is a visit involved.

Include settlements that may result from a court decision that requires a payer to make a settlement, including a multi-year settlement. These payments may apply to either a managed care or non-managed care payer.

Note: Do *not* include eligible provider payments from CMS for implementing electronic health records (commonly referred to as Meaningful Use payments). Record these payments separately on Table 9E, on Line 3a.

Column C4 – Penalty/Payback

Enter payments made by health centers to FQHC payers because of overpayments collected earlier.

In addition, enter "penalty" payments made to managed care plans for over-utilization of the inpatient or specialty pool funds. (This is now a rare occurrence.)

Do *not* include as paybacks bonuses that were not earned because P4P goals were not met, regardless of whether or not it was budgeted.

Note: If a center arranges to have its "repayment" deducted from its monthly payment checks, show the amount deducted in Column c4 *as if it had actually been paid to the third-party in cash during the year and* add the same amount to the amount received in Column B. In addition, add the repayment to Column D as an allowance. Such paybacks may stretch across multiple reporting periods. Show only the amount paid back in the current reporting period.

Column D – Allowances

Report in Column D, allowances granted as part of an agreement with a third-party payer. Virtually all insurance companies have a maximum amount they pay for a given service and the center agrees to write-off the difference between what they charge and that contracted amount.

In some states Medicaid pays the contracted amount and then later pays a wrap-around and/or reconciliation. In these instances, reduce the initial *allowance by the amount of retroactive settlements and receipts* (reported in Columns c1, c2, and c3), including current and prior year FQHC reconciliations, managed care pool distributions, quality or pay-for-performance awards, and other payments. *This will often result in reporting a negative number as the allowance in Column D.*

If, as a result of a contract or agreement, Medicaid, Medicare, other third-parties, or other public payers reimburse less than the health center's full charge, and the health center cannot bill the patient for the remainder, enter (and write off) the remainder or reduction on the appropriate payer line in Column D at the time the explanation of benefits (EOB) or advice of allowance (AOA).

Under FQHC programs, where the health center is paid based on cost, it is possible that the cash payment will be greater than the charge. In this case, record the adjustment in Column D as a negative amount. (Report financial adjustments received under FQHC programs in Columns c1 and c2, as well as in Column B.)

Note: Do not report amounts for which another third-party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payers for co-payments) as allowances. Reduce these amounts from the initial charges to the primary payer and record or reclassify as charges due from the secondary source of payment. Classify these amounts as adjustments only when all sources of payment have failed and further collection is not anticipated.

Because capitated plans typically pay on a per-member per-month basis, and make this payment in the current month of enrollment, these plans typically do not carry any receivables. For capitated plans (Lines 2a, 5a, 8a, and 11a *only*) the allowance column (Column D) is the arithmetic difference between the charge recorded in Column A and the collection in Column B unless there were early or late capitation payments (received in a month other than when they were earned) *which span the beginning or end of the calendar year.*

In addition, note that self-pay, Line 13, Column D is greyed out because allowances given to self-pay patients based on their income and family size are

recorded as sliding discounts and valid self-pay receivables that are not paid should be recorded as self-pay bad debt.

Column E - Sliding Discounts

Report reductions to patient charges based on the patient's ability to pay. Processes detailed in the health center's sliding discount policies and procedures determine these discounts. Include discounts to required co-payments and deductibles, as applicable.

Do not report discounts to patients who are provided with other write-offs, most commonly a discount for prompt payment or prepayment, anywhere in the UDS Report.

Do not report automatic discounting of charges for specific categories of patients (e.g., students, homeless persons, or agricultural farmworkers), even though a health center's board-approved policies may permit them to self-declare their income with no presentation of documentation. Only report amounts discounted if the patient qualifies based on income.

Note: Only the patient may be granted a sliding discount based on their ability to pay. Column E is greyed out on all other lines. When a sliding discount is used to write off part of a charge originally made to a third-party, such as Medicare or a private insurance company's co-payment or deductible, ***first reclassify the charge to self-pay***.

To reclassify, first reduce the third-party charge by the amount due from the patient and then increase the self-pay charges by this same amount. No other types of discounts should be wrapped into or included in–the sliding discount.

Column F - Bad Debt Write-Off

Report amounts billed and defaulted on by any patient. **In the UDS, record only self-pay bad debts.** Bad debt write-off (Line 13, Column F) may occur due to the health center's inability to locate persons, a patient's refusal to pay, a patient with an income greater than 200 percent of the poverty guideline who is unable to pay, or a patient's inability to pay even after the sliding discount is granted. Health centers are encouraged to write-off bad debts (see PIN 2014-02) but may not consider the write-off or forgiveness to be a sliding discount.

If the current clinic record, at the time of service, shows that the patient would be entitled to a sliding discount, show the write-off as a sliding discount (Column E). However, if they would otherwise be ineligible, do not report the write-off as a sliding discount. This situation occurs most frequently when a source of funds permits a discount to persons whose income exceeds 200 percent of poverty (for example, the Title X Family planning program which mandates discounts up to 250 percent of the Federal Poverty Guidelines [FPG] or the Ryan White program which mandates discounts for patients with incomes up to 300 percent of FPG). By law, the discount may not be granted using health center grant-related resources or shown as a sliding discount on the UDS, but this does not preclude the health center from writing off or waiving the charges under some other policy.

In order to keep responsible financial records, write-off bad debts on a routine basis. (We recommend doing this at least annually, though most health centers do so more frequently.) In some systems, this is accomplished by posting an allowance for bad debts rather than actually writing off individual patient accounts. Record amounts removed from the center's self-pay receivables through either (but not both) mechanism here.

Make reductions to the collectable amount for the self-pay category based on the patient's income and family size and report the amount as a sliding discount on Line 13, Column E. If the health center has not recorded the patient's income and family size and eligibility level, do not write-off the

amount as a sliding discount. If there are no sliding discounts, charges must either be collected or written off as a bad debt.

Under no circumstances are bad debts to be reclassified as sliding discounts, even if the write-off to bad debt is occasioned by a patient's inability to pay the remaining amount due. For example, a patient eligible for a sliding discount is supposed to pay 50 percent of full charges for a visit. If the patient does not pay, even if he or she later qualifies for a 100 percent discount, still report the amount written off as bad debt, not sliding discount. At the time of the visit, it was a valid debt collectable from the patient.

Only record bad debts *from patients* on this table. While an insurance company may default on legitimate debts as they go bankrupt, do not calculate or report these data.

Other Write-Offs

Some health centers use additional write-offs. In some cases, a private, local, or state grant permits writing off charges to a certain class of individuals. In other cases, a cash discount is provided for pre-payment or payment at time of service. Some providers claim the right to grant "courtesy discounts" to patients. Do not record these discounts on the UDS. In any such case, show the full undiscounted charge in Column A and the amount collected in Column B. Do not report the amount of the other write-off.

Total Patient-Related Income (Line 14)

Enter the sum of Lines 3, 6, 9, 12, and 13. (The EHB will calculate this line automatically.)

Additional information is available to clarify reporting. View **FAQs for Table 9D**.

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

Reporting Period: January 1, 2017, through December 31, 2017

				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 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)									

				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 Payments: P4P, Risk Pools, Withholds, etc. (c3)**	**Penalty/ Payback (c4)**	**Allowances (d)**	**Sliding Discounts (e)**	**Bad Debt Write Off (f)**
8b.	Other Public, including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public** (Lines 7 + 8a + 8b)									
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	**Total Private** (Lines 10 + 11a + 11b)									
13.	Self-pay									
14.	**TOTAL** (Lines 3 + 6 + 9 + 12 + 13)									

Instructions for Table 9E: Other Revenue

This table collects and reports information on non-patient income received during the reporting period that supported activities described in the scope of project(s) covered by the Health Center Program grant, the look-alike program, or the HRSA BHW primary care program. (Look-alike health centers and BHW Primary care clinics will file this table, but will show no income from the BPHC Health Center Grant program on Line 1.) Report income received on a "cash basis" and include all funds received during the calendar year that supported the federally approved project even if the revenue was accrued (earned) during the previous year or was received in advance and considered "unearned revenue" in the center's books on December 31.

Use the "**last party rule**" to report "other" revenues. The "last party rule," for UDS reporting purposes, means that *grant and contract funds should always be reported based on the entity from which the health center received them, regardless of their original origin*. For example, funds awarded by the state for maternal and child health services usually include a mixture of Federal funds, such as Title V, and state funds. Nonetheless, report these as state grants. Similarly, WIC funds provided by the Federal Department of Agriculture generally pass through the state, and are reported on Line 6 as State funds, not on Line 3 as Federal. A rare exception to the rule is for the Medicare and Medicaid EHR Incentive Grants received for eligible providers (Line 3a). In rare cases, these payments may go directly to the clinic's providers. It is presumed that these funds will be turned over to the clinic. Report these funds on Line 3a even though the payment may come from the provider and not directly from the CMS. (See below for further details on Meaningful Use [MU] funds.)

BPHC Grants

Lines 1a through 1e

Report drawdowns made during the reporting period for the Health Center Program (section 330) grant. Amounts should be consistent with the PMS-272 federal cash transaction report.

- Report Migrant Health Center grant drawdowns on Line 1a.
- Report Community Health Center grant drawdowns on Line 1b.
- Report Health Care for the Homeless drawdowns on Line 1c.
- Report Public Housing Primary Care drawdowns on Line 1e.

Total Health Center Program (Line 1g)

The EHB automatically calculates the total of Lines 1a through 1e.

Capital Improvement Program Grants (Line 1j)

Report the amount of Capital Improvement Program grant dollars drawn down. This is a legacy

program which is almost extinct at this time. Do not use this line unless you are certain you have some of these funds.

Capital Development Grants (Line 1k)

Report the amount of Capital Development grant dollars drawn down. This includes funds from the Health Center Program facility program as well as funds from the HRSA administered School-Based Health Center capital grant program.

Total BPHC Grants (Line 1)

The line shows the total of Lines 1g (Total Health Center Program), 1j (Capital Improvement Program Grants), and1k (Capital Development Grants). Be sure that all BPHC Health Center Program (section 330) grant funds drawn down during the year are included on Line 1. This calculation is done automatically in the EHB.

Reflect *direct funding only* on the BPHC Grant Lines.

Do not include BPHC funds passed through from another BPHC health center and do not reduce the amounts by money that the health center passed through to other centers including "sub-grantees" or "sub-recipients".

Other Federal Grants

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

Report the amount of Ryan White Part C funds the health center has drawn down during the reporting period. Guidance for reporting other Ryan White funds:

- Report Ryan White Part A, Impacted Area grants, from county or city governments on Line 7 (unless they are first sent to a third-party – in which case report the funds on Line 8. Report on Line 3 when the reporting entity *is* a county or city government and the funds were received directly by the Ryan White Part A federal program).
- Report Part B grants from the state on Line 6, unless they are first sent to a county or city government (in which case, report on Line 7) or to a third-party (in which case, report the funds on Line 8).
- Report Special Projects of Regional and National Significance (SPRANS) grants that are generally direct Federal grants on Line 3.
- The one exception to this rule is when the health center is a state, county, or city entity, in which case, the source of the funds will generally be "one level higher."

Other Federal Grants (Line 3)

Report the amount and source of any other Federal grant revenue received during the reporting period that falls within the scope of the project(s). These grants include only those funds received directly by the health center from the U.S. Treasury.

Do not include Federal funds first received by a state or local government or other agency and then passed on to the health center such as WIC, or Part A or Part B Ryan White funds. Include these below on Lines 6 through 8.

Describe ("Specify") the program(s) so the UDS Reviewer can make sure that the classification of the program as a Federal grant is appropriate. (The most common "other federal" grants reported are from the Office of Minority Health (OMH), Indian Health Service (IHS), Housing and Urban Development (HUD), and Substance Abuse and Mental Health Services Administration (SAMHSA).)

Dually funded IHS/HRSA-funded health centers report IHS funds, *not including any* PL 93-638 Compact funds on this line. Report PL 93-638 Compact funds on Line 6a, Indigent Care.

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

Report funds from the Medicare and Medicaid Electronic Health Record Incentive Program grants (also known as "Meaningful Use awards") funded through the American Recovery and Reinvestment Act of 2009 (ARRA). They provide incentives to Eligible Providers (as defined under ARRA) for the adoption, implementation, upgrading, and Meaningful Use of certified electronic health records. In rare cases, these payments go directly to the clinic's providers but they are most commonly paid to the providers' designee – generally the health center. It is presumed that, if the payment goes to the employees, these funds will be turned over to the health center. Report them on this line *even though the payment may come from the provider and not directly from the CMS*. This is an exception to the "last party" rule. In the event the provider retains some or all of these grants as part of their compensation, *record the total amount on this line and the amount retained by the provider on Table 8A, Line 1, as staff compensation*.

Total Other Federal Grants (Line 5)

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

Non-Federal Grants or Contracts

"Grants and Contracts" are defined as all *amounts received* (not only grants) on a line item or similar basis which are not tied to the delivery of services.

State Government Grants and Contracts (Line 6)

Report the amount of funds received from state government grants or contracts.

Include grants of flat sums to support the operation of the health center with no specific tie to a level of service.

Do *not* include funds from state indigent care programs or from Medicaid or CHIP here. When a state grant or contract program *other than an indigent care program* pays a health center based on the amount of health care services provided or on a negotiated fee for service or fee per visit, report the charges, collections and allowances on Table 9D as "Other Public," not here on Table 9E. This is most commonly seen in Family Planning and Cancer Detection programs.

Describe ("Specify") the program so the UDS Reviewer can make sure that the classification of the program as a state grant is appropriate.

State/Local Indigent Care Programs (Line 6a)

Report the amount of funds received from state/local indigent care programs that subsidize services rendered to the uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Tax program, and the Colorado Indigent Care Program). Include dually funded IHS/Health Centers with IHS *PL 93-638 Compact funds* that are allocated to the health center by the tribe on this line.

Report private contracts between a health center and a tribe as Private on Table 9D.

Describe ("Specify") the program so the UDS Reviewer can make sure that the classification of the program as a state/local indigent care program is appropriate. Do not use this line for any program not listed above without specific instructions provided at a state or regional UDS training program, the UDS Support Center, or in communications with the UDS Reviewer.

