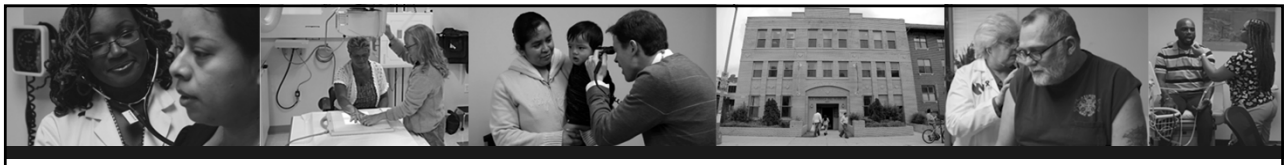

Uniform Data System (UDS) Reporting Requirements Training

Calendar Year 2018

Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

HRSA Health Resources & Services Administration

Agenda

- **Who, What, When, Where, and Why of the UDS**
- **Table-by-Table Instructions**
- **2019 UDS Proposed Changes and Modernization Update**
- **Tips for a Successful UDS Submission**

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List of Acronyms

- BCCCP – Breast & Cervical Cancer Control Program
- BHW – Bureau of Health Workforce
- CDC – Centers for Disease Control and Prevention
- CHC – Community Health Center
- CHIP – Children's Health Insurance Program
- CMS – Centers for Medicare & Medicaid Services
- eCQI – Electronic Clinical Quality Improvement
- eCQMs – e-Specified Clinical Quality Measures
- EHBs – Electronic Handbooks
- EHR – Electronic Health Record
- EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
- FTE – Full-time Equivalent
- HCH – Health Care for the Homeless
- HIT – Health Information Technology
- HP – Healthy People
- HUD – United States Department of Housing and Urban Development
- LAL – Look-alike
- MAT – Medication-assisted Treatment
- MCO – Managed Care Organization
- MHC – Migrant Health Center
- PHPC – Public Housing Primary *Care*
- PRE – Performance Reporting Environment
- SAMHSA – Substance Abuse and Mental Health Services Administration
- SOGI – Sexual Orientation/Gender Identity
- TA/T – Technical Assistance/Training
- UDS – Uniform Data System
- USHIK – United States Health Information Knowledgebase
- WIC – Women, Infants, and Children

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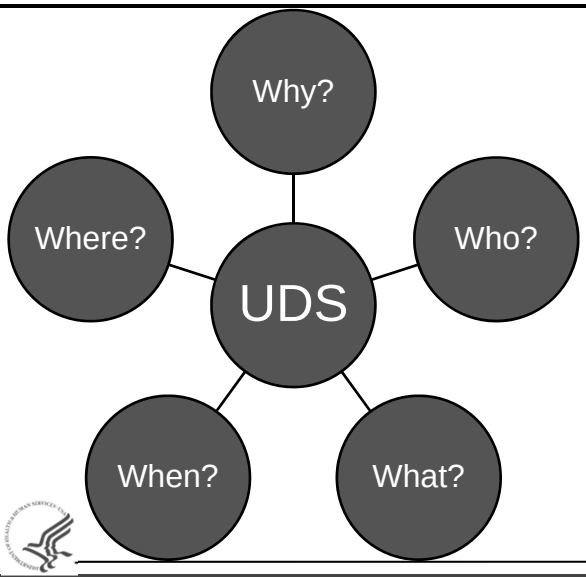
Why, Who, What, When, and Where of the UDS



- **Why:** Legislatively mandated; used for program monitoring and improvement
- **Who:** CHCs, HCHs, MHCs, PHPCs, LALs and BHW primary care clinics funded or designated before October 2018
- **What:** Annual snapshot of all in scope activities
  - Universal and grant reports (if applicable)
- **When:** January 1-December 31, 2018
- **Where:** Report through the EHBs starting January 1, 2019; PRE available in fall 2018

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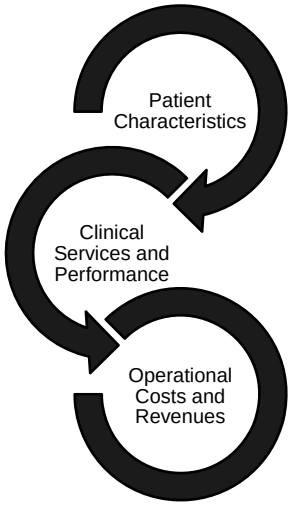
Overview of UDS Report

12 Tables and Two Forms

- **Universal report—**completed by all reporting health centers
  - All tables and forms are completed in a Universal Report
- **Grant report(s)—**completed only by awardees that receive 330 grants under multiple funding streams

Table	Report GRANT REPORT(S) if you receive 330 grants under multiple program authorities: CHC (330 (e)) ◆ HCH (330 (h)) MHC (330 (g)) ◆ PHPC (330 (i))
ZIP Code	No
3A, 3B, 4	Yes
5	Yes, but patients and visits only
5A	No
6A	Yes
6B, 7, 8A, 9D, 9E	No
Health Information Technology & Other Data Elements Forms	No



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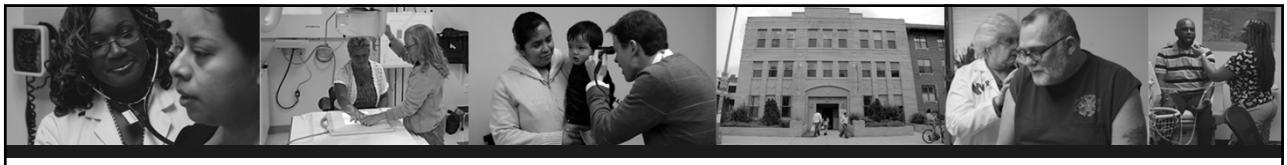

UDS Tables

Definitions and Instructions

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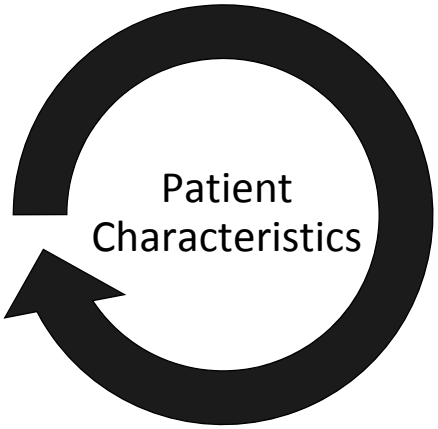
Patient Tables

ZIP Code, 3A, 3B, and 4



Why these characteristics?

- ZIP Code
- Age and Sex at Birth
- Sexual Orientation and Gender Identity
- Race, Ethnicity, and Language
- Income
- Insurance
- Special Populations

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Are You Serving HRSA Priority Populations?

- **Are you serving the number of patients you agreed to serve?**
- **Are you serving your area? (UDS Mapper)**
- **Are you serving patients with access barriers?**

Table	Description
ZIP Code	Patients by ZIP Code and Insurance
3A	Patients by Age and Sex at Birth
3B	Patients by Race, Ethnicity, Language, and SOGI
4	Patients by Income, Insurance, and Special Populations

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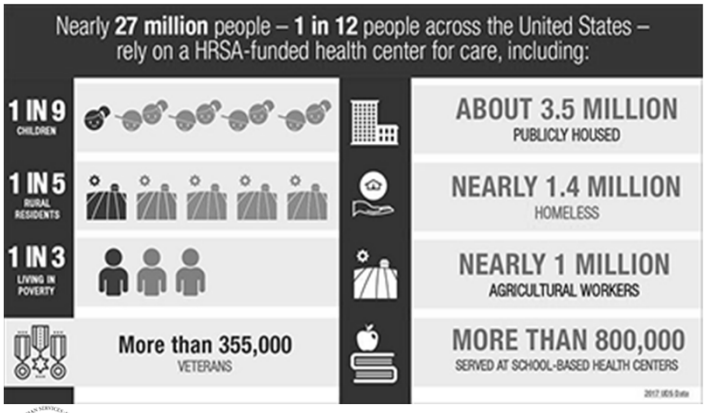
Who Are We Serving?

National Statistics – 2017 Rollup



Other Statistics	% of Total
Women Age 21-64	40%
Racial and/or Ethnic Minority	71%
Best Served in Language Other than English	24%
Uninsured	23%

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Who is Counted on the UDS?