Cross-Table Reporting Guidance for Indigent Programs:

- Report payments received from state or local indigent care programs subsidizing services rendered to the uninsured on Line 6a of this table whether the actual payment to the health center is made on a per visit basis or as a lump sum for services rendered.
- Report patients covered by these programs as uninsured on Table 4 unless they have some other form of insurance.

- Report all associated charges, sliding discounts, and bad debt write-offs on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on Table 9D in Column B.
- Care should be taken to ensure that none of the funds reported on Line 6a of Table 9E are also reported as income in Column B of Table 9D.

Local Government Grants and Contracts (Line 7)

Report the amount received from local governments during the reporting period that covers costs included in the scope of the health center's project(s). Include grants of flat sums to support the operation of the health center with no specific tie to a level of service.

Do *not* include funds from local indigent care programs here.

When a local grant or *contract* pays a health center based on the amount of health care services provided or on a negotiated fee for service or fee per visit, report the charges, collections, and allowances on Table 9D as "Other Public" services, not here on Table 9E.

Describe ("Specify") the program so the UDS Reviewer can make sure that the classification of the program as a local grant is appropriate.

Foundation/Private Grants and Contracts (Line 8)

Report the amount received from foundations or private organizations during the reporting period that covers costs included within the scope of the project(s). Include funds transferred from a Primary Care Association, another health center or another community service provider on this line regardless of their origin.

Describe ("Specify") the program so the UDS Reviewer can make sure that the classification of the program as a foundation/private grant or contract is appropriate.

Total Non-Federal Grants and Contracts (Line 9)

The total of Lines 6, 6a, 7, and 8. The EHB calculates this number automatically.

Other Revenue (Line 10)

Report Other Revenue receipts included in the federally approved scope of project that are unrelated to charge-based services or to grants and contracts described above. Include fund-raising, interest income, rent from tenants, medical records fees, individual monetary donations, vending machines, pharmacy sales to the public (i.e., non-health center patients), etc.

"Describe ("Specify") these sources of "other revenue."

Do not enter the value of in-kind or other donations made to the health center—show these only on Table 8A on Line 18.

In addition, *do not* show the proceeds of any loan received, either for operations or in the form of a mortgage.

Do not report the receipt or recognition of in kind "community benefit" from a third-party here or anywhere else on the UDS unless it is received as a cash donation.

Under no circumstances should payments or net payments from a pharmacy contracted to dispense 340(b) pharmaceuticals appear on this line. Report all patient pharmacy income (gross income) on Table 9D and record all expenses on Table 8A. (In addition, see Appendix B for cross-table pharmacy reporting.)

Total Other Revenue (Line 11)

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

Additional information is available to clarify reporting. View **FAQs for Table 9E.**

Table 9E: Other Revenues

Reporting Period: January 1, 2017, through December 31, 2017

Line	Source	Amount (a)
	BPHC Grants (Enter amount drawn down – Consistent with PMS 272)	
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	**Total Health Center** (Sum Lines 1a through 1e)	
1j.	Capital Improvement Program Grants	
1k.	Capital Development Grants, including School Based Health Center Capital Grants	
1.	**Total BPHC Grants** (Sum Lines 1g + 1j + 1k)	
	Other Federal Grants	
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify: _____)	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5.	**Total Other Federal Grants** (Sum Lines 2–3a)	
	Non-Federal Grants or Contracts	
6.	State Government Grants and Contracts (specify: _____)	
6a.	State/Local Indigent Care Programs (specify: _____)	
7.	Local Government Grants and Contracts (specify: _____)	
8.	Foundation/Private Grants and Contracts (specify: _____)	
9.	**Total Non-Federal Grants and Contracts** (Sum Lines 6 + 6A + 7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify: _____)	
11.	**Total Revenue** (Lines 1 + 5 + 9 + 10)	

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. Not all services delivered by a "provider" count as visits. Do not count interactions with "non-providers" as visits. Use the Provider definitions to classify personnel as a "provider" or "non-provider."

Personnel by Major Service Category	Provider	Non-Provider
Physicians		
Family Practitioners (Line 1)	X	
General Practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetricians/Gynecologists (Line 4)	X	
Pediatricians (Line 5)	X	
Licensed Medical Residents—line determined by specialty	X	
Other Specialist Physicians (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other Specialists and Sub-Specialists	X	
Nurse Practitioners (Line 9a)	X	
Physician Assistants (Line 9b)	X	
Certified Nurse Midwives (Line 10)	X	
Nurses (Line 11)		
Clinical Nurse Specialists	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses (RNs)	X	
Licensed Practical Nurses/Licensed Vocational Nurses		X
Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT)	X	
Other Medical Personnel (Line 12)		
Nurse Aides/Assistants (Certified and Uncertified)		X
Clinic Aides/Medical Assistants (Certified and Uncertified Medical Technologists)		X
Unlicensed Interns and Residents		X
EMS/EMT Staff (not credentialed as a nurse)		X

Personnel by Major Service Category	Provider	Non-Provider
Laboratory Personnel (Line 13)		
Pathologists		X
Medical Technologists		X
Laboratory Technicians		X
Laboratory Assistants		X
Phlebotomists		X
X-Ray Personnel (Line 14)		
Radiologists		X
X-Ray Technologists		X
X-Ray Technicians		X
Radiology Assistants		X
Ultrasound Technicians		X
Dentists (Line 16)		
General Practitioners	X	
Oral Surgeons	X	
Periodontists	X	
Endodontists	X	
Other Dental		
Dental Hygienists (Line 17)	X	
Dental Therapists (Line 17a)	X	
Dental Assistants, Advanced Practice Dental Assistants (Line 18)		X
Dental Technicians (Line 18)		X
Dental Aides (Line 18)		X
Dental Students (including Hygienist Students) (Line 18)		X
Mental Health (Line 20) and **Substance Abuse** (Line 21)		
Psychiatrists (Line 20a)	X	
Psychologists (Line 20a1)	X	
Social Workers - Clinical (Line 20a2 or 21)	X	
Social Workers - Psychiatric (Line 20b or 21)	X	
Family Therapists (Line 20b or 21)	X	
Psychiatric Nurse Practitioners (Line 20b)	X	
Nurses - Psychiatric and Mental Health (Line 20b)	X	
Unlicensed Mental Health Providers, including trainees (interns or residents) and "Certified" staff (Line 20c)	X	
Alcohol and Drug Abuse Counselors (Line 21)	X	
RN Nurse Counselors (Line 20b or 21)	X	
All Other Professional Personnel (Line 22)		

Personnel by Major Service Category	Provider	Non-Provider
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Community Health Aides and Practitioners	X	
Herbalists	X	
Massage Therapists	X	
Naturopaths	X	
Registered Dietitians, including Nutritionists/Dietitians	X	
Occupational Therapists	X	
Podiatrists	X	
Physical Therapists	X	
Respiratory Therapists	X	
Speech Therapists/Pathologists	X	
Traditional Healers	X	
Vision Services Personnel (Line 22a-22d)		
Ophthalmologists (Line 22a)	X	
Optometrists (Line 22b)	X	
Ophthalmologist/Optometric Assistants (Line 22c)		X
Ophthalmologist/Optometric Aides (Line 22c)		X
Ophthalmologist/Optometric Technicians (Line 22c)		X
Pharmacy Personnel (Line 23)		
Pharmacists, Clinical Pharmacists		X
Pharmacy Technicians		X
Pharmacist Assistants		X
Pharmacy Clerks		X
Enabling Services (Line 29)		
Case Managers (Line 24)		
Case Managers	X	
Care/Referral Coordinators	X	
Patient Advocates	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses/Licensed Vocational Nurses	X	

Personnel by Major Service Category	Provider	Non-Provider
Health Educators (Line 25)		
Family Planning Counselors	X	
Health Educators	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses /Licensed Vocational Nurses	X	
Outreach Workers (Line 26)		X
Patient Transportation Workers (Line 27)		
Patient Transportation Coordinators		X
Drivers		X
Eligibility Assistance Workers (Line 27a)		
Benefits Assistance Workers		X
Pharmacy Assistance Program Eligibility Workers		X
Eligibility Workers		X
Patient Navigators		X
Patient Advocates		X
Registration Clerks		X
Certified Assisters		X
Interpretation (Line 27b)		
Interpreters		X
Translators		X
Community Health Workers (Line 27c)		
Community Health Workers		X
Community Health Advisors or Representatives		X
Lay Health Advocates		X
Promotoras		X
Other Enabling Services Personnel (Line 28)		X
Other Program Related Services Staff (Line 29a)		
WIC Workers		X
Head Start Workers		X
Housing Assistance Workers		X
Child Care Workers		X
Food Bank/Meal Delivery Workers		X
Employment/Educational Counselors		X
Exercise Trainers/Fitness Center staff		X
Adult Day Health Care, Frail Elderly Support staff		X
Quality Improvement Staff (QI) (Line 29b)		

Personnel by Major Service Category	Provider	Non-Provider
QI Nurses		X
QI Technicians		X
QI Data Specialists		X
Statisticians, Analysts		X
Quality Assurance/Quality Improvement and HIT/EHR Design and Operation Staff		X
Management and Support Staff (Line 30a)		
Project Directors		X
Chief Executive Officer/Executive Directors		X
Chief Financial Officers/Fiscal Officers		X
Chief Information Officers		X
Chief Medical Officers		X
Secretaries/Administrative Assistants		X
Administrators		X
Directors of Planning And Evaluation		X
Clerk Typists		X
Personnel Directors		X
Receptionists		X
Directors of Marketing		X
Marketing Representatives		X
Enrollment/Service Representatives		X
Fiscal and Billing Staff		
Finance Directors		X
Accountants		X
Bookkeepers		X
Billing Clerks		X
Cashiers		X
Data Entry Clerks		X
IT Staff (Line 30c)		
Directors of Data Processing		X
Programmers		X
IT Help Desk Technicians		X
Data Entry Clerks		X
Facility (Line 31)		
Janitors/Custodians		X
Security Guards		X
Groundskeepers		X
Equipment Maintenance Personnel		X
Housekeeping Personnel		X
Patient Services Support Staff (Line 32)		

Personnel by Major Service Category	Provider	Non-Provider
Medical and Dental Team Clerks		X
Medical and Dental Team Secretaries		X
Medical and Dental Appointment Clerks		X
Medical and Dental Patient Records Clerks		X
Patient Records Supervisors		X
Patient Records Technicians		X
Patient Records Clerks		X
Patient Records Transcriptionists		X
Registration Clerks		X
Appointments Clerks		X

Appendix B1: Frequently Asked Questions (FAQs)

The following section, which is organized by table, provides guidance on common questions you may have about UDS data reporting. We encourage health center staff completing the UDS Report to review this section after reading the corresponding table chapter to best understand the reporting requirements.

FAQs for ZIP Code by Medical Insurance

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

2. **Do we need to collect information on and report on the ZIP code of all our patients?**
   Yes. Although health centers report residence by ZIP code for all patients, some centers may draw patients from a large number of ZIP codes outside of their normal service area. To ease the burden of reporting, ZIP codes with 10 or fewer patients, consolidate them in the "other" category.

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

4. **If a patient did not receive medical care, do we still need their medical insurance information? What about dental patients?**
   Yes, include *medical* insurance information for all patients, even dental-only patients.

5. **Does the number of patients reported by ZIP code need to equal the total number of unduplicated patients reported on Tables 3A, 3B, and 4?**
   Yes. Several tables and sections must match:

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

FAQs for Tables 3A and 3B

1. **Have the data elements for Tables 3A or 3B changed?**
   No.

FAQs for Tables 3A and 3B continued

2. **Our health center collects more robust race and ethnicity data than is required on the UDS. Why is the data limited?**
   The UDS classifications are consistent with those used by the Census Bureau as per the October 30, 1997, Federal Register Notice entitled, "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity," issued by the Office of Management and Budget (OMB). These standards govern the categories used to collect and present federal data on race and ethnicity. The OMB requires a minimum of five categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian, or Other Pacific Islander) for race. In addition to the five race groups, the OMB also states that respondents should be offered the option of selecting more than one race. Line 6 permits reporting of those people who have chosen to report two or more races.

3. **How are patients of Hispanic or Latino ethnicity reported?**
   Table 3B, race and ethnicity data appears in a matrix. Patients who in other systems might be reported as Hispanic or Latino independent of race are reported in Column A of the UDS as Hispanic or Latino where you can also show the race of these patients. Report patients on Lines 1 through 7 based on their race. If Hispanic/Latino is the only identification recorded in the center's patient files, report these patients in Column A on Line 7 as having an "unreported" racial identification.

4. **Can we just have a choice on our registration form of "more than one race"?**
   No. To count a patient as being of "more than one race" they must have the option of checking two or more boxes under race and have indeed checked more than one. This methodology is the same as used in the census and mandated by OMB.

5. **How are individuals who receive different types of services or use more than one of our health centers' service delivery sites reported, for example, a person who receives both medical and dental services or a woman who receives primary care from one clinic site but gets prenatal care at another?**
   UDS Tables 3A and 3B provide unduplicated counts of patients. Report each patient only once on Table 3A and on Table 3B, regardless of the type or number of services they receive or where they receive them. Count each person who has at least one visit reported on Table 5 only once on Table 3A and on Table 3B. We define visits in detail in the Instructions for Visits, Patients, and Providers section (page 17). Note the following:

   - Do not count people who receive WIC services and no other services at the health center as patients on Table 3A or 3B (or anywhere on the UDS).
   - Do not count people who only receive imaging or lab services or whose only service was an immunization or screening test as patients on Table 3A or 3B (or anywhere on the UDS).
   - Do not count people who only receive health status checks and health screenings as patients on Table 3A or 3B (or anywhere on the UDS).

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

FAQs for Tables 3A and 3B continued

be initiated as soon as the year ends to ensure sufficient completion time prior to the initial submission date.

7. **Must the numbers on Tables 3A and 3B tie to UDS data reported on other tables?**
Yes.

   The sum of Table 3A, Line 39, Column A + B (total patients by age and by sex assigned at birth) must equal:

   - Total Patients by ZIP Code;
   - Table 3B, Line 8, Column D (total patients by Hispanic or Latino ethnicity and race);
   - Table 3B, Line 19 (total patients by sexual orientation);
   - Table 3B, Line 26 (total patients by gender orientation);
   - Table 4, Line 6 (total patients by income); and
   - Table 4, Line 12, Column A + B (total patients by insurance status).

   The sum of Table 3A, Lines 1-18, Column A + B (total patients age 0-17 years) must equal:

   - Table 4, Line 12, Column A (total patient's age 0-17 years).

   The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal:

   - Table 4, Line 12, Column B (total patients age 18 and older).

8. **Do we have to report the race and Hispanic or Latino ethnicity of all our patients?**
Yes. The UDS requires the classification of race and Hispanic/Latino ethnicity information in order to assess health disparities across sub-populations. OMB has stipulated the format for the classification of this information, and the UDS follows the standards established by the Office of the Assistant Secretary for Planning and Evaluation. Health centers whose data systems do not support such reporting must enhance their systems to permit the required level of reporting rather than using the "unreported/refused to report" categories.

9. **I have a separate data system for my mental health patients. How do I include their data on these tables?**
Health centers must not duplicate their data. Count patients only once, regardless of the number of different types of services they receive. This may require the downloading and merging of data from each system in order to eliminate duplicates, or to check them manually. This can be a time consuming and potentially expensive process, and should start as soon as the year ends to ensure sufficient time to complete it prior to the submission due date.

10. **For patients who were seen before the sexual orientation and gender identity elements were added to the intake form, what is the appropriate reporting?**
All health centers should have these data elements added to the intake forms. If you did not implement the gathering of sexual orientation and gender identity data, report them on Table 3B as 'Don't know' on Line 17 (sexual orientation) and as 'Other' on Line 24 (gender identity).

11. **How can I communicate a hardship in reporting sexual orientation and gender identity data?**
Any health center can contact the UDS Support Center regarding UDS content and reporting, including hardships at 866-UDS-HELP or udshelp330@bphcdata.net. Report a potential hardship by making a note in the comments section of Table 3B of the UDS submission. The comment should include an explanation of the hardship experienced.

FAQs for Tables 3A and 3B continued

The comment documenting the hardship will go to the assigned UDS Reviewer upon submission. Health centers should notify the Bureau of any potential UDS reporting hardship every reporting cycle (i.e., calendar year).

12. **Will UDS require health care providers to ask minors for sexual orientation and gender identity data?**
The collection of sexual orientation and gender identity data is not required for minors although the information should be included in system in the event that a patient prefers to offer clarification about sexual orientation and gender identity.

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

14. **How are the categories for sexual orientation and gender identity defined?**
The UDS classifications are developed using the guidance provided in the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program.

FAQs for Table 4

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

2. **If we do not receive direct funding under the Health Care for the Homeless, Migrant Health Center, or Public Housing Primary Care programs, do we need to report the total number of special population patients served?**
Yes. All health centers that do not receive targeted grant funding for special populations are required to complete:

   - Line 16 (the total number of patients seen during the reporting period who were agricultural workers or their family members),
   - Line 23 (total number of patients known to have been homeless at the time of any service during the year),
   - Line 24 (patients of an approved, in-scope school based health center),
   - Line 25 (Veterans), and
   - Line 26 (total number of patients served at a health center located in or immediately accessible to a public housing site).

   You will not be able to complete the shelter arrangement details on Lines 17-22 if you did not receive HCH funding – only enter the total.

   You will not be able to complete the agricultural worker details on Lines 14 and 15 if you did not receive MHC funding – only enter the total.

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

FAQs for Table 4 continued

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

   For information on public housing, please see the Housing and Urban Development (HUD) website at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph.

5. **If a patient is seen only for dental care, do we report the patient's dental insurance on lines 7–12?**
No. Table 4 reports the medical coverage that patients have. All health centers must collect medical coverage information from all patients even if the patient is not seeking medical services. ***Note:*** If a patient has Medicaid, Private, or Other Public dental insurance, you may assume they have the same kind of medical insurance. If they do not have dental insurance, you may not assume they are uninsured for medical care.

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

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

8. **Our state is using Medicaid Expansion provisions to assist patients with buying private insurance. Should we count them as Medicaid or Private?**
If they are Medicaid expansion patients, report them as Medicaid, line 8a. (This may require looking for specific plan numbers or other identifying characteristics in their insurance enrollment.) If you are unable to identify Medicaid Expansion patients, report them as Private, line 11.

9. **What timing determines a patient's homeless status and shelter arrangement?**
For all health centers (irrespective of HCH funding), include the total number of patients who were homeless at any point of service during the year on Line 23.

   For grantees that receive HCH funding, also continue to count patients seen who are no longer homeless as a result of becoming residents of permanent housing for 12 months after their last visit as homeless.

FAQs for Table 4 continued

For grantees who receive HCH funding, report all of those patients reported on Line 23 by their shelter arrangement on Lines 17-22.

The statement that the health center should report homeless patients by their sheltering arrangements as of their first encounter during the reporting year is made in order to help health centers determine to which shelter arrangement they should report a patient as if they change shelter statuses throughout the year.

10. Do the totals need to equal other sections or Tables?
The following totals must be equal across tables and sections:

- ZIP Code Table, Column B must equal Table 4, Line 7, Column A + Column B.
- ZIP Code Table, Column C must equal Table 4, Line 8 + 10, Column A + Column B.
- ZIP Code Table, Column D must equal Table 4, Line 9, Column A + Column B.
- ZIP Code Table, Column E must equal Table 4, Line 11, Column A + Column B.
- The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Line 8, Column D (total patients by race and Hispanic/Latino ethnicity); Table 4, Line 6 (total patients by income); and Table 4, Line 12, Column A + B (total patients by medical insurance status).
- The sum of Table 3A, Lines 1-18, Column A + B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0-17 years).
- The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).
- The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 12 Column A + B (total patients by insurance status).

The same is true for Grant Reports.

FAQs for Table 5

1. Are there changes to this table?
No.

2. How do I count participants in a group session?
If you have group treatment sessions for substance abuse, mental health, or behavioral health, record the visit in each participant's chart. If interaction with an individual in a group is not recorded in a participant's chart, that participant is not counted as a patient and the interaction is not counted as a visit. Each patient charted in a group session must be billed and the service must be paid for consistent with health center policy by either the patient, their insurance, or another contract maintained by the health center. If some patients/visits are billed and others are not billed, only count those that are billed. *Do not count group medical visits or group health education visits*. Although in some instances they may be billable, the UDS specifically does *not* count these as visits.

3. How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call for the remaining 25 percent of his/her salary?
Count a person who is hired as a full-time clinician as a 1.0 FTE regardless of the number of direct patient care or face-to-face hours they provide. Count providers hired as full-time who have released time to compensate for on-call hours, hours spent on clinical committees, or

FAQs for Table 5 continued

who receive leave for continuing education or other activities as 1.0 FTE.

Do not adjust the time spent by a physician (for example) while not in face-to-face contact with the patient, such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals – it is to be considered part of his/her time as a physician. The exception to this rule is when a Medical Director or Chief Medical Officer is engaged in non-clinical activities at the corporate level, in which case allocate time to the non-clinical category. This does not, however, include non-clinical activities in the medical area such as chairing or attending meetings, supervising staff, writing clinical protocols, designing formularies, or approving specialty referrals.

Note: Count loan-repayment recipients as full-time. In addition, note that the FQHC Medicare intermediary has different definitions for full-time providers and are not to be used in reporting on the UDS.

4. **Our physicians work 35-hour weeks. Do we report as 87.5 percent (35 ÷ 40) FTEs?**
No, count as 1.0 FTE. It is not required by BPHC to have a 40-hour workweek. Use whatever workweek time is considered full-time.

5. **Should the total number of patients reported on Table 3A be equal to the sum of the several types of service patients on Table 5?**
Not unless the only services you provide are medical services. On Table 5, report *patients for each* ***type*** *of service received*. For example, count a patient who receives both medical and dental services once as a medical patient on Line 15 and once as a dental patient on Line 19. Because there are seven different types of patients identified on Table 5, a patient who is counted only once on Table 3A may be counted in up to seven different places on Table 5.

6. **If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?**
Usually there should be a logical consistency between Table 5 and Table 8A. If a health center reports the costs for case management services, one would expect to see case managers reported on Table 5, unless the service was contracted with no staff time specifically identified. Similarly, if there are staff members on Table 5, we would expect costs on Table 8A unless staff are volunteers. Some services do not involve staff. Spending funds on bus tokens, for example, would involve transportation costs on Table 8a, but no staff on Table 5.

7. **How are contracted providers and their activities reported on Table 5?**
If the contracted provider is paid on the basis of time worked (for example, one day a week), report the FTE on Table 5, Column A, as well as the visits and patients receiving services from this provider. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) If the contracted provider is paid on a fee-for-service basis, do not report FTE on Table 5, Column A, but report the visits and patients. Note that this is likely to trigger an edit in the EHB data entry system that you must explain, but it is not an error.

8. **Where should we report behavioral health?**
In some systems, behavioral health is another name for mental health, and the staff and visits are reported on Lines 20a through 20c. However, some health centers have merged the roles of mental health provider and substance abuse provider into a single role, which they call a behavioral health provider. In this instance, the health center has two choices. The first is to assert that substance abuse problems are mental health problems and classify its behavioral health staff as mental health staff on Lines 20a,

FAQs for Table 5 continued

20a1, 20a2, 20b, or 20c. Another method would be to carefully record the time and activities of these dual function providers. In this case, identify each visit as either a mental health visit or a substance abuse visit so the patients and visits can be correctly classified. In addition, keep track of providers' time so that FTEs on Table 5 (and associated costs on Table 8A) can be accurately allocated and recorded to the appropriate line.

9. **If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during a visit, how should we count this?**
Because substance abuse is also seen as a mental health diagnosis, count the visit under mental health. Do not count the visits as one of each type. In addition, classify the provider and costs (on Table 8A) as mental health. ***Note:*** This does not apply to physicians. If a medical provider provide the behavioral health service, count the visit as medical.

10. **Do I count the time of volunteer clinicians, interns, or residents?**
Yes. Volunteers, (some) interns, and residents are licensed practitioners and you count their time like any other practitioner. Note, however, that some may work shorter days because they are in educational sessions, may have more vacation time or other time off than other practitioners, or, in the case of volunteers, do *not* have vacations or holidays. This would make them less than full-time. In addition, see the more complete discussion of counting volunteers, interns, and residents in Appendix B.

11. **We contract with a number of licensed physicians to over-read our tests; an ophthalmologist reads the retinal photos that our medical assistant takes, a radiologist over-reads the x-rays that our x-ray tech takes, the outside laboratory's pathologist provides the test results from their machines, and a consulting cardiologist confirms findings of our electrocardiograms (EKGs). Should we report them as staff and do we count what they do as visits?**
Tests are not counted as visits anywhere in the UDS. Do not count the time (FTE) of any person who is working on a contract basis where the payment is not for their time worked but rather, is for the activity that they perform. Do not count these activities, *which are important to the provision of comprehensive care to patients,* separately. In addition, count the costs on Table 8A. EHB is likely to identify an exception that you will need to explain.

12. **Where do we report community health workers that we employ?**
Report staff with responsibility as a community health worker on Line 27c.

13. **Where do we report providers whose only activity at a visit is medication-assisted treatment?**
Report this activity on the line of the credentialed staff providing this treatment (i.e., the physicians are counted in medical [Lines 1-8], even if they are only providing substance abuse services at the visit). Do not count on substance abuse line.

FAQs for Table 5A

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

2. **Are we to reflect FTE or whole numbers to report persons on Table 5A?**
Unlike Table 5, where you report staff FTEs, report persons on Table 5A in Columns A and C based on their *year-end* employment status. Regardless of whether the person works a full- or part-time schedule or works for the full year or part of the year, report them as one person if they were part of your workforce on December 31.

FAQs for Table 5A continued

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

4. **We received our health center funding/designation status in 2017, should we count months of tenure as of the date of funding/designation?**
   Months of tenure are not limited to the start of funding or designation, or even to the calendar year. Count months of tenure from when the person started working for the health center in their current position. For example, count a family physician first employed at the health center on January 15, 2014 as having 48 months' tenure, even though funding or designation occurred in 2017. If someone had a gap in employment, exclude the time prior to the gap. Round months up to the nearest whole number for reporting purposes.

5. **If we report staff on Table 5 for a particular line, should we report this same staff on the corresponding line of Table 5A?**
   Not necessarily. Although all staff included on Table 5A will also appear on Table 5, the reverse is not always true. In cases where someone stopped working at the health center before the last day of the reporting year, do not count him or her on Table 5A. For example, if the chief executive officer left your health center in November, you would not report them on Table 5A because they were not there at the end of the year, but you would report the calculated FTE on Table 5.

FAQs for Table 6A

1. **Are there changes to this table?**
   Yes. Some diagnosis and service codes have been updated.

2. **If a case manager or health educator serves a patient who, for example, has diabetes, we often show that diagnostic code for the visit. Should we report this on Table 6A?**
   No. Report only visits with medical, dental, mental health, substance abuse, and vision providers on Table 6A. Note that diagnoses are generally limited to those professionals in the specific area of expertise.

3. **The instructions call for diagnoses and services at visits. If we provide the service but it is not counted as a visit (such as an immunization given at a health fair), should it be reported on this table?**
   Do not count services given at health fairs, regardless of who provides the service or the level of documentation that is done. *Count the visit* if a service is provided *because of a prescription or plan from an earlier counted visit*. For example, count it if a provider asks a woman to come back in four months for a mammogram. However, do not count it if the service is a self-referral where no clinical visit is necessary or provided (such as an HIV test at a health fair or a senior citizen coming in for a flu shot).

4. **Some diagnostic and/or procedure codes in our system are different from the codes listed. What do we do?**
   It is possible that information for Table 6A is not available using the codes shown because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes other than the

FAQs for Table 6A continued

normal CPT code for state billing purposes (e.g., EPSDT) or (b) internal or state confidentiality rules mask certain diagnostic data. The following table provides examples of problems and solutions:

Line #	Problem	Potential Solutions
1	HIV diagnoses are kept confidential and alternative diagnostic codes are used	Include the alternative codes used at your center on these lines as well
23	Pap tests are charged to a state BCCCP using a special code	Add these special codes to the other codes listed
26	Well child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y, or Z)	Add these special codes to the other codes listed and count all such visits as well. Do not count EPSDT follow-up visits in this category.