Patient Defined

- **Any person who received at least one reportable visit during the reporting year**
  - (e.g., medical, dental, behavioral health)
- **Each person counts once regardless of the number of visits or services received**

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ZIP Code Table

- **Report total patients by ZIP code of residence and primary medical insurance**
- **List ZIP codes with 11 or more patients in column (a)**
  - Aggregate ZIP codes with 10 or fewer patients as "other"
- **Total patients' ZIP code by insurance must equal counts on Table 4**
- **Use local address for migratory agricultural workers and people from other countries; use clinic address for persons experiencing homelessness if no other address**

ZIP Code (a)	None/ Uninsured (b)	Medicaid / CHIP/ Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
03824	5	4	2	1	12
<system allows insertion of rows for more ZIP codes>					
Other ZIP Codes					
Unknown Residence					
Total	5	4	2	1	12

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Patients by Age and Sex at Birth
Table 3A

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
…	…	…	…
7	Age 6		1
8	Age 7		
9	Age 8		1
10	Age 9		
11	Age 10	1	
12	Age 11		
13	Age 12		1
14	Age 13		
15	Age 14		
16	Age 15	1	1
17	Age 16		
18	Age 17		1
…	…	…	…
23	Age 22	1	
24	Age 23		
25	Age 24		
26	Ages 25-29		1
27	Ages 30-34		
28	Ages 35-39		
29	Ages 40-44		1
30	Ages 45-49		
31	Ages 50-54		
32	Ages 55-59		
33	Ages 60-64	1	
34	Ages 65-69		1
…	…	…	…
39	**Total Patients (Sum lines 1-38)**	4	8

Report total patients by age and sex at birth or as reported on birth certificate

- Use age as of June 30
- Patients by age must equal Table 4 insurance by age groups (0-17 years old and 18 and older)

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Ethnicity, Race, and Language

Table 3B

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		1		1
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (sum Lines 2a + 2b)				
3	Black/African American	3	1		4
4	American Indian/Alaska Native				
5	White	2	4		6
6	More than one race				
7	Unreported/refused to report race	1			1
8	Total Patients (sum Lines 1 + 2 + 3 to 7)	6	6		12

Line	Patients by Linguistic Barriers to Care	Number (a)
12	Patients best served in a language other than English	4

- **Report total patients by ethnicity and race**
  - Self-reported by patients or caregivers
  - If race is known, but ethnicity is not, report in column (b)
  - If patients select multiple races, report as "more than one race"
  - Only report patients with unknown race and unknown ethnicity on line 7, column (c)
- **Report patients best served in another language than English on line 12**

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Sexual Orientation and Gender Identity

Table 3B

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	1
14	Straight (not lesbian or gay)	7
15	Bisexual	
16	Something else	
17	Don't know	1
18	Chose not to disclose	3
19	**Total Patients (Sum Lines 13 to 18)**	12
Line	**Patients by Gender Identity**	**Number (a)**
20	Male	3
21	Female	7
22	Transgender Male/Female-to-Male	
23	Transgender Female/Male-to-Female	
24	Other	1
25	Chose not to disclose	1
26	**Total Patients (Sum Lines 20 to 25)**	12

Report total patients by SOGI

- Self-reported by patients or caregivers
- Only use "chose not to disclose" if patient selected this option
- Use "don't know" or "other" if patient selected this option or if data is missing (include minors)

The National LGBT Health Education Center can help.

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Special Populations
Table 4

- **All health centers report lines 16, 23, 24, 25, and 26**
  - **Line 16:** Number of agricultural workers
  - **Line 23:** Individuals who experience homelessness at any time when receiving services during the reporting year
  - **Line 24:** Patients who received primary care services at a school-based health center
  - **Line 25:** Patients who have been discharged from the uniformed services of the United States
  - **Line 26:** Total patients served at a health center located in or immediately accessible to a public housing site regardless of whether the patient is a resident of public housing

Line	Special Populations	Number of Patients (a)
14	Migratory (330g awardees only)	
15	Seasonal (330g awardees only)	
16	**Total Agricultural Workers or Dependents**(All health centers report this line)	
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report this line)	1
24	**Total School-Based Health Center Patients** (All health centers report this line)	
25	**Total Veterans** (All health centers report this line)	1
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	

- **MHC Awardees**
  - Report migratory (**line 14** - temporary home) and seasonal (**line 15**)
- **HCH Awardees**
  - Report (**lines 17-22**) where individuals who experience homelessness are housed as of first visit during reporting year

Special Populations Resources: HRSA funded National TA/T Centers

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The Rest of Table 4 Will Be Discussed with Table 9D

Income and Insurance
Patient Revenues

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Test Your Understanding!

A few patient-related edits:

Short Description	Common Edit Flag
Patient Numbers Do Not Agree by Insurance	Tables ZIP and 4: Total patients by insurance reported on the ZIP Code table is not equal to the same insurance categories reported on Table 4
SOGI Reporting Questioned	Table 3B: All patients by gender identity have been reported as male or female
Patient Numbers Do Not Agree on Tables 3A/4	Tables 3A and 4: Total patients age 18 and older on Table 4, line 12, is not equal to the sum of Lines 19 - 38 on Table 3A
Grant Count More than Universal	Tables 3A, 3B, and 4: The value reported on the Grant report, for line 1, column a, is greater than the number reported on the Universal report for the same line

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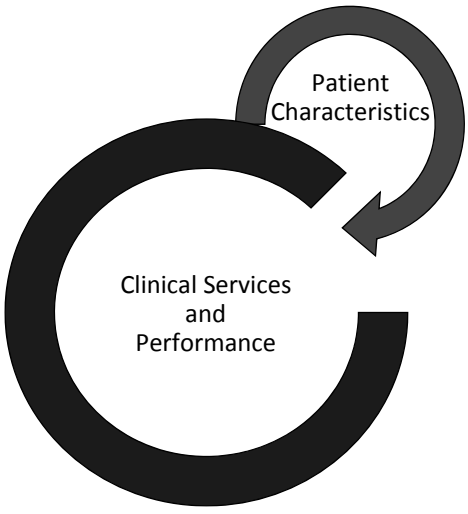
Clinical Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7



Why these clinical services and quality of care indicators?

- Patient visits by service type
- Patient visits by diagnosis
- Quality of care indicators
  - ✓ Preventive screenings
  - ✓ Prenatal and delivery outcomes
  - ✓ Chronic conditions

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How High Is Your Standard of Care?

- **How are you providing comprehensive services?**
- **Are patients getting adequate access to care?**
- **Are you identifying all patients for indicated services?**
- **Are desired outcomes achieved?**
- **Are patients being screened/ treated in a timely manner?**
- **Are there health outcome differences between groups of patients?**

Table	Description
5	Visits and Patients by Service
6A	Diagnoses and Services
6B	Quality of Care Measures
7	Health Outcomes and Disparities

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How Are We Doing?

National Statistics – 2017 Rollup

Service Category	Average Number of Visits/Patient/Year	% of Total Patients Utilizing Services
Medical	3.13	84%
Dental	2.56	23%
Mental Health	4.82	8%
Substance Use	7.29	1%
Vision	1.32	2%
Other Professional	2.95	3%
Enabling	2.48	9%

Performance Rates and Goals		
Quality of Care and Outcome Measures	**Awardees**	**HP 2020 Goal**
Early Entry into Prenatal Care	74%	78%
Low Birth Weight	8%	8%
Childhood Immunization Status	40%	80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	66%	-
Body Mass Index (BMI) Screening and Follow-Up Plan	64%	-
Tobacco Use Screening and Cessation Intervention	88%	-
Cervical Cancer Screening	56%	93%
Colorectal Cancer Screening	42%	71%
Screening for Depression and Follow-Up Plan	66%	-
Use of Appropriate Medications for Asthma	87%	37%
Coronary Artery Disease (CAD) and Lipid Therapy	81%	-
Ischemic Vascular Disease (IVD) Aspirin or Other Another Antiplatelet	79%	-
HIV Linkage to Care	85%	-
Controlling High Blood Pressure	63%	61%
Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%)	33%	16%
Dental Sealants for Children between 6-9 Years	51%	28%

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Defining a Visit

- **Documented**
- **Face-to-face contact**
- **Provided by a licensed or credentialed provider**
- **With a provider who exercises independent, professional judgment in the provision of services to the patient**
  - (e.g., medical, dental, substance use, mental health)
  - Exception: Group and virtual (telehealth) visits count for behavioral health

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Counting Visits

Reportable Visit - Locations

- **Must take place in the health center site or at another approved location**
  - Count visits provided by both paid and volunteer staff
  - Include paid referral visits
  - Count when following current patients in a nursing home, hospital, or at home
    - ✓ Do not count if patient is first encountered at these locations unless the site is listed on Form 5B as being in your approved scope

Count Only One Visit Per…

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

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Counting Visits Considerations

Other Considerations

- **Nurses**
  - Must meet all the visit definition requirements
  - Common visits that might count: triage, nurse evaluation of patient's medical condition and patient not seen by another provider, home health care
  - Do not count drug or vaccine administration, tests, blood draws, or visit where patient sees another medical provider that same day

- **Interns and Residents**
  - Count visits between a licensed intern or resident and a patient in the credentialing category they are pursuing
- **MAT**
  - Credit the visit to the credentialed medical or psychiatric staff providing treatment (not as substance use)

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Contacts That Don't Count as Visits

- **Health screenings**
  - Blood pressure
  - Screenings for conditions
  - Vision screenings
  - Foot care
- **Group visits and telemedicine *(except for behavioral health)***
  - Chronic disease management groups
  - Health education classes
  - Telemedicine
- **Tests and ancillary services**
  - Laboratory (e.g., blood pressure tests, pregnancy tests, prothrombin time, hemoglobin A1c)
  - Imaging (e.g., sonography, radiology, mammography)
- **Dispensing or administering medications**
  - Dispensing, whether by a clinical pharmacologist or a pharmacist
  - Administering (e.g., Buprenorphine or Coumadin)
  - Injections (e.g., vaccines, allergy shots, family planning methods)
  - Agonists or antagonists (e.g., methadone, opioid blockers)
- **Health status checks**
  - Follow-up tests or checks
  - Wound care
  - Taking health histories
  - Making or following up on referrals
- **Other Services**
  - Services under WIC Program
  - Outreach
  - Group education
  - Info sessions for prospective patients
  - Health fairs
  - Immunization drives
  - Dental varnishes or sealants

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Patients and Visits by Service

Table 5

Clinic Visits (b)	Patients (c)
What: Count visits that meet definition ▪ Not all staff generate visits ▪ Not all contacts = visits ▪ A single visit may consist of multiple services, but count as one visit **Where:** Report countable visits by service provider	**What:** Unduplicated count of patients by service category ▪ Same person can receive multiple services ▪ Sum of patients by service does NOT = total patients *(See sample patient counts: 16 here vs. 12 on demographics)*

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians		12	
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians		13	
7	Other Specialty Physicians			
8	**Total Physicians (Sum lines 1-7)**		25	
9a	Nurse Practitioners		3	
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**		3	
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**		28	10
16	Dentists		5	
17	Dental Hygienists		4	
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum lines 16-18)**		9	5
…	…	…	…	…
24	Case Managers		6	
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 (Sum lines 24-28)**		6	1
…	…	…	…	…
34	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)**		43	

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Test Your Understanding!

A few edits relating to services:

Short Description	Common Edit Flag
Tables 3A and 5 Patient Conflict	Tables 3A and 5: The total of medical patients reported on Line 15 Column (c) through enabling service patients reported on Line 29 Column (c) on Table 5 equals the total patients reported on Table 3A, line 39
Medical Visits per Patient	Table 5: Medical visits per medical patient (4.75) varies substantially from national average. *(Note: 3.13 nationally)*
Inter-year Patients Questioned	Table 5: A large change in dental patients from the prior year is reported on Line 19 Column (c)

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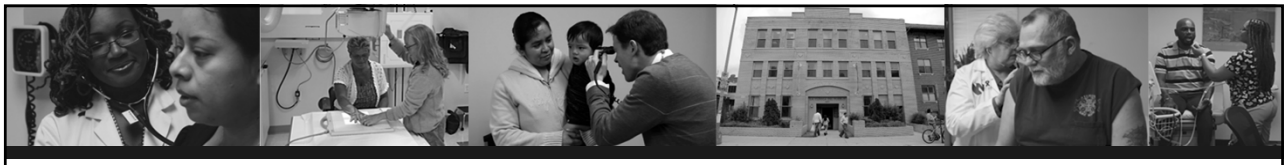


The Rest of Table 5 Will Be Discussed with Table 8A

Staffing Levels
Operating Costs

Selected Diagnoses and Services

Table 6A

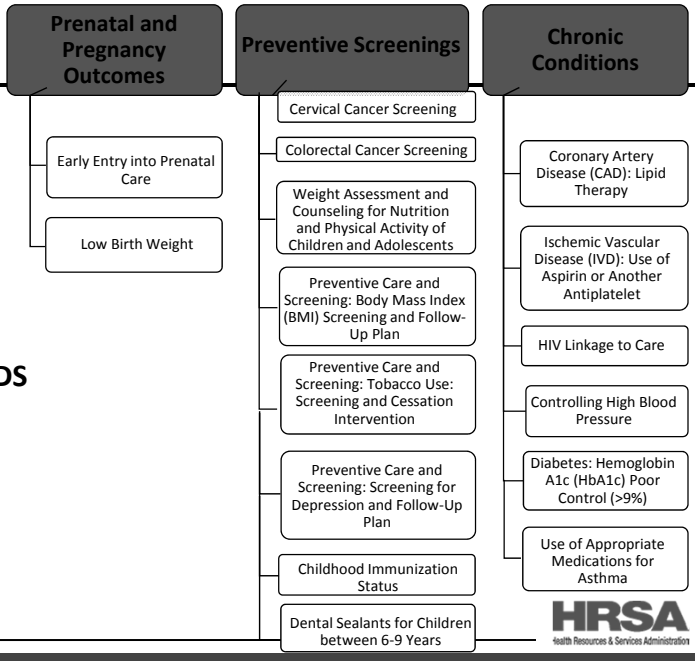
	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	6	1
3	Tuberculosis	A15- through A19-, O98.01		
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)	4	2
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-		
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52		
Selected Diseases of the Respiratory System				
5	Asthma	J45-	11	2
6	Chronic lower respiratory diseases	J40- through J44-, J47-	6	3
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-, D49.3-, N60-, N63-, R92-		

- **Only report services/diagnoses if part of countable visit**
- **Column (a):** Report the number of visits with the selected service or diagnosis
  - If a patient has more than one reportable service or diagnosis during a visit, count each
  - Do not count multiple services of same type at one visit (e.g., two immunizations, two fillings)
- **Column (b):** Report the number of unduplicated patients receiving the service or with the diagnosis

Clinical Process and Outcome Measures

Tables 6B and 7

- **Most measures align with eCQMs (https://ecqi.healthit.gov/)**
- **Differences are noted under UDS Reporting Considerations in the UDS Manual and the *Clinical Quality Measures Handout***



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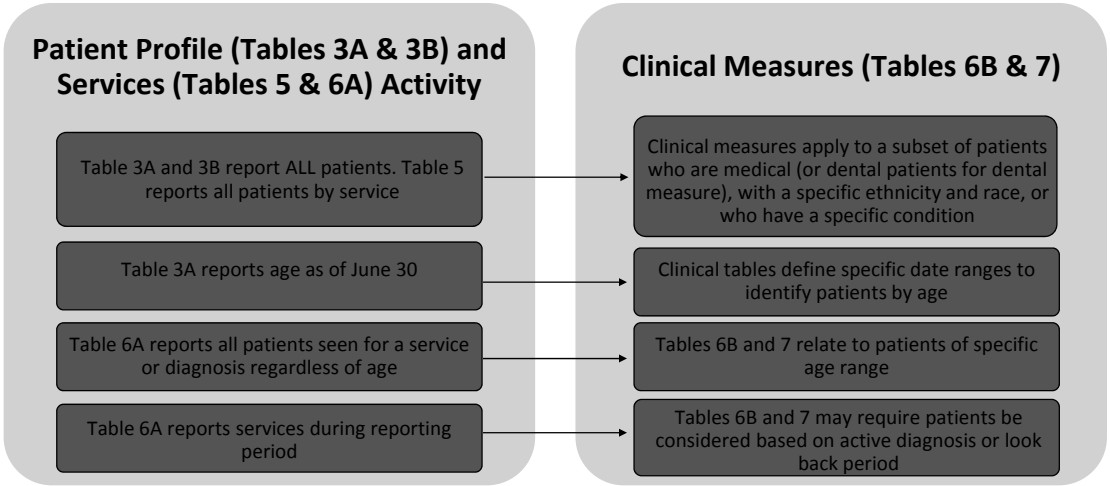
Relating Clinical Measures to Patient Profile



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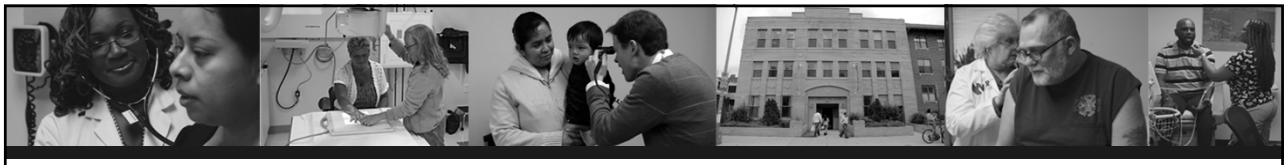

Most UDS Clinical Measures Align with eCQMs

If you have a certified EHR, you need to:

- Understand how to access and read specifications
- Know where your EHR is looking for required data elements to calculate eCQMs
- Make sure your providers are recording required data in correct fields

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Clinical Measures and Differences from eCQM

Tables 6B and 7

Table 6B Line	Description	eCQM	Difference(s) between UDS and eCQM
7-9	Early Entry into Prenatal Care	No eCQM	Not applicable
10	Childhood Immunization Status	CMS117v6	None
11	Cervical Cancer Screening	CMS124v6	None
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v6	eCQM denominator is limited to outpatient visits with a primary care physician (PCP) or obstetrician / gynecologist (OB/GYN). UDS includes children seen by nurse practitioners and physician assistants Numerator BMI, nutrition, and activity are reported separately in the eCQM, but combined in the UDS
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v6	None
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v6	Denominator patient population and numerator are reported separately in eCQM, but combined in the UDS
16	Use of Appropriate Medications for Asthma	CMS126v5	eCQM is no longer electronically specified

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Measures and Differences from eCQM Continued

Tables 6B and 7

Table 6B Line	Description	eCQM	Difference(s) between UDS and eCQM
17	Coronary Artery Disease (CAD): Lipid Therapy	No eCQM	Not applicable
18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v6	None
19	Colorectal Cancer Screening	CMS130v6	None
20	HIV Linkage to Care	No eCQM	Not applicable
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v7	None
22	Dental Sealants for Children between 6-9 Years	CMS277 draft	Although draft eCQM reflects age 5 through 9 years of age, use age 6 through 9 as measure steward intended
Table 7 Section	**Description**	**eCQM**	**Difference(s) between UDS and eCQM**
Part A	Low Birth Weight	No eCQM	Not applicable
Part B	Controlling High Blood Pressure	CMS165v6	None
Part C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v6	None

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Table 6B Format

Format: Measure Name				
Line	Measure Name	Denominator (Universe) (a)	Number Charts Sampled or EHR total (b)	Numerator (c)
#	Measure Description	All eligible patients (n)	n, 70, or (80+%)n	# in (b) that meet standard

Example: 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	100	93	75

Measure Description	Describes the quantifiable indicator to be evaluated
Denominator (Universe)	Patients who fit the detailed criteria described for inclusion in the measure
Numerator	Patients included in the denominator whose records meet the measurement standard for the measure
Exclusions/ Exceptions	Patients not to be considered for the measure or included in the denominator
Specification Guidance	CMS measure guidance that assists with understanding and implementation of eCQMs
UDS Reporting Considerations	HRSA best practices and guidance to be applied to the measure

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Table 7 Format

- **Report by race and ethnicity**
- **High blood pressure and diabetes:**
  - **Column (a)**: Universe
  - **Column (b)**: Universe, at least 80% of universe, or exactly 70 patient records
  - **Column (c) or (f)**: Number of patients in column (b) who meet the standard (numerator)
- **Deliveries and birth weight will be discussed later**

Example	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 Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	*Total*			

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eCQM-Specific Discussion

- **Guidance:**
  - Refer to the UDS Clinical Quality Measures Handout
  - Review 2018 reporting eCQM specifications through eCQI and USHIK
  - Use UDS Reporting Considerations in the UDS Manual
  - Interpret data from EHR and engage with system vendors

- **TA/Training:**
  - Listen to the Introduction to Clinical Measures webinar recording
  - Contact the UDS Support Line at 866-837-4357 or udshelp330@bphcdata.net
  - Ask me!