FAQs for Table 6A continued

5. The instructions specifically say that the source of information for Table 6A is "billing systems or HITs." There are some services for which we do not bill and/or for which there are no visits in our system. What do we do?

Do not count referrals for which you do not pay (e.g., sending women to the County Health Department for a mammogram). Although health centers are only required to report data derived from billing systems or HITs, the reported data may understate services in the circumstances described below. In today's EHRs, virtually all of these diagnoses and/or services should be captured in one of the templates available. To more accurately reflect the level of service, use other codes in their system to enable the tracking.

Line #	Problem	Potential Solutions
21	HIV tests are collected by us, but processed and paid for by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge.
Multiple	Tests (such as HIV tests, Pap tests, etc.) are ordered and collected by us, and we send it to a reference lab for processing, but the lab bills Medicaid or Medicare directly.	Preferred: Use the correct code, but show a zero charge.
22	Mammograms are paid for but are conducted by a contractor and do not show in the billing system for individual patients.	Preferred: Use the correct code, but show a zero charge. Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid for by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but show a zero charge.
24	Flu shots and other vaccinations are not counted because the vaccines are obtained at no cost to the center.	Preferred: Use the correct code, but show a zero charge.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a Z30- diagnosis or ICD V25- attached to it.	Preferred: Add a "dummy code" you can map to the Z30- or V25- code. Alternative: Code with both the Z30- (or V25-) and the state-mandated code, but suppress printing of the Z30- or V25- code. Take care not to count the same visit twice.

6. **Are we required to report all diagnoses and services rendered during a visit?**
   Yes and No. No, because there are a large number of diagnoses that may be used but not reported on Table 6A. Yes, because documentation and reporting of all diagnoses (not just primary diagnosis) and services rendered during all UDS-countable visits is required. It is important that you appropriately document the breadth of comprehensive services delivered during each visit, including documentation of behavioral health services provided during a medical visit (e.g., screening, brief intervention, and referral to treatment [SBIRT] and/or treatment and counseling for mental health and/or substance use disorders).

7. **What happens if the CPT or ICD-10-CM codes change again?**
   The codes are reviewed annually by the UDS Support Center staff. If you think that there is a CPT, ICD, ADA code for a measure that is not being reflected in the list, contact the UDS Support Center at udshelp330@bphcdata.net. Staff will review the code(s) with BPHC and incorporate approved changes to codes in the manual for future reporting.

FAQs for Table 6B

1. **Are there any changes to the table this year?**
   Yes, the specifications for the clinical measures reported have been revised to align with the Centers for Medicare and Medicaid Services' electronic-specified Clinical Quality Measures (e-CQMs). The quality of care measures are aligned with the e-CQMs for Eligible Professionals January 2017 Addendum eReporting update for the 2017 reporting period. (Although there are other updates available, they should not to be used for the 2017 reporting.)

2. **A child came in only once during the year for an injury and never returned for well childcare. If her record is selected for the immunization measure sample, do we have to consider her chart to not have met the measurement standard?**
   Yes. After a patient enters a health center's system of medical care, the center is expected to be responsible for providing all needed preventive health care and/or document that s/he has received it.

3. **What if a woman we treat for hypertension and diabetes goes to an Ob/Gyn in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not do Pap tests?**
   After the patient has been seen in your clinic, you are responsible for providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to coordinate care and document Pap test results by contacting providers. Consider the woman as part of your universe if she received *any* medical visit(s) in the measurement year. If there is no copy of the results of her Pap test included in her chart, consider this as not having met the measurement standard.

4. **If we pull a record during our sampling process for a woman who we sent to the health department for her Pap test but the results are not posted, can we call the health department, get the results, post them, and then count the record as having met the measurement standard?**
   The health center should obtain a copy of her test result to include in the patient's record for future care. However, the record has not met the measurement standard for the reporting year (although the record may now be valid for successive years depending on when the test was performed) since the information was not obtained during the reporting year (it was obtained at time of sample).

FAQs for Table 6B continued

5. **If we inform parents of the importance of immunizations but they refuse to have their child immunized, may we count the record as having met the measurement standard if the refusal is documented?**
   No. A child is fully immunized only if there is documentation that the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, or history of illness.

6. **Are parents required to bring to the health center documentation of childhood immunizations received from outside the health center?**
   Parents are encouraged to provide documentation of immunizations that their children receive elsewhere, but other mechanisms of obtaining this information are also acceptable. Document childhood immunizations by contacting providers of immunizations directly to obtain documentation by fax, to request health center patients mail a copy of their immunization history, through receipt of payment for the vaccine from the pharmacy, to find the child in a state or county immunization registry, or through other appropriate means.

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

8. **We want to use these reviews to compare our sites and our providers to one another. As a result, we would like to sample using a larger universe. Is there any problem with this?**
   Yes. A sample size of 70 charts must be used. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. A health center *may* draw a larger random sample and use only the first 70 for UDS reporting, but the larger sample must be a random sample of the entire organization—do not over-sample specific sites or providers to facilitate internal QI activities.

9. **Is the Pap test review for women starting at age 21 or at age 23?**
   For this measure, look only at women who were 23 years through age 64 at some point in the measurement year. Do not look at any women who were 21 or 22 years old at the end of the measurement year. Because the measure asks about Pap tests *administered* in 2017, 2016, or in 2015, it is possible that a 23 year-old woman would have been 21 in 2015. If she received a Pap test in that year, she would be considered to have met the measurement standard. Although you look only at women who are 23 through 64, their qualifying test may have been done when they were 21 through 64.

10. **Does "counseling for nutrition and ... physical activity" have specific content that must be provided? Does it need to be provided if the child is within the normal range?**
    No, the counseling has no specific required content. It is tailored by the clinician given the patient's BMI percentile.

    However, yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for *all* children and adolescents.

FAQs for Table 6B continued

Starting children and adolescents off right is important in efforts to improve long-term health outcomes and quality of life.

11. **For adult patients, our protocol calls for a weight to be measured at every visit, but for height to be measured "at least once every two years." Is this acceptable?**
BMI is calculated from current height and weight. Since height in adults does not normally change more than a quarter of an inch in a two-year period, it is reasonable to follow such a protocol if your clinical staff has approved it.

12. **The measure says that there must be intervention for tobacco users. What specific interventions must be used?**
The system defines a broad range of counseling and pharmacotherapy for this measure, which is at the discretion of the clinicians.

13. **If our provider documents that they felt maintaining a dust-free environment and a diet low in allergens coupled with a "rescue inhaler" is adequate to treat a patient with persistent asthma, can we consider this patient's treatment to have met the measurement standard?**
No. For persistent asthma, one of the listed pharmacologic interventions is required. Rescue inhalers are not sufficient to meet the requirement of a pharmacologic intervention.

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

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

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

17. **Do DNA colorectal cancer screening tests meet the measurement standard for the colorectal cancer screening measure?**
No. DNA colorectal cancer screening tests (Cologuard) do not meet the standard for colorectal cancer screening measure.

18. **What should we do if we do not have adequate documentation about the tooth on which a sealant was placed?**
In these situations, pull 70 patient charts using a random sample and have the reviewer evaluate the chart records to find evidence for the sealant being applied to a permanent first molar. If the tooth descriptor (tooth number) is undocumented and there is insufficient documentation to determine whether at least one of the sealant(s) was placed on a permanent

FAQs for Table 7 continued

first molar, the record will not be included in the numerator and may lower the overall measure score (percentage).

19. **If a newly diagnosed HIV patient dies before they receive treatment, do we count them in the HIV measure?**
Yes. Include the patient in the denominator (universe) assuming they met the diagnosis criteria, but if they died before receiving the first visit for initiation of treatment, do not count them in the numerator.

FAQs for Table 7

1. **Are there any changes to the table this year?**
Yes. The specifications for the clinical measures reported have been revised to align with the Centers for Medicare and Medicaid Services' electronic-specified Clinical Quality Measures (e-CQMs). The quality of care measures are aligned with the e-CQMs for Eligible Professionals January 2017 Addendum eReporting update for the 2017 reporting period. (Although there are other updates available, they are not to be used for the 2017 reporting.)

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

3. **Data are requested by race and Hispanic or Latino ethnicity. How are these to be coded?**
Code race and Hispanic or Latino ethnicity on this table in the same manner coded on Table 3B. Refer to instructions for Table 3B for further information. Care should be taken to ensure the same information is recorded in both the medical chart and the registration form to avoid errors.

4. **Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**
The health center is required to have HbA1c test results in patient charts. If the health center does not perform the test, contact the provider who performed tests. The documentation can be by fax, by requesting that the patient mail a copy of test results, or through other appropriate means. Do not ask patients to return to the center just to provide test results; however, failure to document results means that the patient does not meet the measurement standard.

5. **We want to use these reviews to compare our sites and our providers to one another. As a result, we would like to use a larger universe. Is this permitted?**
No. A sample size of 70 charts must be used. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. A health center *may* draw a larger random sample and use only the first 70 for UDS reporting, but the larger sample must be a random sample of the entire organization—do not over-sample specific sites or providers to facilitate internal QI activities.

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

FAQs for Table 8A continued

ethnicity may be different from the mother.

7. **How do we report miscarriages and pregnancy terminations?**
   Report all pregnant women in your (direct or by referral) prenatal care program on Table 6B, but report only those women who deliver on Table 7. Consider a still-birth to be a delivery for purposes of reporting in column 1a, but do not report the baby in columns 1b, 1c, or 1d.

8. **How do we determine 'active diagnosis' that is required for some measures?**
   Patient health records frequently contain a "problem list," a list of "active diagnoses, or lists by other names. When and if a provider considers a diagnosis to no longer be active, it is removed from the list. Any diagnosis on the list for part or all of the measurement year is considered active.

FAQs for Table 8A

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

2. **How do we account for donated services?**
   If a provider comes to your health center and renders a service to your patients, show both the FTE (on Table 5) and the value, which is determined by "what a reasonable person would pay" *for the time* (not the service), on Table 8A, Line 18. For example, if an optometrist sees five patients in a two-hour period, show as the amount what you would pay an optometrist for two hours of work, not the total charges for the five visits.

   However, if you refer a patient for a service to a provider outside of your site who donates these services *do not report the charge or the value of the time or service on the UDS*. For example, if you refer a patient to the county hospital for a hip replacement that is provided to your patient at no cost to you or the patient, do not report the time of the surgical team or the UCR charge for the service on the UDS.

3. **How do we account for donated drugs?**
   If drugs are donated directly to the health center, which then dispenses them to a patient, calculate and report on Line 18 the value of the drugs is *at what a reasonable payer would pay for them*. This is NOT the retail cost of the drug; it is the 340(b) price of the drug—an amount that is generally 40 percent – 60 percent of the average wholesale price (AWP). *Technically,* if the drug is donated directly to the patient, even though it may be sent to the health center, this is not a donation to the center and you do not need to report it. However, since we are interested in knowing the total value of supplies provided to the health center *directly or indirectly*, we encourage you to include the value on Line 18.

4. **We get most of our vaccines through Vaccines for Children (VFC) or other state and county programs. Are these considered donated drugs and accounted for here?**
   Yes. Report the value of donated drugs that are used in the clinic, such as vaccines, on Table 8A, Line 18, again at the reasonable cost.

5. **My doctors were paid the EHR Incentive Payments directly by CMS. If we let them keep some or all of these dollars, are they reported anywhere on Table 8A?**
   Yes. Establish reporting mechanisms whereby your providers inform you of payments received and account for these funds. If providers are permitted to retain some or all of these funds, report the amount on Line 1. In addition, report the Meaningful Use EHR payments received from Medicare or Medicaid on Table 9E on Line 3a.

FAQs for Table 8A continued

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

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

8. **Why do our financial statements not tie to the UDS financials?**
   The UDS financials (Tables 8A, 9D, and 9E) will not tie to your financial statements for the following possible reasons:

   (1) If the fiscal year is not January 1 – December 31,

   (2) Out-of-scope activities will be in your financial statements but must not be included in the UDS,

   (3) Tables 9D and 9E are on a cash basis, not accrual, and

   (4) Contributed services are not shown as income or as expenditure as they would be in an audit.

FAQs for Table 9D

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

2. **How should charges and collections for patients enrolled in an indigent care program be handled?**
   Report such charges on the self-pay Line 13, Column A. Do not report payments received from state or local indigent care programs subsidizing services rendered to the uninsured on this table. Report these payments, whether made on a per visit basis or as a lump sum for services rendered, are recorded on Table 9E on Line 6a. See Table 9E for specific instructions. If you receive payments from state/local indigent care programs that subsidize services rendered to the uninsured:

   - Report all charges for these services (Column A) and the collections *from patients* as "self-pay" (Column B, Line 13 of this table);
   - Report all amounts not collected from the patient as sliding discounts (Column E) or bad debt (Column F), as appropriate, on Line 13 of this table;

     Note: Report as bad debt only the amount the patient was responsible for and failed to pay.

   - Report collections from the state/local indigent care programs on *Table 9E on Line 6a*.

3. **Are the data on this table cash- or accrual-based?**
   Table 9D is a "cash" table. Entries represent gross charges and adjustments for the reporting calendar year and actual cash receipts for the year.

4. **Should the lines of the table "balance?"**
   No. Normally charges (Column A) minus collections (Column B) minus adjustments (Columns D+E+F) will not equal zero. Because the table is on a "cash" basis, the columns for amount collected and for allowances will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will be

FAQs for Table 9D continued

remaining in accounts receivable at the end of the year. The one exception is on the capitated lines (Lines 2a, 5a, 8a, and 11a) where allowances are defined in the UDS to be the difference between charges and collections, provided there are no early or late capitation payments that cross the calendar year.

5. **If we have not received any reconciliation payments for the reporting period, what do we show in Column c1 (current year reconciliations)?**
Since you only report current *reconciliations* in Column c1 enter zero (0).

6. **We regularly use our sliding discount program to write-off the co-payment portion of the Medicare charge for our certified low-income patients. The sliding discount column (Column E) is blanked out for Medicare. How do we record this write-off?**
Remove the amount of the co-payment from the charge column of the Medicare line (Lines 4–6, as appropriate) and then add into the self-pay line (Line 13). It can then be written off as a sliding discount on Line 13. Use the same process for any other co-payment or deductible write-off.

7. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Must we, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**
Yes—regardless of whether or not it is done automatically by your PMS/HIT/EHR, reflect this reclassification of charges that end up being the responsibility of a party other than the initial party. (As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred.)

8. **How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?**
We discuss this at length in Appendix B, page 166. In general, report the full charge in Column A by payer. Then, show the amount received from the patient (on Line 13) or insurance company (on Line 10) in Column B. Report the amount that is written off for an insurance company in Column D. Report the amount written off for a patient as a sliding discount in Column E.

9. **How should we report the charges associated with 'G-codes'?**
G-codes specify a reimbursement rate associated with a package of services that your health center has described to Medicare. (Similar amounts may be paid to you by other third-party payers as well.) For UDS, report in:

   - Column A: The sum of actual fee schedule/CPT-related charges for visits
   - Column B: What your health center received for payment
   - Column D: The difference between charges and the amount received

   Remember to reduce the charges by the Medicare co-payment (20% of the allowable charge) and, the payment from Medicare will be similarly adjusted. See discussion of reclassifying co-payments.

   Note: If both the actual charge and the G-code charge are routinely used in your system, you can remove the G-code charges by running a report to get the total for G-code charges for the year and then subtracting this number from the total charges (actual + G-code) and report the difference in Column A.

FAQs for Table 9E

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

2. **Are there any important issues to keep in mind for this table?**
   This table collects information on cash receipts for the reporting period that supported activities described in the scope of project covered by any of the four BPHC grant programs, the FQHC Look-Alike program, or the BHW Primary Care Clinics program. Report only cash receipts received during the calendar year. In the case of a grant, this amount equals the cash amount received during the year not the award amount unless the full award was paid/drawn down during the year.

3. **How should we report indigent care funds?**
   Report payments received from state or local indigent care programs subsidizing services rendered to the uninsured (including patients covered by a tribes 638 funds) on Line 6a of Table 9E whether or not the actual payment to the health center is made on a per visit basis or as a lump sum for services rendered.

   Report patients covered by these programs as uninsured on Table 4.

   Report all charges, self-pay patient collections, sliding discounts, and bad debt write-offs on the self-pay line (Line 13) on Table 9D.

   Report monies collected from the patients covered by indigent programs on Table 9D. However, do not report funds reported on Line 6a of Table 9E on Table 9D.

Appendix B: Special Multi-Table Situations

Several conditions require special consideration in the UDS because they affect multiple tables that must then be reconciled. This appendix presents some of these special situations, along with instructions on how to deal with them, including:

- Contracted care (specialty, dental, mental health, etc.) that is paid for by the reporting health center
- Services provided by a volunteer provider
- Interns and residents
- WIC
- In-house pharmacy or dispensary services for health center's patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Donated drugs
- Clinical dispensing of drugs
- Adult Day Health Care (ADHC)/Program of All-inclusive Care for the Elderly (PACE)
- Medi-Medi cross-overs
- Certain grant-supported clinical care programs (BCCCP, Title X, etc.)
- State or local safety net programs
- Workers' compensation
- Tricare, Trigon, Public Employees Insurance, etc.
- Contract sites
- CHIP
- Carved-out services
- Migrant voucher programs and other voucher programs
- Incarcerated patients
- New start or new access point
- Relationship between staff on Table 5 and costs on Table 8A
- Relationship between race and ethnicity on Table 3B and Table 7

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

Contracted care is services paid for by the health center.

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

Services Provided by a Volunteer Provider

Volunteers are not paid by the health center for services, which they provide on-site.

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

Tables Affected	Treatment
5	**Column A: Provider FTE** – Report FTE for services provided on site at health center's clinic. FTE must be calculated. Use hours volunteered as the numerator. Because volunteers do not receive paid leave benefits, the denominator is the number of hours that a comparable employee spends performing their job. Reduce a full-time schedule of 2080 hours (for example) by vacation, sick leave, holidays, and continuing education normally provided to employees. As a rule, use hours worked divided by a number somewhere around 1800. Do not count providers who provide services at their own offices. **Column B: Clinic Visits** – Count visits only for services provided at a site in the health center's scope of service and under its control.
6A	Count diagnoses and/or services provided on site, as applicable.
8A	**Column C, Line 18** – Show the value of the time donated by volunteers on this line *only*.
9D	The charges for their services are treated exactly the same as for staff if the provider is on-site. Do not include charges for volunteer providers who are off-site.

Interns and Residents

Health centers often make use of people who are in training, referred to variously as students, interns, or residents, depending on their field and their licensing. Medical residents are generally licensed practitioners. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing.

Tables Affected	Treatment
5	**Column A:** Count licensed interns and residents in their credentialing category they are w*orking toward*. For example, count a family practice resident on Line 1 as a Family Physician. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the health center) or like a volunteer (if they are not being paid). See volunteer providers, immediately above. **Column B:** Record visits between a medical resident and a patient as visits *to that resident or intern. Do not credit the visits to the supervisor of the resident or intern under any circumstance*. Count visits of a *licensed* mental health provider on Lines 20a, 20a1, 20a2, or 20b. Count unlicensed mental health providers on Line 20c.
8A	*If the intern or resident is paid by the health center* ***or*** their cost is being paid through a contract that pays a third-party for the interns or residents, show the cost in Column A on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the health center is not paying an intern, resident or third-party, report the *value of the donated time* on Line 18. Be sure to describe the nature of the donation on the table.

Women, Infants, and Children (WIC)

Tables Affected	Treatment
3A, 3B, 4	Do not count clients whose only contact with the health center is for WIC services and who receive no other services listed on Table 5 from providers outside of WIC. Do not count as patients anyone whose only health center contact is for WIC nutritional, health education, or enabling services
5	**Count staff (Column A) o**n Line 29a. **Do not report visits and patients (Columns B and C).**
8A	**Column A: Net costs**—Include the total cost of the program on Line 12 in Column A. **Column B: Facility and non-clinical support services**—Since much of the non-clinical support services cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.

Tables Affected	Treatment
9D	Do not report anything associated with the WIC program.
9E	Income for WIC programs, though originally federal, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center is receiving WIC funds from a state government, the grant/contract funds received go on Line 6. Report funds from an intermediary on Line 8.

In-house Pharmacy or Dispensary Services for Health Center's Patients

Including only that part of the pharmacy that is paid for by the health center and dispensed by in-house staff (see below for other situations)

Tables Affected	Treatment
5	**Column A: Staff** —Report pharmacy staff on Line 23. If they have only an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs (PAPs), include them on Line 23. Include clinical pharmacists on Line 23 even if they spend time outside of the pharmacy. Report staff members other than pharmacists who spend time with PAP programs on Line 27a, Eligibility Assistance. **Column B: Visits** —The UDS does not count interactions with pharmacy staff as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for clinical pharmacists as well.
8A	**Line 8b, Column A: Pharmaceutical Direct Costs** —Place the actual cost of drugs the pharmacy bought on Line 8b. Include the cost of vaccines, birth control pills, injectable antibiotics, and other drugs dispensed in the clinic and not in a pharmacy on line 8b. The value of donated drugs is not reported here. Do not report the value of donated drugs here; that amount is reported on Line 18 in Column C. **Line 8a, Column A: Other Pharmacy Direct Costs** — Show all other operating costs of the pharmacy on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. **Line 11e, Column A: Eligibility Assistance Direct Costs** — Show (on Line 11e) the cost of staff (full-time, part-time, or allocated time) helping patients to become eligible for PAPs and all related supplies, equipment depreciation, etc. **Column B: Facility and Non-clinical Support Services** — Report all facility and non-clinical support services costs associated with pharmacy and pharmaceuticals (Lines 8a and 8b) on Line 8a. Although there may be some facility and non-clinical support services cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. **Column C, Line 18:** Show the value of donated drugs (generally calculated at 340(b) rates) on this line only.

Tables Affected	Treatment
9D	**Column A: Charge** is the health center's full retail charge for dispensed drugs. **Column B: Collection** is the amount received from patients or other third-parties/insurance companies. **Column D: Allowance** is the amount a third-party disallows for the charge (if on Lines 1–12). **Column E: Sliding Discount** is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge, minus amount collected from patient, minus amount owed by patient as their share of payment.
9E	Do ***not*** report the value of donated drugs on this table—report on Table 8A, Line 18 (see above). The charges for drugs dispensed to patients go on Table 9D, not this table.

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

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center patients. Careful records must be maintained at these pharmacies to ensure that non-patients do not receive drugs purchased under section 340(b) provisions. Some of these pharmacies are totally in-scope, while others have their "public" portion out of scope. If the public aspect is "out of scope," do not report its activities on the UDS. If it is in scope, treat the public portion as an "other activity" as follows:

Tables Affected	Treatment
5	**Column A: Staff**—Report allocated public portion of staff on Line 29a: Other Programs and Services.
8A	Report all related staff and pharmacy costs, including cost of pharmaceuticals, on Line 12: Other Related Services.
9E	Report all income from public pharmacy on Line 10: Other, and specify from "Public-access Pharmacy."

Contract Pharmacy Dispensing to Clinic Patients, Generally Using 340(b) Purchased Drugs

Tables Affected	Treatment
5	Do not report staff, visits, or patients for pharmacy dispensing. Report PAP staff under enabling services on Line 27a: Eligibility Assistance Workers.
8A	**Report the amount the pharmacy charges** for "managing dispensing" of drugs on Line 8a. **Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy** on Line 8b. **If the pharmacy buys prepackaged drugs,** and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs will go on Line 8a in Column B, even though Line 8a Column A is blank. **Report payments to pharmacy benefit managers** on Line 8a. **Share of profits:** Some pharmacies engage in fee splitting and keep a "share of profit." Report this as a payment to the pharmacy on Line 8a.
9D	**Charge (Column A)** is either the health center/contract pharmacy's full retail charge for the drugs dispensed or, if retail is unknown, the amount charged by the distributer/pre-packager. **Collection (Column B)** is the amount received from patients or insurance companies. Health centers must identify and report this amount. (***Note:*** Most health centers do not have this sort of arrangement for Medicaid patients, unless explicitly stated.) **Allowance (Column D)** is the amount disallowed by a third-party for the charge (if on Lines 1–12). **Sliding Discount (Column E)** is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge (or pharmacy charge), minus amount collected from patient (by pharmacy or health center), minus amount owed by patient as their share of payment.
9E	Do not report pharmacy income on Table 9E, and do not use Table 9E *to show net income from the pharmacy*. Report actual gross income on Table 9D.

Donated Drugs, Including Vaccines

Tables Affected	Treatment
8A	*If the drugs are donated to the health center, and then dispensed to patients,* show their value (generally calculated at 340(b) rates) on Line 18, Column C. *If the drugs are donated directly to the patient*, the health center is not required to report the value of the drugs; however, it is preferred that the value be included for a better understanding of the program.
9D	If the health center charges patients a dispensing fee, show this amount (only) and its collection and/or write-off.
9E	Do not show any amount, even though generally accepted accounting principles (GAAP) might suggest another treatment for the value.

Clinical Dispensing of Drugs

Clinic areas of health centers dispense many pharmaceuticals, including vaccines, allergy shots, contraceptives, and drugs used in medication-assisted treatment of opiate use. This may be a service associated with the visit or, in the case of vaccinations, a community service. These services do not count as a visit, but charging patients for them is appropriate unless the clinic received the drugs for free.

Tables Affected	Treatment
3A, 3B, 4	Do not count these people as patients if this is the only service they received during the year.
5	Do not count these services as visits.
6A	Do not count these on Table 6A; they are not visits.
8A	Report drug costs on Line 8b – pharmaceuticals (*not* on Line 3, other medical costs). In the case of vaccines obtained at no cost through Vaccines For Children or other state or local programs, report the value on Line 18: Donated Services and Supplies.
9D	Report full charges, collections, allowances, and discounts, as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated, though an administration and/or dispensing fee is appropriate. Note that Medicare has separate flu vaccine rules.
9E	Do not show any amount, even though GAAP might suggest another treatment for the value.

Adult Day Health Care (ADHC) and the Program of All-inclusive Care for the Elderly (PACE)

Medicare, Medicaid, and certain other third-party payers often recognize ADHC programs. They involve caring for an infirm, frail, elderly patient during the day to permit family members to work, and to avoid the institutionalization of, and preserve the health of, the patient. They are quite expensive and may involve extraordinary per member per month (PMPM) capitation payments, but are cost effective compared to institutionalization. Patients who have both Medicare and Medicaid coverage are treated as Medi-Medi, as described below. The PACE program is even more expansive and may include ADHC services, as well as additional services to maintain independence for the elderly.

Tables Affected	Treatment
5	When a provider does a formal, separately billable, examination of a patient at the ADHC/PACE facility, treat as any other medical visit. Do not count the nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service as a visit for the purposes of reporting. Staff are included on Line 29a, Other Programs and Services.
8A	If the health center provides and bills medical services separately from the ADHC charge, the associated costs are on Lines 1–3. Report all other costs on Line 12. Similarly, include PACE costs over and above medical and pharmacy costs on Line 12.
9D	Report ADHC charges and collections on this table, generally as Medicaid and/or Medicare. Because of FQHC procedures, it is possible that there will also be significant positive or negative allowances. In addition, see Medi-Medi below.

Medi-Medi/Dually Eligible

Some individuals are eligible and enrolled in both Medicare and Medicaid (commonly referred to as Medi-Medi or Dually Eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC/geographic rate) fee, the remainder is billed to Medicaid, which pays an amount based on policy that varies from state to state.

Tables Affected	Treatment
4	Report patients on Line 9, Medicare. Do not report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare.
9D	While initially the entire charge shows as a Medicare charge, after Medicare makes its payment the remaining allowable amount is reclassified to Medicaid. Report the payment received from Medicaid on Line 1 in Column B. Show the difference between the charge and the collection as a positive or negative allowance, depending on the amount.

Certain Grant-supported Clinical Care Programs: BCCCP, Title X, etc.

Some programs pay providers on a fee-for-service or fee-per visit basis under a contract, which may or may not also have a cap on total payments per grant period – usually the state fiscal year. They cover a very narrow range of services. Breast and Cervical Cancer Control and Family Planning programs are the most common, but there are others.

These are fee-for service or fee-per-visit programs only.