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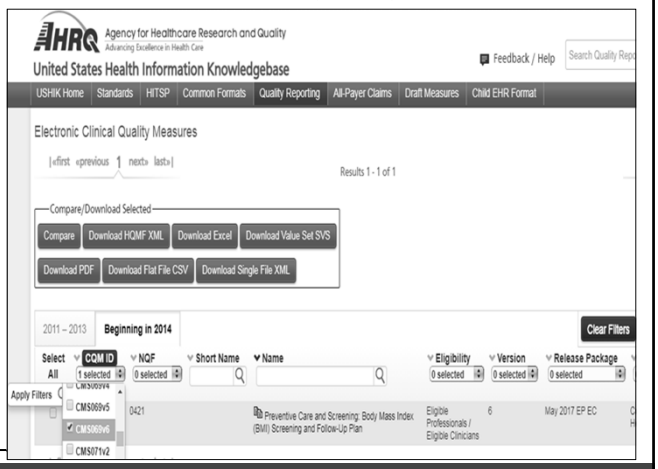
Understanding Clinical Reporting Specifications

eCQI Resource Center:
https://ecqi.healthit.gov/

USHIK:

https://ushik.ahrq.gov/QualityMeasuresListing?&system=mu&stage=Stage%202



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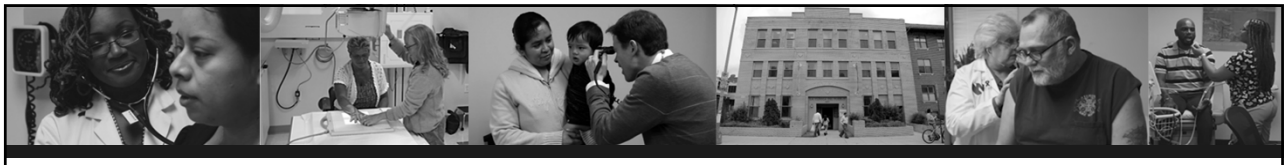

Demonstration of eCQI Resource Center and USHIK

eCQI Resource Center
USHIK
Demonstration Video

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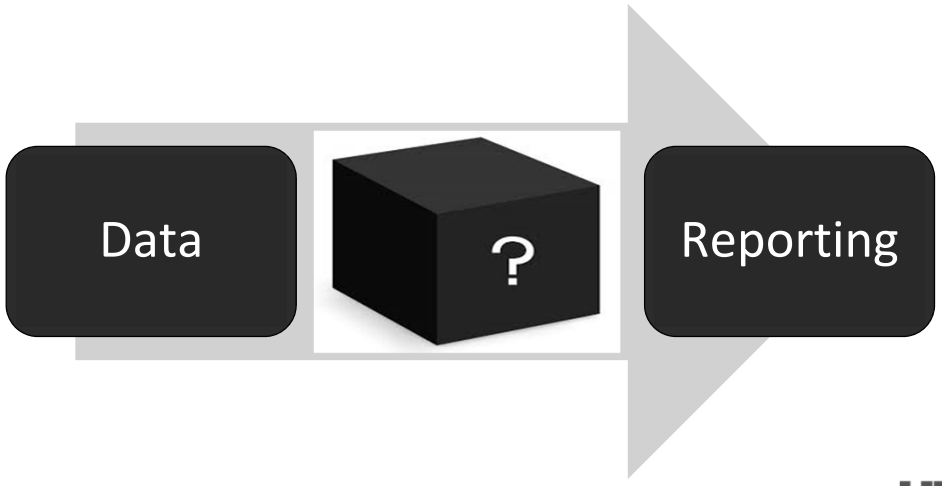
Don't Let Your EHR Be a Black Box!



What is really going on in there?

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Tool: Data Definition Worksheet

- **This tool will lead you through the eCQI Resource Center and USHIK site**
- **It provides step-by-step instructions and a place to document findings**
- **Access the worksheet**

HEALTH INFORMATION TECHNOLOGY, HITEQ EVALUATION, AND QUALITY CENTER

PERFORMANCE MEASURE DATA DEFINITION WORKSHEET

WHAT IS IT AND HOW CAN IT HELP ME?

ONC EHR Certification criteria means that vendors use eCQMs' (electronic Clinical Quality Measures') specifications to define measures. Therefore, reported data for a measure should be consistent regardless of vendor. In practice, however, it is important to confirm the vendor's logic is consistent with the health center's definition and workflows. This tool supports alignment of the health center's data definition with the vendor's reporting logic.

HOW TO USE THIS TOOL:

1. Review performance on all health center measures to prioritize measure(s) for further investigation. Consider measures for which health center performance is not consistent with provider expectation suggesting inconsistencies between where health center is documenting information and where vendor is pulling information for reporting.
2. In the ***Measure:*** box, write the measure that you intend to evaluate (i.e. hypertension control, diabetes control, colorectal cancer screening, etc.). Reference the eCQI Resource Center address for the eCQM in ***ecQI Reference:*** box.

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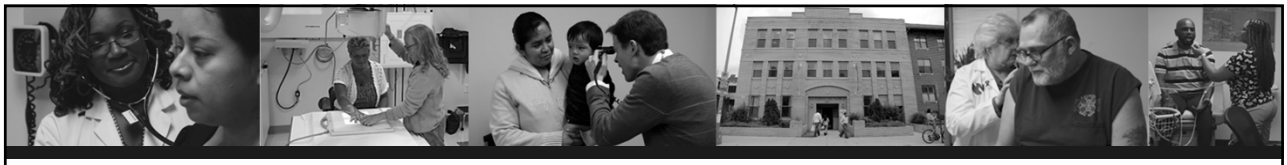
Worksheet Format

Measure:				
eCQI Reference:				
Description	A. Definition from specifications in eCQI Resource Center	B. Where and how is data documented in EHR?	C. Where is vendor pulling data for reporting?	D. Reconciliation and Follow-up Action Required?
Numerator				
Denominator (Initial Patient Population)				
Exclusions (Denominator)				
Value Set (USHIK)				

Test Your Understanding!

A few clinical measure edits:

Short Description	Common Edit Flag
Visits per Patient Questioned	Table 6A: Immunization visits per patient (2.91) on Line 24 is high compared with the national average *(Note: 1.36 nationally)*
Universe of Patients in Question	Table 6B: You are reporting 64% of total possible medical patients in the universe for the Cervical Cancer Screening measure (line 11 Column A). This appears low compared to estimated medical patients in the age group being measured *(Note: 93% nationally)*
Compliance Rate Questioned	Table 6B: A compliance rate of 100% is reported for the Colorectal Cancer Screening measure, Line 19 *(Note: 42% nationally)*
Universe in Question	Tables 3A, 5, and 7: Based on the universe for total patients with Hypertension reported on Line i Column 2a we estimate a prevalence rate of 43%. This appears high compared to national averages *(Note: 27% nationally)*
Patients with Diabetes by Race or Ethnicity in Question	Tables 3B and 7: The total number of Asian patients with diabetes reported on Table 7 (100) is high compared to total Asian patients reported on Table 3B (200)



Non-eCQM Measures

- Prenatal and Birth Outcomes
- HIV Linkage to Care
- Coronary Artery Disease (CAD)

Prenatal and Birth Outcome Measures

Table 6B: Prenatal Care Patients	≠	Table 7: Deliveries	≠	Table 7: Birth Outcomes
Report **ALL**** (*no sampling*) **prenatal care** patients who received directly, or were referred for, prenatal care services during reporting period		Report all prenatal care patients who **delivered** regardless of outcome (*exclude miscarriage*) during reporting period by race and ethnicity of mother regardless of outcome		Report babies according to their **birth weight** in grams (*exclude stillbirths*) by race and ethnicity of baby; if multiple births report each baby separately

**** Include women who a) began prenatal care in previous year, b) began and delivered in reporting period, and c) will not deliver until next year**

Prenatal Patients by Age and Entry into Prenatal Care
Table 6B

- **Line 0:** Mark the check box if your health center provides prenatal care through direct referral only
- **Lines 1-6:** Report all prenatal care women by age (as of June 30)
- **Lines 7-9:** Report all prenatal care patients by trimester they began prenatal care
  - Prenatal care begins with a comprehensive prenatal care physical exam
  - Report in column (a) if care began at your health center (including any women you may have referred out for care)
  - Report in column (b) if care began with another provider and was then transferred to you

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

Section A - Age Categories for Prenatal 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	1
5	Ages 45 and over	
6	**Total Patients (Sum lines 1-5)**	1

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	1	
8	Second Trimester		
9	Third Trimester		

Deliveries and Birth Outcomes
Table 7

Section A

- **Line 0:** Number of health center patients who are pregnant and are HIV positive regardless of whether or not they received prenatal care from the health center
- **Line 2:** Number of women who had deliveries performed by health center clinicians, including deliveries to non-health center patients

Reminders

- Prenatal Women ≠ Deliveries ≠ Birth Outcomes
- Report mothers in prenatal program and their babies, even if prenatal care or delivery was done by a non-health center provider

Section A: Deliveries and Birth Weight		
Line	**Description**	**Patients (a)**
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	1

Deliveries & Birth Outcomes
Table 7

- **Column 1(a):** Report prenatal care patients who delivered regardless of the outcome (*exclude miscarriages*) during the measurement year by race/ethnicity
  - Report only one woman as having delivered for multiple births
- **Columns 1(b-d):** Report each live birth by birthweight (*exclude stillbirths*) and race/ethnicity of baby
  - Count twins as two births, triplets as three, etc.
  - Very low (VLBW) (Column 1b) is < 1,500 grams
  - Low (LBW) (Column 1c) is 1,500-2,499 grams
  - Normal (Column 1d) is ≥ 2,500 grams

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	1	1	1	
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
—	*Subtotal Hispanic/Latino*	1	1	1	
	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 Race and Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**	1	1	1	

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CAD: Lipid Therapy

Table 6B, 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			

Denominator (a)	Patients 18 years of age and older with an active diagnosis of CAD or diagnosed as having had a myocardial infarction (MI) or had cardiac surgery in the past, with a medical visit during the measurement period and at least two medical visits ever
Numerator (c)	Patients who received a prescription for or were provided or were taking lipid lowering medications during the measurement period
Exclusions	• 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

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HIV Linkage to Care

Table 6B, 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			

Denominator (a)	Patients **first** diagnosed with HIV *by the health center* between October 1, 2017, through September 30, 2018, who had at least one medical visit during the 2-year period (Note: Look back period)
Numerator (c)	Newly diagnosed patients who received medical treatment within 90 days of diagnosis • *Treatment may be initiated with your health center provider or by referral*
Exclusions	None

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Test Your Understanding!

A few prenatal and birth outcome edits:

Short Description	Common Edit Flag
No First Prenatal Visit with Other Provider Reported	Table 6B: No prenatal patients are reported as beginning care with another provider
Low Birthweight Questioned	Table 7: The total "Black/African American" (Line 1c+2c) LBW and VLBW percentage (25%) of births reported appears high *(Note: 12% nationally)*
Inter-year Patients Questioned	Table 7: The total number of Asian prenatal care patients who delivered reported on Table 7 (15) is high compared to total Asian patients reported on Table 3B (50)
Deliveries in Question	The total deliveries on table 7 Line i Column 1a is equal to the total babies delivered by birth weight in Columns *(Note: 1 in 30 babies is born a twin, CDC)*
Number Delivering Questioned	Tables 6B and 7: The total women delivering (200) on Table 7 seems high when compared to the number of women in the prenatal program (260) on Table 6B *(Note: 52% nationally)*

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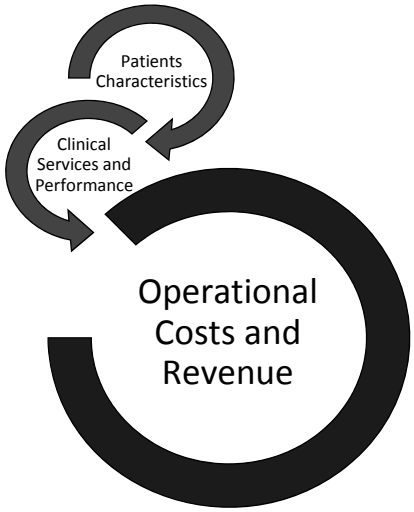
Operational Tables

Income and Insurance (Table 4), Staffing (Tables 5 & 5A), and Finances (Tables 8A, 9D, & 9E)



Why these operational costs and revenue?

- Staffing levels by service type
- Staff tenure
- Program costs
- Patient income and insurance
- Patient revenue
- Non-patient revenue

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How are You Maximizing Resources?

- **Are you working at full capacity?**
- **Are you growing?**
- **Do staffing levels support continuity of care to patients?**
- **How efficient are staffing levels?**
- **How are you retaining staff?**

Table	Description
5	Staffing and Utilization
5A	Tenure of Health Center Staff

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Are You In a Strong Financial Position?

- **How dependent on BPHC funding are you?**
- **Are you maximizing patient revenues?**
- **Are you competitive?**
- **Are you reporting a surplus/deficit?**

Table	Description
8A	Financial Costs
4	Income and Insurance
9D	Income from Patient Revenues
9E	Other Revenues

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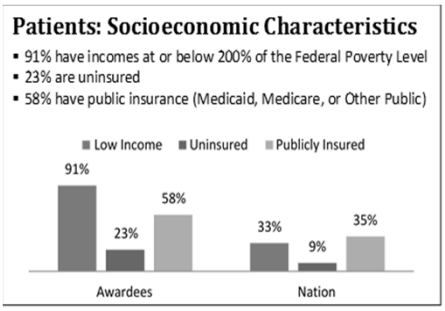
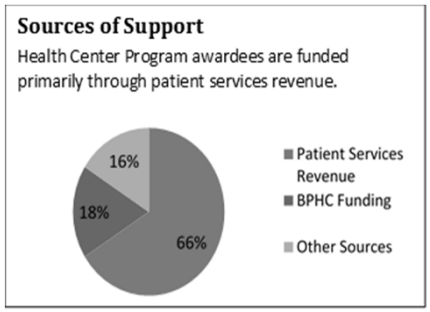
How Are We Doing?

National Statistics – 2017 Rollup



Staff and Financial Category	Average
Total Cost per Total Patient	$942
Medical Cost per Medical Visit	$192
Charge per Billable Visit	$277
Self-pay Charges Written Off as Sliding Discounts	62%
Insured Charges Adjusted as Allowances	28%
Medical Providers of Total FTE	11%
Tenure of Medical Providers	5.3 Years
Medical Visits per Medical Provider	2,914
Surplus/Deficit as Total Cost	3%



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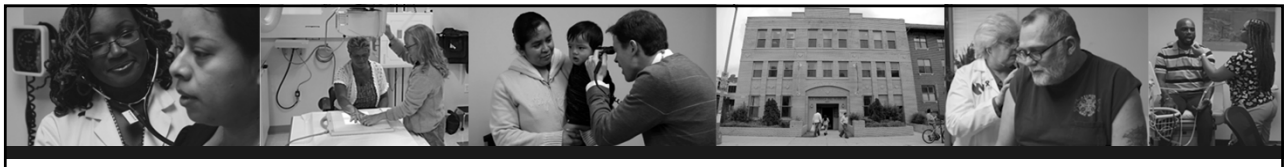

Comparing the Staffing Section of Table 5 with Table 8A

Staffing Levels
Operating Costs

FTE(s) by Service

Table 5

- **Who:** All staff who support "in scope" operations, including employees, interns, volunteers, residents, and contracted staff
  - Do not include paid referral provider FTEs when paid by service (not by hours), but DO count their visits and patients
- **Where:** Based on work performed and credentials
  - Can allocate same person across multiple services except clinicians
- **How:** 1 FTE = 1 person full-time for entire year
  - Full-time defined by health center
  - Employment contract for clinicians
  - Non-exempt, volunteers, based on worked hours *(can exceed 1.0 FTE if paid overtime)*

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians	.25	12	
...	...	...	...	
5	Pediatricians	1.0	13	
7	Other Specialty Physicians			
8	**Total Physicians (Sum lines 1-7)**	1.25	25	
9a	Nurse Practitioners	.6	3	
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	.6	3	
11	Nurses	3.0		
12	Other Medical Personnel			
13	Laboratory Personnel	1.0		
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**	5.85	28	10
16	Dentists		5	
17	Dental Hygienists		4	
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum lines 16-18)**		9	5
...	...	...	...	...
24	Case Managers	2.4	6	
25	Patient/Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers	0.3		
27b	Interpretation Staff	0.3		
27c	Community Health Workers			
28	Other Enabling Services (specify__)			
29	**Total Enabling Services (Sum lines 24-28)**	3.0	6	1
29a	**Other Programs/Services (specify__)**			
29b	**Quality Improvement Staff**			
30a	Management and Support Staff	2.5		
30b	Fiscal and Billing Staff	1.5		
30c	IT Staff	0.5		
31	Facility Staff			
32	Patient Support Staff	3.0		
33	**Total Facility and Non-Clinical Support Staff (Sum lines 30a - 32)**	7.5		
34	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	16.35	43	

Calculate FTE
Example

Regular Employee

One full-time staff worked for 6 months of the year:

1. Calculate base hours for full-time:
   Total hours per year:
   40 hours/week x 52 weeks = 2,080 hours
2. Calculate this staff person's paid hours:
   Total hours for 6 months:
   40 hours/week x 26 weeks = 1,040 hours
3. Calculate FTE for this person:
   1,040 hours/2,080 hours =
   0.50 FTE

Volunteer, Locum, etc.