Tables Affected	Treatment
4	These programs are *not* insurance. They pay for a service, but health centers must classify the patient according to their primary health insurance carrier. Most of these programs do not serve insured patients, so report most of the patients on Line 7 as uninsured.
9D	While the patient is uninsured, there is an "other public" payer for the service. Report the clinic's usual and customary charge for the service (*not* the negotiated fee paid by the public entity) on Line 7 in Column A, and the payment in Column B. Because the payment will almost always be different from the charge, show the difference as an allowance in Column D.
9E	Do not show the grant or contract covering the fee-for-service or fee-per-visit amount on *Table 9E*. Fully account for this on Table 9D.

State or Local Safety Net Programs

These pay for a wide range of clinical services for uninsured patients, generally those under an income limit. They may pay based on a negotiated fee-for-service or fee-per-visit. They may also pay "cents on the dollar" based on a cost report, in which case they are generally referred to as an uncompensated care program. Most of these programs set payment caps, and often make payments in a different fiscal year.

Tables Affected	Treatment
4	While patients may need to qualify for eligibility, these programs are not public insurance. Count patients on Line 7 as uninsured unless they have insurance.
9D	The health center's usual charges for each service are charged directly to the patient (reported on Line 13, Column A). If the patient pays any co-payment, report it in Column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it is collected or is written off as a bad-debt in Column F. Report the rest of the charge (or all the charge if there is no required co-payment) as a sliding discount in Column E.
9E	Report the total amount received during the calendar year from the state or local indigent care program on Line 6a.

Workers' Compensation

Workers' Compensation is a form of liability insurance for employers, not a health insurance for employees.

Tables Affected	Treatment
4	If Workers' Compensation covers a patient's bills, the patient usually has related insurance. Report that on Table 4 even if the health center is not billing the insurance). Patients with work-related insurance go on Line 11 (Private). Those without any health insurance go on Line 7 (Uninsured).
9D	Report charges, collections, and allowances for Workers' Compensation-covered services on Line 10 (Private Non-Managed Care).

Tricare, Trigon, Public Employees Insurance, Etc.

Many government employees have insurance.

Tables Affected	Treatment
4	Report them on Line 11 (Private), *not on Line 10a*.
9D	Report charges, collections, and allowances on Lines 10–12 (Private), *not on Lines 7–9*.

Contract Sites

In-scope sites in schools, workplaces, jails, etc.

Some health centers have **included in their scope of service** a site (such as a school, workplace, or jail) where they provide services to patients at a contracted flat rate per session or other similar rate *that is not based on the volume of work performed*. The agreement generally stipulates whether and under what circumstances the clinic may bill third-parties.

Tables Affected	Treatment
4	**Lines 1–6 - Income:** Get income from patients. In prisons, assume that all are below poverty (Line 1). In schools, income should be that of the parent or "unknown" or, in the case of minor consent services, below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). **Lines 7–12 - Insurance:** Record the form of medical insurance the patient has, regardless of the clinic's ability to bill that source. (Medicaid often covers children in school-based clinics even though they have another provider. Show these children as Medicaid patients.) The clinic's contracting agency is not an insurer. (Schools and jails are not "other public insurance.") *Except for confidential minor consent services, it is not acceptable to report a student as uninsured.*
5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
8A	Costs will generally be considered medical (Lines 1–3) unless other services (mental health, case management, etc.) are being provided. *Do not report on Line 12: Other Related Services.*
9D	*Unless the clinic charges a visit to a third-party such as Medicaid,* report the clinic's usual and customary charges on Line 10, Column A (Private). Show the amount paid by the contractor in Column B. Report the difference (positive or negative) in Column D (Allowances).
9E	*Do not report contract revenue on Table 9E.*

CHIP

The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Tables Affected	Treatment
4	**Medicaid:** If Medicaid handles CHIP and the enrolled patients are identifiable, report them on Line 8b. *If it is not possible to differentiate CHIP from regular Medicaid,* report the enrolled patients on Line 8a with all other Medicaid patients. **Non-Medicaid:** Report CHIP-enrolled patients in states that do not use Medicaid as "Other Public CHIP" on Line 10b. Do not report the enrollees on Line 11 (Private) even if a commercial insurance plan administers the program.
9D	**Medicaid:** Report on Lines 1–3, as appropriate. **Non-Medicaid:** Report on Lines 7–9 (Private), as appropriate. *Do not report on Lines 10–12 (Other Public), even if a commercial insurance company administers the plan.*

Carve-Outs

Relevant to capitated managed care only: The health center has a capitated contract with an HMO that stipulates that one set of CPT codes will be covered by the capitation, regardless of service frequency, and another set of codes (or all other codes) the HMO will pay for on a fee-for-service basis (the carve-outs) when appropriate. Most common carve-outs involve mental health, lab, radiology, and pharmacy, but may include specific specialty care or diagnoses (e.g., perinatal care or HIV).

Tables Affected	Treatment
4	**Patient Member Months:** Member months are reported on Line 13a in the appropriate column, regardless of whether or not the patient made use of services in any or all of those months. *Make no entry on Line 13b (fee-for-service managed care member months) for the carved out services, regardless of payments received.*
9D	**Lines 2a/b, 5a/b, 8a/b, 11a/b:** Report capitation payments on the "a" lines and carve-out payments on the "b" lines. Report wrap-around payments on both lines using the health center's allocation process.

Incarcerated Patients

Some health centers contract with jails or prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.

Tables Affected	Treatment
4	Assume prisoner income is below poverty (Line 1). Unless the state has arranged for inmate Medicaid enrollment, assume that inmates are uninsured. Classify patients according to their primary health insurance carrier regardless of whether the services will be billed to the insurer. These patients are usually uninsured.
9D	The jail or prison pays for the patient's services. Report the clinic's usual and customary charge for the service on Line 10 (Private) in Column A and the payment in Column B. Because the payment will almost always be different from the charge, show the difference as an allowance in Column D.
9E	Do not show the grant or contract on *Table 9E*. Report fully on Table 9D.

HIT/EHR Staff and Costs

Health Information Technology (HIT), including Electronic Health Record (EHR) systems (some of which have integrated Practice Management Systems) record clinical activities and help clinicians manage and integrate patient services. As such, they are part of a quality improvement program, though some aspects count in other service categories.

Tables Affected	Treatment
5	Include staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service* category they perform these functions for, not as IT staff or quality improvement staff. Report staff members dedicating some or all of their time to design, operation, and oversight of quality improvement systems, data specialists, statisticians, and HIT/EHR or medical form designers as quality improvement staff on Line 29b. Report staff managing the hardware and software of a practice management billing and collection system as non-clinical support staff, under IT, Line 30c.
8A	Report costs for staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service* category they perform these functions for, not as IT staff or quality improvement staff. Report costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the HIT/EHR on Line 3: Other Medical. If the HIT/EHR covers dental and/or mental health, then you may logically allocate some of costs to these lines as well. Report costs for staff noted above as being included in quality improvement on Line 12a. Report costs for staff managing the hardware and software of a practice management billing and collection system as non-clinical support, Line 15.

Issuance of Vouchers for Payment of Services

Voucher programs have traditionally delivered primary and specialty care services to agricultural workers in geographically dispersed areas. Some homeless and other health center programs also use vouchers to outsource care they cannot provide in-house. This involves contracting with providers outside of the health center. Vouchers authorize a third-party provider to deliver the services and the voucher goes to the health center for payment. Payment is generally at less than the provider's full fee, but is consistent with other payers, such as Medicaid.

Tables Affected	Treatment
3A, 3B, 4	**Count patients** even if the only service that they receive is a paid vouchered service, if these services would make the patient eligible for inclusion if the center provided them. A vouchered taxi ride or prescription would not make the patient "countable" because health centers do not count transportation and pharmacy services on Table 5, but a vouchered eye exam does count.
5	**Column A:** There is no way to account for the time of the voucher providers. As a result, report zero FTEs for these services. If there is a provider who works at the center, count the FTE of that provider. For example, count the one-day-a-week family practitioner (FP) as 0.20 FTEs on Line 1. **Column B:** Count all visits covered by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (i.e., a "voucher" to a doctor who donates five visits per week does NOT generate a visit on Table 5).
6A, 6B, 7	**Diagnoses and Services:** The Voucher Program should receive a bill from the provider similar to a HCFA-1500 that lists the services and diagnoses. Health centers should track these and report them on Table 6A, 6B, and 7.
8A	**Cost of Vouchered Services:** Report the costs on the appropriate service line. Report medical vouchers on Line 1, not Line 3. Report *only* those costs paid directly by the health center. **Discounts:** Virtually all clinical providers receive less than their full fee. Some health centers like to report the amount of these discounts as "donated services." *While this is not required*, health centers may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on Line 18, Column C.
9D	**Column A: Charges –** Report the full charge that the provider shows on their HCFA-1500 on Line 13: Self-pay. Do not use the voucher amount as the full charge. **Column B: Collections –** If the patient paid the voucher program or the voucher provider a nominal or other fee, show this in Column B. **Column E: Sliding Discounts –** Show the difference between the full charge and the amount that the patient was *supposed* to pay in Column E. Do not show the full amount in Column E if the patient should have paid the health center or voucher provider but did not. **Column F: Bad Debt –** Show any amount (such as a nominal fee) that the patient was supposed to pay to the health center but did not. Report bad debts according to the health center's financial policies. Do not report amounts that were due to but not paid to the referral provider.

New Start or New Access Point

Health center sites may be added in-scope at any point during the reporting period. Health centers must submit data for the calendar year, so health centers operational prior to the start of the Notice of Award must submit data on all tables with activity covering January 1 to December 31.

Tables Affected	Treatment
ZIP, 3A, 3B, 4	It is understood that a health center may have never collected some of the data required to be reported in the UDS prior to the start of Notice of Award, such as veteran status, gender identity, member months in managed care, etc. Provide the best data available, but for this first year *only*, you may have some unusual numbers. Work with your UDS Reviewer to explain apparent data inconsistencies.
5A	Report how long key staff have been with the health center going back to your founding, not the start date of award. For example, if the CEO has been with the health center for seven years, report seven years of tenure.
6B, 7	When it comes to the clinical measures, you may need to use a sampling process instead of being able to rely on your PMS or HIT/EHR. See Appendix C for details. If the added site or the health center will transition HIT/EHR during the year, gather the information for the year across the two systems, and analyze them in a separate database to remove any duplication in the data.

Relationship between Staff on Table 5 and Costs on Table 8A

Staff classifications should be consistent with cost classifications. The staffing on Table 5 is routinely compared to the costs on Table 8A during the review and analysis process. If there is a reason why such a comparison would look strange (e.g., volunteers on Table 5 resulting in no cost on Table 8A or contractor costs on Table 8A with no corresponding FTEs on Table 5) be sure to include an explanation on Table 8A. The chart below illustrates the relationship between the two tables.

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical providers and clinical support staff	1: Medical staff
13–14: Lab and X-ray	2: Lab and X-ray
16–18: Dental (e.g., dentists, dental hygienists, dental therapists)	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists)	9: Other Professional

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
22a–22c: Vision (ophthalmologists, optometrists, optometric assistants, other vision care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling (e.g., case management, outreach, eligibility)—relationship of the detail follows. Note that the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.	11a–11g: Enabling
24: Case Managers	11a: Case Management
25: Patient/Community Education Specialists	11d: Patient and Community Education
26: Outreach Workers	11c: Outreach
27: Transportation Staff	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Staff	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other programs and services (non-health related services including WIC, job training, housing, childcare, etc.)	12: Other Related Services
29b: Quality Improvement staff	12a: Quality Improvement
30a–30c and 32: Non-clinical support services including patient support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Non-Clinical Support Services
31: Facility (e.g., janitorial staff)	14: Facility

Relationship between Race and Ethnicity on Tables 3B and 7

The patient population for each clinical measure on Table 7 is defined in terms of race and ethnicity and comparisons are made to the race and ethnicity numbers reported on Table 3B. The following table illustrates the crosswalk between the comparable fields across the two tables.

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

Appendix C: Sampling Methodology for Manual Chart Reviews

Introduction

For each measure discussed on Table 6B and 7 (with the exception of the perinatal measures), health centers have the option of reporting on their entire patient population as a universe or selecting a scientifically drawn random sample. To report on the universe, the data source, including an EHR or other HIT, must include a minimum of 80 percent of all medical (or dental for the sealants measure) patients from all service delivery sites and grant-funded programs in the defined universe. In addition, the data source must cover the review period (e.g., 5 years for Pap tests, 2 years for immunizations) and include information to assess meeting the standard with the clinical measure, as well as to evaluate exclusions.

If you can meet all conditions, reporting on the universe – even a reduced universe - generally provides access to pre-programmed tools, which can facilitate you with reporting. Use a reduced universe count only if the factors that led to reduced universe are unrelated to the measure variables (see instructions for Tables 6B and 7). This is not a sample and the methods discussed here are not relevant to these situations.

If the health center cannot report on at least 80 percent of the universe (or chooses not to use its HIT/EHR), a random sample must be used to report. Note that the health center can report on the full universe for some measures, a reduced universe for others, and a sample for still others.

Random Sample

A random sample is a part of the universe where each member of the universe has the exact same chance of inclusion as every other member.

A true random sample generates outcomes similar to those of the universe of patients because the sample is representative.

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

Perform the following steps for each sample. Create a new random sample for each measure.

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

Define the universe for the measure. The universe must:

- Include all active (measurement year) medical patients
- Include all sites in the scope of project
- Include all funding streams
- Include contracted medical services

Identify the number of patients who fit, or who initially appear to fit, the criteria for that measure. (Because you will review each record in the sample, you can remove any that was mistakenly included.) Create a list and number each member of the patient population in the universe. The list may be in any sequence because randomization will remove any order bias.

Step 2: Prepare the correct sample size

BPHC mandates a sample size of 70.

Step 3: Select the random sample

Using one of the two recommended sampling methodologies (see below); identify the sample of 70 charts.

Step 4: Review the sample of records to determine for each record whether it has met the standard for the clinical measure

For each measure, review available data sources to identify any automated sources to simplify data collection. Because health centers augment the automated data fields (if any) for these sources with text and scanned documents, they do not need to be available for all patients. Examples of data sources include:

- Electronic health records
- Disease-specific (PCDEMS, PECs, i2i-track, etc.) databases
- State immunization registries for vaccine histories
- Logs
- Practice management system

For each patient in the sample, determine whether sufficient information is available in these alternative resources to confirm meeting the standard. If you cannot meet the standard using the alternative source, review text and scanned information to retrieve required information. (For example, a woman's chart shows she is an active medical patient, but does not show the CPT or ICD-10-CM code for a Pap test, review scanned documents to see if there is a copy of a Pap test done by another agency in the record.)