Four individuals who had worked 1,040 hours scattered throughout the year:

1. Calculate base hours for full-time:
   Total hours per year:
   40 hours/week x 52 weeks = 2,080 hours
2. Deduct unpaid benefits: (10 holidays, 12 sick days, 5 continuing medical education [CME] days, and 3 weeks vacation)
   10+12+5+15 = 42 days * 8 hours = 336
   2080-336 = 1,744
3. Calculate combined person hours:
   Total hours: 1,040 hours
4. Calculate FTE:
   1,040 hours/1,744 hours =
   0.60 FTE

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Selected Staff by Service Category

Use **Appendix A** (from UDS Manual)

- **Other Medical Personnel (Line 12):** Medical assistants, nurses' aides, unlicensed interns or residents, but do not report quality improvement (QI), medical records, patient support, or HIT/EHR staff
- **Dental Therapists (Line 17a):** Only licensed in Maine, Minnesota, Vermont, and Alaska tribal lands
- **Other Professionals (Line 22):** Chiropractors, acupuncturists, physical, speech, and occupational therapists, nutritionists, podiatrists, etc.
- **Other Programs and Related Services (Line 29a):** Non-healthcare program staff (e.g., child care, adult day health, job training, housing programs)
- **Quality Improvement (QI) Staff (Line 29b):** Staff who design and have oversight of QI systems; include QI staff, data specialists, statisticians, HIT including EHR designers, and those who design medical forms or conduct analysis of HIT data
- **IT Staff (Line 30c):** Technology and information systems staff supporting maintenance and operation of computing systems and those managing hardware and software of HIT
- **Patient Support Staff (Line 32):** Intake staff, front desk staff, and patient records

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Tables 5 and 8A Crosswalk

Table 5

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians	.25	12	
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians	1.0	13	
7	Other Specialty Physicians			
8	**Total Physicians (Sum lines 1-7)**	1.25	25	
9a	Nurse Practitioners	.6	3	
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	.6	3	
11	Nurses	3.0		
12	Other Medical Personnel			
13	Laboratory Personnel	1.0		
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**	5.85	28	10
16	Dentists		5	
17	Dental Hygienists		4	
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum lines 16-18)**		9	5
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 (Sum lines 20a-c)**			

Table 8A

	Cost Center
	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 Use Disorder
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: _____)
9a	Vision
10	**Total Other Clinical Services** (Sum Lines 5 through 9a)

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Tables 5 and 8A Crosswalk Continued

Staff FTE on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Providers and Clinical Support Staff	1: Medical Staff
13–14: Lab and X-ray	2: Lab and X-ray
16–18: Dental (e.g., dentists, dental hygienists)	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional (e.g., nutritionists, podiatrists)	9: Other Professional
22a–22c: Vision Services (ophthalmologists, optometrists, optometric assistants, other vision care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling (e.g., case management, outreach, eligibility)	11a–11h: Enabling *Note: Cost categories on Table 8A are not in the same sequential order as they appear on Table 5*
29a: Other Programs/Services (e.g., non-health-related services including WIC, job training, housing, child care)	12: Other Related Services
29b: Quality Improvement	12a: Quality Improvement
30a–30c and 32: Non-clinical Support Services and Patient Support (e.g., corporate, intake, medical records, billing, fiscal, and IT staff)	15: Non-clinical Support Services
31: Facility (e.g., janitorial staff)	14: Facility

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Financial Costs
Table 8A

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Accrued direct costs Include costs of: ▪ Staff ▪ Fringe benefits ▪ Supplies ▪ Equipment ▪ Depreciation ▪ Related travel Exclude bad debt	Allocation of facility and non-clinical support services ▪ Allocate to all other cost centers (lines) Must equal Line 16, Column a	Sum of Columns a + b (done automatically in EHBs) Represents cost to operate service Used to calculate cost per visit and cost per patient

	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 Use Disorder			
8a	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9	Other Professional (Specify: _____)			
9a	Vision			
10	**Total Other Clinical Services** (Sum Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			

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Column a, Lines 1-13
Table 8A

- **Line 1:** Medical staff salary and benefits, including:
  - Paid medical interns or residents
  - Vouchered or contracted medical services
- **Line 2**: Medical lab and x-ray direct expense
- **Line 3**: Non-personnel including HIT/EHR expenses
- **Lines 8a-8b**: Separate drug (8b) from other pharmacy costs (8a)
  - Dispensing fees on 8a
  - Pharmacy assistance program on 11e
- **Lines 5-13 (excluding 8a-8b):** Direct expenses including personnel (hired and contracted), benefits, supplies, and equipment
  - Line 12: Other Related Services includes space rented out within the health center, WIC, retail pharmacy to non-patients, etc.
  - Line 12a: staff dedicated to HIT/EHR design and QI

	Cost Center
	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 Use Disorder
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: _____)
9a	Vision
10	**Total Other Clinical Services** (Sum Lines 5 through 9a)
	Financial Costs of Enabling and Other Services
11a	Case Management
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)

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Column a, Lines 14-19
Table 8A

- **Line 14:** Facility-related expenses including, direct staff costs, rent or depreciation, mortgage interest payments, utilities, security, grounds keeping, janitorial services, maintenance, etc.
- **Line 15:** Costs for all staff reported on Table 5, lines 30a-32, including corporate administration, billing collections, medical records and intake staff; facility and liability insurance; legal fees; managing practice management system; and direct non-clinical support costs (travel, supplies, etc.)
  - Include malpractice insurance in the service categories, not here

Line	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)

- **Line 16:** Total indirect costs to be allocated in Column b
- **Line 18:** "In-kind" services; donated facilities, supplies, and pharmaceuticals; and volunteer hours
  - Value pharmaceuticals at 340B pricing
  - "In-kind" at replacement value

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Allocating Indirect Expenses to Column b
Table 8A

Facility (Line 14)

- **For each facility, identify square footage utilized by each cost center and cost per square foot**
- **Distribute facility costs to each cost center**
- **Common spaces not dedicated to a specific cost center and administrative space is added to non-clinical support costs and distributed**

Non-Clinical Support (Line 15)

- **Distribute non-clinical support costs to the applicable service (optional)**
  - Decentralized front desk staff, billing and collection systems and staff, etc.
  - Consider lower allocation of overhead to contracted services and enabling services
- **Allocate remaining costs using straight-line method (proportion of costs to each service category)**

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Test Your Understanding!

A few staff- and cost-related edits:

Short Description	Common Edit Flag
Productivity Questioned	Table 5: A significant change in Productivity (visits/FTE) of Family Physicians Line 1 (5982) is reported from the prior year (2958)
Quality Improvement in Question	Tables 5 and 8A: You report QI Costs in Table 8A, but no FTEs are reported on Table 5 (Line 29b)
Cost per Visit	Tables 5 and 8A: Mental health cost per visit is substantially different than the prior year–Current Year ($118.26); Prior Year ($85.64)
Overhead Costs Questioned on Line 12	Table 8A: You report direct costs on line 12, Other Related Services, but no overhead allocation has been made

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

Tenure for Health Center Staff

Table 5A

- **Persons:** Number of staff (not FTE) in each category as of December 31, 2018
  - **Full-/Part-Time (a):** employees, contracted onsite staff, and NHSC assignees
  - **Locum, On-call, etc. (b):** residents, locum tenens, on-call providers, volunteers
- **Total Months:** Continuous months of employment in position
  - Employment may pre-date health center grant or look-alike designation - Use employee record hire date
- **Note:**
  - Staff may be reported on more than one line if they hold multiple positions at the end of the year
  - **Table 5A does not equal Table 5!**

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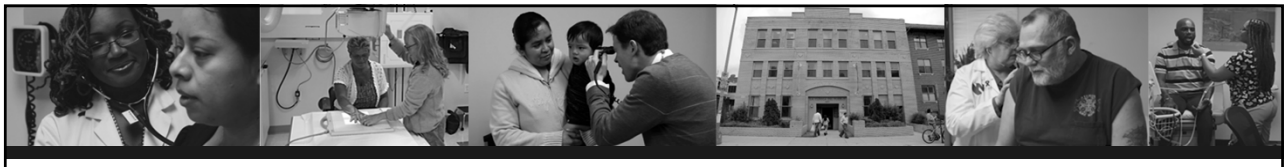

Relationship between Table 4 and Table 9D

Income and Insurance
Patient Revenue

Income and Insurance

Table 4

Line	Characteristic	Number of Patients (a)	
Income as Percent of Poverty Guideline			
1	100% and below	7	
2	101 - 150%	1	
3	151 - 200%	1	
4	Over 200%	1	
5	Unknown	2	
6	**Total (Sum lines 1-5)**	12	
Line	**Principal Third-Party Medical Insurance**	**0-17 years old (a)**	**18 and older (b)**
7	**None/Uninsured**	1	1
8a	Medicaid (Title XIX)		1
8b	CHIP Medicaid	1	
8	**Total Medicaid (Line 8a + 8b)**	**1**	**1**
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		**2**
10a	Other Public Insurance (Non-CHIP) (specify)	1	
10b	Other Public Insurance CHIP		
10	**Total Public Insurance (Line 10a + 10b)**	**1**	
11	**Private Insurance**	**4**	**1**
12	**TOTAL (Sum Lines 7 + 8 + 9 + 10 + 11)**	**7**	**5**

- **Lines 1-4:** Patients by income
  - Use income based on Federal Poverty Guidelines
    - ✓ Most recent income data collected during the measurement year
    - ✓ Can be based on documents submitted or self-reported per Board policy (consistent with the Health Center Program Compliance Manual)
    - ✓ Do not use insurance or special population status as proxy for income
- **Line 5:** Unknown income
- **Lines 7-11:** Patients by primary medical insurance
  - Use medical insurance at last visit
  - Patients by insurance and age must equal detail on ZIP Code and Table 3A