Step 5: Replace patients you exclude from the sample

Best practices would dictate that the methodology used to select the sample (or the universe) should be able to test for each required criteria. Some criteria (such as the age of the patient) are easily implemented. Others, such as whether a woman has ever had a hysterectomy, may not be available. When you cannot use criteria to include patients in the universe, you may use them to exclude patients from a sample. If you determine that a record does not meet the standard criteria, remove the case (record). If the review is of a sample of records, then select another record to replace the original.

Replace an excluded record with a substitute. Use the replacement methodology described for the sample selected. Any criteria that was missed in selecting a record (e.g., not noting that the woman had a hysterectomy) may be used to exclude a record.

Methodology for Obtaining a Random Sample

You may use either of the two approved methods for generating a random sample and a sample of replacements for excluded patients:

- Work with a list of random numbers generated for your total patient population.
- Select a random starting point and use a calculated interval to find each next member of the sample.

Use either method to create a "replacement list" to replace records that were excluded during the review process.

Option #1: Random Number List

The preferred method for selecting a random sample is to use a random number list. You can create an individualized list of random numbers at the Randomizer website at https://www.randomizer.org/. The website requires no password or subscription to access. To obtain a list of random numbers, complete the questions as documented below.

Identifying an Initial List

1. Request one list of 70 numbers.
2. Complete the "Number Range" by entering 1 as the first number and the total number of patients in the universe for the particular measure under consideration as "n." For example, if there are 628 children who turn 2 in the reporting year in the universe, enter 628 as n.
3. Click on the button, "Randomize Now!" The site will produce a list of randomly generated numbers. These numbers correspond with the numbered list of patients in the universe prepared in Step 1, above. (It is helpful to ask the site to sort the selected random numbers from lowest to highest.)

Identifying a Replacement

To create a "sample" of records to substitute for excluded records, follow the instructions for creating a list of random numbers for a replacement sample. Rather than selecting 70 numbers for the set, select a smaller sample of 5 to 10 charts. In this instance, do not sort the list because doing so will "bias" the replacement sample toward the lower numbers on the list.

If, upon review, you have to exclude a record from the original random sample of 70, replace it with one from the replacement sample. Because of the need to replace ineligible charts, you may have to exclude more than 70 records to meet the standard for a particular measure, but the final sample will include 70 records that meet all the selection criteria.

Alternatively, you can draw a sample of 80 patients (for example) and use the first 70. If you have to replace one, use the 71st, then the 72nd, and so on. In this instance, do not request a sorted list because it will have a bias toward lower numbers.

Input	Initial Sample	Replacements
Set of numbers	1	1
Number per set	70	At least 5 or more if needed
Number range = 1-n	Last number in sequence	Last sequence number in list
Unique numbers	Yes	Yes
Sort numbers	Yes, least to greatest	No

Option #2: Interval

Identifying an Initial List

Sample Interval Size (SI) = Population Size (number in universe) ÷ Sample Size (70)

The second method uses the same numbered list of records in the universe created in Step 1, above. To generate the sample:

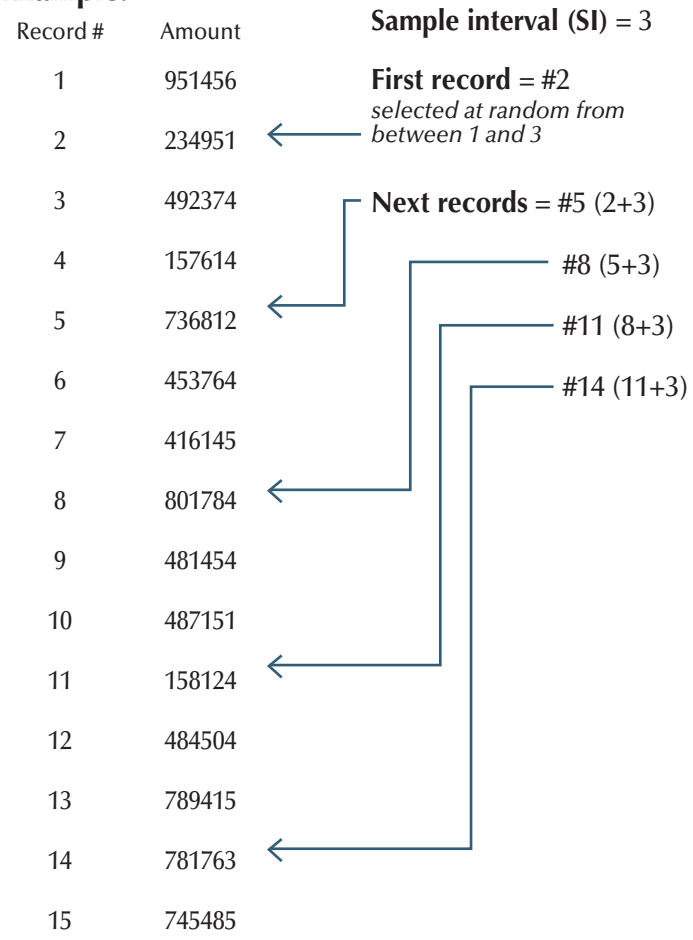
1. Calculate the "sample interval" by dividing the number of records in the universe by 70.
2. Randomly pick a record from the first sampling interval. For example, if the sampling interval is 10, the first sampling interval includes charts number 1 through number 10. Randomly select one record from this interval to use as your first record.

3. Then, select every nth record where n is the sampling interval until you reach the desired sample size. In our example, if the first patient selected is number 8, and the sampling interval is 10, then the remaining patients to be selected are numbers 18, 28, 38, etc.

   First sequence # + SI = second #

4. Continue through list until you have identified all 70.

Example:



Identifying a Replacement

If a selected record needs to be excluded from the sample, return to the original list and substitute the next record on the list after the excluded record. If the replacement record needs to be excluded, select the record after that on the list until an eligible record is selected. Resume selection using the next chart you had pre-selected for the sample. (If you run out of records on the list, continue your count back at the beginning of the universe.) In this manner, more than 70 records may be evaluated for meeting the standard for a particular measure, but include 70 records in the final sample, which meet all the selection criteria.

Identifying Dental Sealants Universe Where Codes and Caries Risk Level Are Unavailable

Under certain situations, you may need to identify a larger number of records to identify the necessary 70 random records. Some health centers may not have used the ADA Dental Risk Assessment codes or may not have tracked caries risk. If so, use these alternative instructions to determine the size of the universe and measure the performance standard.

1. Identify all children age 6 through 9 who had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement year.

2. Review these records to find 70 records where the dental records or other documentation demonstrates the level of caries risk. You may need to have providers retrospectively review the records to determine caries risk based on available diagnostic information at that time if the caries risk level is not in the patient record.

3. Continue to review charts until 70 charts meet the universe criteria (dental patients aged 6 through 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year with moderate to high risk for caries).

4. *Estimate* the size of the universe by:

   a. Dividing the 70 charts that met the universe criteria by the number of records you had to review to find the 70.

   b. Multiplying this result by the total number of children age 6 through 9 who had an oral health visit (the value from step 1). The resulting value will be your estimated universe.

5. Enter the estimated universe in Column A, 70 in Column B, and the number of the 70 who met the performance standard (received a sealant on a permanent first molar tooth in the measurement year).

Appendix D: Health Center Health Information Technology (HIT) Capabilities and Quality Recognition

Instructions

The Health Information Technology (HIT) Capabilities and Quality Recognition Form includes a series of questions on health information technology (HIT) capabilities, including electronic health record (EHR) interoperability and eligibility for Meaningful Use. The HIT and Quality Recognition Form must be completed and submitted as part of the UDS submission. The first part includes questions about the health center's implementation of an EHR, certification of systems, how widely adopted the system is throughout the health center and its providers, and national and/or state quality recognition (accreditation or PCMH).

Questions

The following questions appear in the EHB. Complete them before you file the UDS Report. Instructions for the HIT questions are on screen in EHB as you are completing the form. Respond to each question based on your health center status as of December 31.

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?

   a. Yes, installed at all sites and used by all providers

   b. Yes, but only installed at some sites or used by some providers

   If the health center installed it, indicate if it was in use by December 31, by:

   a) Installed at all sites and used by all providers: For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response a. For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients and does not include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. You may check this option even if a few, newly hired, untrained employees are the only ones not using the system.

   b) Installed at some sites or used by some providers: Select option b if one or more permanent sites did not have the EHR installed, or in use (even if this is planned), or if one or more medical providers (as defined above) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do not select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.

c. No

Select "no" if no EHR was in use on December 31, even if you had the system installed and training had started.

This question seeks to determine whether the health center installed an EHR by December 31 and, if so, which product is in use, how broad is access to the system, and what features are available and in use. While they can often produce much of the UDS data, do not include practice management systems or other billing systems. If the health center purchased an EHR but had not yet placed it into use, answer "No."

If a system is in use (i.e., if a or b has been selected above), indicate if your system has been certified by the Office of the National Coordinator - Authorized Testing and Certification Bodies (ONC-ATCB).

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

a. Yes

b. No

Health centers are to indicate in the blanks the vendor, product name, version number, and ONC-certified health IT product list number. (More information is available at https://chpl.healthit.gov/#/search) If you have more than one EHR (if, for example, you acquired another practice which has its own EHR), report the EHR that will be the successor system.

Vendor

Product Name

Version Number

ONC-certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

a. Yes

b. No

If "yes, but only at some sites or for some providers" is selected above, a box expands for health centers to identify how many sites have the EHR in use and how many (medical) providers are using it. Please enter the number of sites (as defined above) where the EHR is in use and the number of providers who use the system (at any site). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one site as just one provider:

1c. How many sites have the EHR system in use?

1d. How many providers use the EHR system?

1e. When do you plan to install the EHR system?

With reference to your EHR, BPHC would like to know if your system has each of the specified capabilities that relate to the CMS Meaningful Use criteria for EHRs and if you are using them (more information on Meaningful Use). For each capability, indicate:

a. **Yes** if your system has this capability and it is being used by your center;

b. **No** if your system does not have the capability or it is not being used; or

c. **Not sure** if you do not know if the capability is built in and/or do not know if your center is using it.

Select a (has the capability and it is being used) if the software is able to perform the function and some or all of your medical providers are making use of it. It is not necessary for all providers to be using a specific capability in order to select a.

Select b or c if the capability is not present in the software or if the capability is present, but still unused or if it is not currently in use by any medical providers at your center. Select b or c only if none of the providers use the function.

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.)

   a. Yes

   b. No

   c. Not sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?

   a. Yes

   b. No

   c. Not sure

4. Does your center exchange clinical information electronically with other key providers/health care settings, such as hospitals, emergency rooms, or subspecialty clinicians?

   a. Yes

   b. No

   c. Not sure

5. Does your center engage patients through health IT, such as patient portals, kiosks, or secure messaging (i.e., secure email) either through the EHR or through other technologies?

   a. Yes

   b. No

   c. Not sure

6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?

   a. Yes

   b. No

   c. Not sure

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?

   a. We use the EHR to extract automated reports

   b. We use the EHR but only to access individual patient charts

   c. We use the EHR in combination with another data analytic system

   d. We do not use the EHR

8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as "Meaningful Use"?

    a. Yes, all eligible providers at all sites are participating

    b. Yes, some eligible providers at some sites are participating

    c. No, our eligible providers are not yet participating

    d. No, because our providers are not eligible

    e. Not sure

    If yes (a or b), at what stage of Meaningful Use (MU) are the majority (more than half) of your participating providers attested (i.e., what is the stage for which they most recently received incentive payments)?

    a. Received MU for Modified Stage 2

    b. Received MU for Stage 3

    c. Not sure

    If no (c only), are your eligible providers planning to participate?

    a. Yes, over the next 3 months

    b. Yes, over the next 6 months

    c. Yes, over the next 12 months or longer

    d. No, they are not planning to participate

9. Does your center use health IT to coordinate or to provide enabling services, such as outreach, language translation, transportation, case management, or other similar services?

    a. Yes

    b. No

    c. If yes, specify the type(s) of service: _____

10. Has your health center received or retained patient-centered medical home recognition or certification for one or more sites during the measurement year?

    a. Yes

    b. No

    If yes (a), which third-party organization(s) granted recognition or certification status? (Can identify more than one.)

    a. National Committee for Quality Assurance (NCQA)

    b. The Joint Commission (TJC)

    c. Accreditation Association for Ambulatory Health Care (AAAHC)

    d. State-based initiative

    e. Private payer initiative

    f. Other recognition body (Specify _____)

11. Has your health center received accreditation?

    a. Yes

    b. No

    If yes (a), which third-party organization granted accreditation?

    a. The Joint Commission (TJC)

    b. Accreditation Association for Ambulatory Health Care (AAAHC)

Appendix E: Other Data Elements

Instructions

Health centers are becoming increasingly diverse and comprehensive in the care and services provided. These questions capture the changing landscape of healthcare centers to include expanded services and delivery systems.

Questions

Report on these data elements as part of their UDS submission. Topics include medication-assisted treatment, telehealth, and outreach and enrollment assistance. Respond to each question based on your health center status as of December 31.

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

   a. How many physicians, certified nurse practitioners and physician assistants[10], on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?

   b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?

2. Are you using telehealth? Telehealth is defined as the use of telecommunications and information technologies to share information and provide clinical care, education, public health, and administrative services at a distance.[11]

   a. Yes

   b. No

   If yes (a), how are you using telehealth? (Choose all that apply)

   a. Provide primary care services

   b. Provide specialty care services

   c. Provide mental health services

   d. Provide oral health services

   e. Manage patients with chronic conditions

   f. Other (Please specify: _____)

   If no (b), please explain why you are not using telehealth: _____

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment through the Marketplace, Medicaid or CHIP.

   Enter Number of Assists _____

   Note: Assists do not count as visits on the UDS tables.

10 With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physicians' assistants (PAs).

11 http://www.hrsa.gov/ruralhealth/telehealth/index.html

Appendix F: Health Center Resources

Several resources are available to assist health centers with UDS Reporting or EHB system questions:

Description	Contact	Email	Phone
UDS reporting questions	BPHC UDS Support Center	udshelp330@bphcdata.net	866-837-4357 (866-UDS-HELP)
EHB account and user access questions	HRSA Call Center	HRSA Call Center at http://www.hrsa.gov/about/contact/ehbhelp.aspx	877-464-4772
EHB electronic reporting issues	BPHC Helpline	Health Center Program Support at http://www.hrsa.gov/ about/contact/bphc.aspx	877-464-4772

Other data and resource links, including this manual, a complete set of the UDS tables (note that the table view within EHB may look different but contain the same fields), notifications of changes to reporting criteria, training opportunities, and other materials can be found on the BPHC website at http://bphc.hrsa.gov/datareporting/index.html or the UDS Training Website at http://www.bphcdata.net/html/bphctraining.html.

Strategic partnerships, including Health Center Controlled Networks, National Cooperative Agreements, Primary Care Associations, and Primary Care Offices can be found on the BPHC Quality Improvement website at http://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/index.html.

Resources are available to assist health centers serving special populations with meeting performance requirements and training needs:

Organization	Website	Contact and Email	Phone
National Association of Community Health Centers (NACHC)	http://www.nachc.com	Cindy Thomas; cthomas@nachc.com	301-347-0400

Public Housing Primary Care (PHPC) Program

Organization	Website	Contact and Email	Phone
Community Health Partners for Sustainability (CHPFS)	http://www.chpfs.org	Alexander Lehr O'Connell; alex@chpfs.org	215-821-4004
National Center for Health in Public Housing (NCHPH)	http://www.nchph.org	Jose Leon; jose.leon@namgt.com	703-812-8822

Migrant Health Center (MHC) Program

Organization	Website	Contact and Email	Phone
Migrant Clinicians Network (MCN)	http://www.migrantclinician.org	Theressa Lyons; tlyons@migrantclinician.org	512-579-4511
National Center for Farmworker Health (NCFH)	http://www.ncfh.org	Bobbi Ryder; ryder@ncfh.org	512-312-5453

Health Care for the Homeless Program

Organization	Website	Contact and Email	Phone
National Health Care for the Homeless Council (NHCHC)	http://www.nhchc.org	Darlene Jenkins; djenkins@nhchc.org	615-226-2292
Corporation for Supportive Housing (CSH)	http://www.csh.org	Kim Keaton; Kim.keaton@csh.org	917-297-9033

Other Vulnerable Populations

Organization	Website	Contact and Email	Phone
Association of Asian Pacific Community Health Organizations (AAPCHO)	http://www.aapcho.org	Jen Lee; jlee@aapcho.org	510-272-9536 x118
National LGBT Health Education Center	http://www.lgbthealtheducation.org	Alex Keuroghlian; akeuroghlian@fenwayhealth.org	617-927-6354
National Center for Medical-Legal Partnerships	http://www.medical-legalpartnership.org	Ellen Lawton; ellawton@gwu.edu	617-549-1733
Health Information and Technology, Evaluation, and Quality (HITEQ) Center	http://hiteqcenter.org/	Julia Rossen; hiteqinfo@jsi.com	844-305-7440

Oral Health

Organization	Website	Contact and Email	Phone
National Network for Oral Health Access	http://www.nnoha.org	Phillip Thompson; executivedirector@nnoha.org	303-957-0635 x6

Health centers can access their current year and prior year UDS reports, as well as several standard reports, through the EHB Web-link at https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx.

UDS Production Timeline and Report Availability

- UDS performance data collection environment: September – December 2017
- UDS data collection and reporting: January 1 – February 15, 2018
- Deadline for submitting a complete UDS Report: February 15, 2018
- UDS reporting freeze: March 31, 2018
- Standard UDS Reports are available in EHB as shown below
- Release of UDS Rollup Reports, Grantee and Look-Alike Profiles, and Grantee Comparison Data Views are available on the BPHC webpages in August, 2018
- Service area data are available on the UDS Mapper website in August, 2018

UDS Report Level	Timing	Description	Grantee	Look-Alike
Finalized Health Center Tables and XML Data File	June	Provides health center with data for each of the twelve UDS tables, the HIT and Other Data Elements forms.	HC	HC
Health Center Trend Report	July/August	Compares the health center's performance for key performance measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a three-year period.	HC, S, N	HC, N
UDS Summary Report	July/August	Summary and analysis on the health center's current UDS data using measures across various tables of the UDS report.	HC, S, N	HC, N

UDS Report Level	Timing	Description	Grantee	Look-Alike
UDS Rollup Report	July/August	Compiles annual data reported by health centers. Provides summary data for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues.	S, N	N
Performance Comparison Report	September	Provides the summary and analysis on the health center's latest UDS data giving details at grantee, state, national, urban, and rural levels with trend comparisons and percentiles.	Includes all levels	Includes all levels

Abbreviations indicate geographies and detail level for which each report is available. HC=Health Center, S=State, N=National

The following table crosswalks the UDS clinical quality measures and other national programs using these measures.

ID	Measure Title	Measure Steward	CMS e-CQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS / QPP
Table 6B, Line 7	**Early Entry to Prenatal Care**	n/a	n/a	n/a	n/a	MICH-10.1	No
Table 6B, Line 10	**Childhood Immunization Status**	National Committee for Quality Assurance	CMS117v5	38	Child Core	n/a	Yes
Table 6B, Line 11	**Cervical Cancer Screening**	National Committee for Quality Assurance	CMS124v5	32	Adult Core	C-15	Yes
Table 6B, Line 12	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	National Committee for Quality Assurance	CMS155v5	24	Child Core	n/a	Yes
Table 6B, Line 13	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan**	Centers for Medicare and Medicaid Services	CMS69v5	421	n/a	n/a	Yes
Table 6B, Line 14a	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Physician Consortium for Performance Improvement	CMS138v5	28	Adult Core	n/a	Yes

ID	Measure Title	Measure Steward	CMS e-CQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS / QPP
Table 6B, Line 16	**Use of Appropriate Medications for Asthma**	National Committee for Quality Assurance	CMS126v5	36	n/a	n/a	No
Table 6B, Line 17	**Coronary Artery Disease (CAD): Lipid Therapy**	n/a	n/a	n/a	n/a	n/a	No
Table 6B, Line 18	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	National Committee for Quality Assurance	CMS164v5	68	n/a	n/a	Yes
Table 6B, Line 19	**Colorectal Cancer Screening**	National Committee for Quality Assurance	CMS130v5	34	n/a	C-16	Yes
Table 6B, Line 20	**HIV Linkage to Care**	n/a	n/a	n/a	n/a	n/a	No
Table 6B, Line 21	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Centers for Medicare and Medicaid Services	CMS2v6	418	Adult Core	n/a	Yes
Table 6B, Line 22	**Dental Sealants for Children between 6-9 Years**	Dental Quality Alliance - American Dental Association	CMS277 (draft)	2508 (claims based measure)	Child Core	OH-12.2	No
Table 7, Section A	**Low Birth Weight**	Centers for Disease Control and Prevention	n/a	1382	n/a	MICH-8.1	No
Table 7, Section B	**Controlling High Blood Pressure**	National Committee for Quality Assurance	CMS165v5	18	Adult Core	HDS-12	Yes
Table 7, Section C	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**	National Committee for Quality Assurance	CMS122v5	59	Adult Core	D-5.1	Yes

Notes: n/a = Not applicable, NQF = National Quality Forum, MIPS = Merit-Based Incentive Payment System, QPP = Quality Payment Program

Appendix G: Glossary

Accrual Basis: Reported when the expense occurs, not when the cash is received.

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

Allowances: A discount granted to a third-party payer as part of an agreement between the health center and the payer.

Bad Debt: Amounts billed to and defaulted by a patient responsible for payment.

Capitation: An agreed upon amount that a managed care payer to the provider (health center) for providing all of the services in an agreed upon list. The payer/HMO pays the health center a set amount monthly regardless of whether or not any services were rendered during the month.

Cash Basis: Reported when the cash is received or expended, not when an obligation occurs.

CHIP or CHIP-RA or S-CHIP: The Children's Health Insurance Program Reauthorization Act (CHIP-RA) provides primary health care coverage for children and, on a state-by-state basis, others especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans.

Contract Staff: People who work under contract at the health center as opposed to being on salary. They may or may not work regular assigned hours and may or may not receive benefits. They do not have withholding taxes deducted from their paychecks and they have their income reported to the IRS on a 1099 form.

EHR: An electronic health record (EHR) is a digital record of a patient's status and interactions with a health center, including real-time, patient-centered information available quickly and securely to authorized users.

Exclusions or Exceptions: As used in clinical measure reporting, patients not to be considered or included in the denominator (exclusions) or removed if identified (exceptions).

Federal Poverty Guidelines: An annual statement of the amount of income, below which an individual or family of different sizes are considered to be in poverty.

Fee-for-Service: Charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes and the charge associated with each of these services.

Fee Schedule: A listing of fixed fees for goods or services.

First Trimester (Prenatal Care): Women who were estimated to be pregnant up through the end of the 13th week after their last menstrual period.

Full-Time Equivalent: One person who works full-time for the year. Fractions of an FTE are used to identify part-time or part-year individuals and multiples of an FTE are used to identify multiple individuals.

Full-Time Staff: People generally employed 40 hours a week, but subject to organizational definitions.

Full-time staff generally receives benefits, have withholding taxes deducted from their paychecks, and have their income reported to the Internal Revenue Service (IRS) on a W2 form. Staff may or may not have a contract. Staff are full-time when they are so defined in their contract and/or when their benefits reflect this status.

Gender Identity: A person's internal sense of their gender as a male, female, a combination of male and female, or another gender.

Gross Charges: The full, undiscounted cost of a product or a service.

Hispanic or Latino: Persons of specific Spanish or Latino heritage, lineage, descent, or country of birth.

Homeless: A person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who reside in transitional housing or permanent supportive housing.

Income: Money received (may be from multiple sources, including employment, alimony, child support, investments, etc.).

Indigent Care Programs: State or local programs that pay in whole or in part for services rendered to the uninsured. Indigent care programs include 638 compact programs for tribal groups.

Last Party Rule: Reporting of grant and contract funds based on the entity from which the health center received them, regardless of their original origin.

Locum Tenens: People who work at the health center on an as-needed basis used to fill in for a part-time absence of another provider and used when the center is unable to hire a full- or part-time staff person until the position is filled. Locums are uniquely identifiable because they work for an agency and the center pays the agency rather than the individual. They do not receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

Managed Care: A system where a premium is paid to an organization, which contracts with a health center to provide a range of services to patients assigned to the health center.

Medicaid: Federal and state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

Medicaid Expansion: A program which makes Medicaid available to more patients, which requires states to opt-in to participate.

Medicare: Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

Member Month: One person enrolled in a managed care plan for one month.

Migratory Agricultural Workers: Defined by section 330(g) of the Public Health Service Act, a migratory agricultural worker is an individual whose principal employment is in agriculture and who establishes a temporary home for the purposes of such employment. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have had such work as their principal employment within 24 months of their last visit, as well as their dependent family members who have also used the center. The family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who leave a community to

work elsewhere are classified as migratory workers in their home community, as are those who migrate to a community to work there.

National Health Service Corps (NHSC) Assignees: Members of the National Health Service Corps (NHSC) assigned by the Corps to a health center. This includes members of the NHSC Loan Repayment Program. These individuals are employees of the U.S. government.

Non-Clinical Consultants: Consultants who fill administrative positions.

Numerator: As used in clinical measure reporting, records (a subset of the denominator) that meet the measurement standard for the specified measure.

Off-site Contract Providers: Providers who are contracted for the services who work at a location that is not an in-scope site as defined in a health center application.

On-call Providers: Providers who fill in briefly when someone is absent, but may stay for an extended period if the center is unable to hire a full- or part-time staff person for a position. Unlike locums, health centers pay on-call providers directly. They may or may not receive all the benefits or providers paid a salary and may or may not have payroll and income taxes withheld.

Part-Time Staff: People employed by the health center, for fewer than 40 hours per week. They receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract.

Part-Year Staff: Persons employed or contracted for full or part time for a specific period that may be once or recurring.

Patient: People who have at least one reportable visit in one or more categories of services: Medical, Dental, Mental health, Substance abuse, Vision, Other professional, Enabling.

Penalty/Paybacks: Payments made by health centers to payers because of overpayments collected earlier or for over-utilization of the inpatient or specialty pool funds in managed care plans.

Performance Measure: A quantifiable indicator used to evaluate how well the health center is achieving standards.

Public Housing: Agency-developed, owned, and generally operated housing, including mixed finance projects, for low-income people. It excludes housing units with no public housing agency support other than section 8 housing vouchers.

Race: A physical or social categorization of a person, presumably based on inheritance.

Reclassify: Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations: Lump sum retroactive adjustments based on the filing of a cost report.

Residents/Trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) already have licenses.

Sex: The anatomical and physiological biology of a person assigned at birth or on birth certificate.

School-Based Health Center: A health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides comprehensive preventive and primary health services.

Seasonal Agricultural Workers: Seasonal agricultural workers are individuals whose principal employment is in agriculture on a seasonal basis but who do not establish a temporary home for

purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the last 24 months and their family members who may be patients of the health center.

Second Trimester (Prenatal Care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.

Sexual Orientation: How a person describes their emotional and sexual attraction to others as straight, lesbian or gay, bisexual, or another sexual orientation.

Sliding Fee Discount: A discount applied to the fee schedule which adjusts fees based on the patient's ability to pay based on their income.

Straight-line Allocation: Allocating non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category.

Third Trimester (Prenatal Care): Women who were estimated to be pregnant for 28 weeks or more weeks after their last menstrual period.

Universe (Denominator): As used in clinical measure reporting, patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Veteran: Persons discharged from the uniformed services of the United States.

Visit: A documented, face-to-face contact between a patient and a licensed or credentialed provider who exercises his/her independent, professional judgment in the provision of services to the patient. (Telehealth is allowable for behavioral health only.)

Volunteers: People who work at the health center but not paid for their work.

Wrap-Around Payments: An amount equal to the difference between the usual payment and an agreed upon flat fee, known as an FQHC or PPS rate.

HRSA
Health Center Program

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