Insurance Categories
Table 4

- **None/Uninsured:** Patient had no medical insurance at last visit - Include uninsured patients for whom the health center may be reimbursed through grant, contract or uncompensated care fund
- **Medicaid (Title XIX):** Medicaid and Medicaid managed care programs, including those run by commercial insurers
- **CHIP Medicaid OR Other Public Insurance CHIP:**
  - If CHIP paid by Medicaid report on 8b
  - If CHIP reimbursed by commercial carrier outside of Medicaid report on 10b
- **Dually Eligible (Medicare and Medicaid):** Subset of Medicare patients who are dually eligible
- **Medicare:** Include Medicare, Medicare Advantage, and Dually Eligible
- **Other Public Insurance (Non-CHIP) (specify**): State and/or local government insurance that covers a broad set of services; NOT grant programs reimbursing limited benefits (e.g., EPSDT, BCCCP)
- **Private Insurance:** Commercial insurance, insurance purchased for public employees or retirees, insurance purchased on the federal or state exchanges

Line	Principal Third Party Medical Insurance
7	**None/Uninsured**
8a	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)**

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Managed Care Utilization
Table 4

Report the sum of monthly enrollment for 12 months by type of insurance

A member month = one member enrolled for 1 month

Complete only for managed care contracts where the patient must go to health center for their primary care - Include:

Capitated plans: For a flat payment per month, services from a negotiated list are provided to patients

Fee-for-Service plans: Paid according to the fees established for primary care and other services rendered

There is generally a relationship between:

Member months on Table 4
Example: 36,788 Medicaid member months ÷ 12 = 3,066

Insurance categories on Table 4
Example: 4,174 Medicaid patients

Managed care lines on Table 9D
Example: Medicaid net capitation $1,044,850 ÷ member months 36,788 = $28

Line	Managed Care Utilization	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)**					

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Managed Care

- **Managed Care Organizations (MCOs) have different names (MCOs, Health Maintenance Organization, Accountable Care Organization, Coordinated Care Organization, etc.)**
- **MCOs may have multiple plans with different payers (e.g., Medicaid and Private)**
- **Health center receives a monthly enrollment list of patients in the managed care plan**
- **Patients are in managed care if they must receive all of their primary care from the health center itself**
- **MCOs may include financial risk**

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Managed Care Reporting

Payment Model	How to Report on the UDS
Capitated managed care covering primary care	Enrollees on Table 4, Line 13a; Revenue on Table 9D "a" line
Capitated managed care covering behavioral health or dental, ***only***	No enrollees on Table 4; Revenue on Table 9D "a" line
Fee-for-service managed care	Enrollees on Table 4, Line 13b; Revenue on Table 9D "b" line
Managed care incentive payments	Revenue on Table 9D, Columns b and c3, and deduct from Column d
Primary care case management (small fee paid per member per month [PMPM] for care coordination)	No enrollees on Table 4; Revenue on Table 9D on non-managed care line
Capitated carve out payments paid as fee-for-service	Do not report enrollees on Table 4 as fee-for-service managed care; Revenue as fee-for-service managed care on Table 9D "b" line

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Crosswalk Between Table 4 and 9D

Table 4 – Principal Third Party Medical Insurance Lines	Table 9D – Primary Payer Revenue Lines
7: Uninsured – No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or uncompensated care fund)	13: Self Pay – Include co-pays and deductibles; state and local indigent care programs *(Do not include revenues from programs with limited benefits–See Other Public, Lines 7-9)*
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care programs and all forms of state-expanded Medicaid)	1-3: Medicaid (includes Medicaid expansion)
9a and 9: Dually eligible and Medicare	4-6: Medicare
10a: Other Public non-CHIP – State and local government insurance that covers primary care	7-9: Other Public – Include patient revenue from programs with limited benefits, such as family planning (Title X), EPDST, BCCCP, etc.
10b: Other Public CHIP (commercial carrier outside Medicaid)	7-9: Other Public
11: Private – Commercial insurance, including insurance purchased of federal or state exchange *(Do not include worker's compensation*)	10-12: Private – Charges and collections from contracts with commercial carriers, schools, jails, head start, tribes, and workers' compensation and state and federal exchanges
13a: Capitated managed care enrollees	"a" lines
13b: Fee-for-service managed care enrollees	"b" lines

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Patient-Related Revenue
Table 9D

				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, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Fee 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)									

Report (columns)

> (a) Charges (2018)
> (b) Collections (**cash** basis)
> (c1-c4) Supplemental payments
> (d) Contractual allowances
> (e) Self-pay sliding discounts
> (f) Self-pay bad debt write-off

By Payer (rows)

> Lines 1-3 Medicaid
> Lines 4-6 Medicare
> Lines 7-9 Other Public
> Lines 10-12 Private
> Line 13 Self-pay

By Form of Payment

> Non-managed care
> a) Capitated managed care
> b) Fee-for-service managed care

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Column a: Full Charges
Table 9D

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

- **Report total billed charges by payer source**
  - Undiscounted, unadjusted, gross charges for services based on fee schedule
    - ✓ Include **all service charges** (e.g., medical, dental, mental health, vision, pharmacy including contract 340b pharmacy)
  - Do not include "charges" where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, or free vaccines)
  - Do not include capitation or negotiated rate as charge amount
  - Do not include charges for Medicare G-codes
    - ✓ To learn more about CMS payment codes visit the CMS website

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Column b: Collections
Table 9D

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

- **Include all payments received in 2018 for services to patients**
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - ✓ Include pay for performance, quality bonuses, and other incentive payments
- **Do not include "meaningful use" payments from Medicaid and Medicare here (report on Table 9E)**

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Columns c1-c4: Retroactive Settlements, Receipts, and Paybacks

Table 9D

Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)			
	Collection of Reconciliation /Wrap-Around Current Year (c1)	Collection of Reconciliation /Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
• Payments reported in c1 – c4 are **part of** Column B total, but do **not** equal Column b	• Federally qualified health center (FQHC) prospective payment system (PPS) reconciliations *(based on filing of cost report)* • Wrap-around payments *(additional amount per visit to bring payment up to FQHC level)*		• Managed care pool distributions • Pay for performance (P4P) • Other incentive payments • Quality bonuses • Court-ordered payments	• Paybacks or payer deductions by payers because of over-payments *(report as a positive number)*

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Column d: Allowances

Table 9D

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

- **Allowances are agreed upon reductions/write-offs in payment by a third-party payer**
  - **-** Reduce by amount of retroactive payments in c1, c2, and c3
  - **+** Add paybacks reported in c4
- **May result in a negative number**
- **Non-payment for services not covered/rejected by a third-party, deductibles, and co-payments due from patients are not allowances – Reclassify to second payer**
- **For managed care capitated lines (2a, 5a, 8a, and 11a) only, allowances equal the difference between charges and collections (because they do no typically carry a balance) Column d = a – b**

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Reclassification of Charges

Line	Payer Category	Reclassify Charge: Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c): Collection of Reconciliation /Wrap Around Current Year (c1)	Collection of Reconciliation /Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools,, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
10	Private Non-Managed Care	~~$200~~ $170	$120					$50		
13	Self Pay	$30								

Reclassify co-payments, deductibles, and charges for non-covered services rejected by third-party payers

Example: An insured patient was seen at the health center. On the day of the service, the service charge for the visit was $200. The insurer paid $120 with an allowance of $50.

- Post service charge for private payer = $200 at time of service
- Post payment of $120 with a $50 allowance on the private line when payment is received
- Reduce the initial charge of $200 to private insurance by $30—this is the co-pay owed by the patient
- Reclassify the $30 co-pay to self-pay charges

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Column e: Sliding Fee Discounts
Table 9D

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

- **Report reductions in patient charges based on their ability to pay as a sliding-fee discount**
  - Based on the patient's documented income and family size (per federal poverty guidelines)
- **May be applied:**
  - To insured patients' co-payments, deductibles, and non-covered services
  - Only when charge has been reclassified from original charge line to self-pay
- **May not be applied to past-due amounts**

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Sliding Fee Discounts Example

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation /Wrap-Around Current Year (c1)	Collection of Reconciliation / Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)			
13	Self Pay	$200	$10						$180	$10

An uninsured patient was seen at the health center. On the day of the service, the patient qualified for a sliding discount that required her to pay 10% of the service charge.

- The service's full charge is $200
- A fee of $20 was charged to the patient (10% of full charge)
- The patient paid $10
- The patient still owed $10 and this was written off by the health center

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Column f: Bad Debt Write Off
Table 9D

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

- **Only report patient bad debt (not third-party payer bad debt)**
  - Report on Line 13
  - Third-party payer bad debt is not reported in the UDS
- **Include amounts owed by patients considered to be uncollectable and formally written off during 2018, regardless of when service was provided**
- **Do not change bad debt to a sliding discount**
- **Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount)**

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Test Your Understanding!

A few income, insurance, and payer edits

Short Description	Common Edit Flag
Member Months in Question	Table 4: A large number of Medicaid member months is reported compared with the total Medicaid enrollment served reported on Line 8
Patients Unknown Income Questioned	Table 4: More than 50% of total patients are reported as having Unknown income
Inter-year Change in Uninsured Patients	Table 4: The percentage of Uninsured patients to total patients has significantly increased when compared to prior year–Current Year 33%; Prior Year = 14%
CHIP	Table 4: More than 25% of CHIP patients are adults
Change in Collections in Question	Table 9D: A large change from the prior year in collections per medical+dental+mental health visit is reported
Self-Pay Reporting in Question	Table 9D: More collections and write-offs are reported than charges for self-pay, Line 13
FQHC Medicaid Non-Managed Care Retroactive Payments Questioned	Table 9D: FQHC Medicaid Non-Managed Care retros exceed 50% of collections

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Test Your Understanding!

More income, insurance, and payer edits:

Short Description	Common Edit Flag
Possible Material Reclassification Problem	Table 9D: The self pay collection rate 0.76 exceeds the combined collection rate for Medicare and Private Insurance 0.52
Large change in accounts receivable for Total Medicaid is reported	Table 9D: Total Medicaid, Line 3: When we subtract collections (Column b) and adjustments (Column d) from your total Medicaid charges (Column a) there is a large difference—53%
Charge to Cost Ratio Questioned	Tables 8A and 9D: Total charge to cost ratio of 0.7 is reported that suggests that charges are less than costs
Inter-year Capitation PMPM questioned	Tables 4 and 9D: The average Medicaid capitation PMPM reported on Line 2a $56 is significantly different from the prior year $24
Patient Revenue Reported in Question	Tables 4 and 9D: Private Managed Care Collections are reported on Table 9D with no matching Private Managed Care Member months on Table 4, Line 13c Column d

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Other Revenue
Table 9E

- **Report non-patient income received in 2018**
  - **Cash basis** – amount drawn down (not award)
  - Include income that supported activities described in your scope of services
  - Report funds from the entity from which you received them
  - Complete specify fields
- **Revenue reported on Tables 9E and 9D represent total income supporting scope of services**

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 BHPC Grants (Sum Lines 1g + 1j + 1k)**	
Other Federal Grants		
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify:___)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5	**Total Other Federal Grants (Sum Lines 2-3a)**	
Non-Federal Grants Or Contracts		
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)**	

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Income Categories

- **BPHC Grants:** Funds received directly from BPHC, including funds passed through to another agency
- **Ryan White:** Report Part C (Part A is usually reported on line 7; Part B is usually reported on line 6)
- **Other Federal Grants:** Grants received directly from the federal government other than BPHC (e.g., Ryan White Part D, HUD, SAMHSA, CDC)
- **EHR Incentive Payments:** Report Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule)

Line	Source
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 BHPC Grants (Sum Lines 1g + 1j + 1k)**
Other Federal Grants	
2	Ryan White Part C HIV Early Intervention
3	Other Federal Grants (specify:___)
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers
5	**Total Other Federal Grants (Sum Lines 2-3a)**

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Income Categories

- **State and Local Government:** Funds received by a state or local government, taxing district, or sovereign tribal entity (e.g., WIC)–Do not include fee-for-service payments (e.g., BCCCP) or indigent care programs (see next slide) here
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue:** Contributions, fundraising income, rents, sales, interest income, patient record fees, pharmacy sales to the public (i.e., non-health center patients), etc. Do not report bad debt recovery or 340B payments here–These revenue are reported on Table 9D

Line	Source
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)**

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Reporting Indigent Care Programs

Table	Line	Report
4	**7**	**Patient as uninsured, not other public**
9D	**13**	**Charges, collections, bad debt (if any) as self-pay, balance not owed by patient as sliding fee**
9E	**6a**	**Funds received from state and local program that subsidize/pay for health care (general) services to uninsured and IHS PL 93-638 Compact funds** • Based on a current or prior level of service or lump sum per visit (not fee-for-service) • Private contracts with tribes are to be reported as private, on Table 9D • Do not report these funds on both Tables 9D and 9E

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Other Forms to Complete

HIT Capabilities Form

- **Questions about health center's implementation of EHR, certification of systems, and how widely adopted the system is**
  - For clinical measure reporting the use of a certified EHR fully installed at all sites and used by all providers is critical for accuracy
  - The use of EHRs to report on all CQMs provides opportunity to be recognized as an Improving Quality of Care EHR Reporter, as part of a Quality Improvement Award

Other Data Elements

- **Telehealth**
- **Medication-assisted treatment (MAT)**
  - Count only MAT (specifically buprenorphine) provided by providers with a Drug Addiction Treatment Act of 2000 (DATA) waiver
- **Outreach and enrollment assistance**
  - Assists reported here do not count as visits on the UDS tables

Report forms based on your health center's status *as of December 31*

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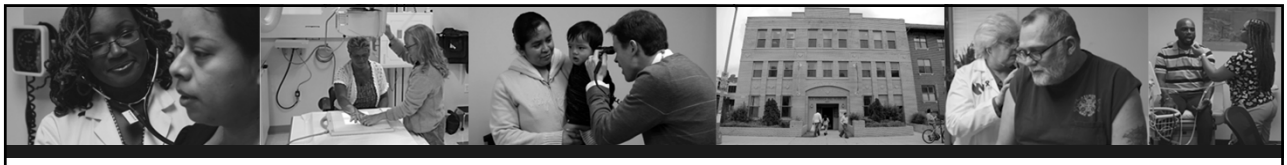

Proposed Changes to 2019 UDS Reporting

Program Assistance Letter (PAL) 2018-03

Modernization Update

UDS Modernization

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2019 Proposed Changes

- **Tables 6B and 7:** Update Quality of Care Measures to align with eCQMs
  - eCQMs align with version 7 except for:
    - ✓ Use of Appropriate Medications for Asthma – version 5
    - ✓ Depression Screening and Follow-up Plan – version 8
    - ✓ Dental Sealants – CMS277

- **Table 5A:** Removal of tenure for health center staff table
- **Appendix D:** Revisions to HIT Capabilities Form
  - To further streamline, clarify, and focus on interoperability and patient access to health information
- **Appendix F:** New Workforce Form
  - To collect information on health center workforce training and staff satisfaction surveys

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Addition of Column in Table 5

Staffing and Utilization To Capture Virtual Visits

- **The addition of a Column (b2) in Table 5 to capture virtual visits to quantify the use of virtual visits among health centers**
  - Two-way interactive live video and/or audio
  - If the health center provider delivers service, count the visit and patient (need patient record)
  - If the health center patient receives service from a non-health center provider, only count if the health center pays for the visit
  - All other rules for reporting visits apply

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	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)	blank			
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-20c)				
*	***Excerpt from Table 5***				

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Addition of Mental Health and Substance Use Disorder
Selected Service Detail

- **To understand the breadth of behavioral health services being provided**
  - Mental health and substance use disorder treatment by medical providers
  - Substance use disorder treatment provided by mental health providers
  - Will be reported in a new part of Table 5
  - These visits will be reported here IN ADDITION TO reporting the visits in the main part of Table 5

Selected Service Detail					
Line	**Mental Health Service Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
20a01	Physicians (other than psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Clinical Nurse Midwives				
blank	**Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Psychiatrists				
21b	Physicians (other than psychiatrists)				
21c	Nurse Practitioners				
21d	Physician Assistants				
21e	Clinical Nurse Midwives				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Worker				

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New Clinical Measures
Table 6B

Addition of CMS50v7: Closing the Referral Loop: Receipt of Specialist Report

Line	Closing the Referral Loop: Receipt of Specialist Report	Total Patients Referred by One Provider to Another Provider (a)	Charts Sampled or EHR Total (b)	Number of Patients with a Referral, for which the Referring Provider Received a Specialist Report (c)
23	MEASURE: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred			

Replacement of Coronary Artery Disease Measure with CMS347v2: Statin Therapy for the Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed, or on Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events- who were prescribed or were actively using statin therapy			

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Modernization Updates

Major Updates

- **Major Updates**
  - Complete the UDS report outside of the EHBs
  - Download UDS tables in Excel
  - Or download an offline HTML file that works and looks like the EHBs
  - Data can be entered by multiple staff offline
  - Upload completed UDS reports back into the EHBs
  - Additional training on new UDS reporting features available
    - ✓ October 31 from 1 to 3 p.m. (ET)
    - ✓ November 9 from 1 to 3 p.m. (ET)

Preliminary Reporting Environment (PRE)

- **New reporting features available in the PRE:**
  - New reporting features available in the PRE
  - Comparison tool to check current UDS report to last year's UDS report
  - Data entered into the PRE will automatically transition over when the reporting period opens on January 1
  - For more information watch the UDS Enhancements video

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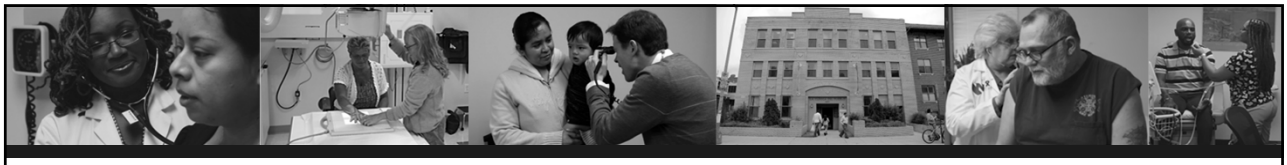

UDS Support

Support is available to help you produce a complete and accurate UDS report

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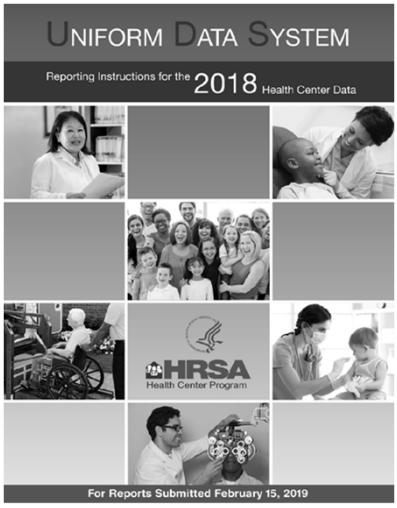
Available Resources

- **UDS Content Support Phone and Email:**
  - 1-866-UDS-HELP
  - udshelp330@bphcdata.net
- **Manual and fact sheets**
- **Trainings (including webinars)**
- **Login / system support:**
  - HRSA Call Center for EHBs access and roles:
    - ✓ 877-464-4772, Option 3
  - Health Center Program Support for EHBs system issues:
    - ✓ 877-464-4772, Option 1
- **UDS system overview and enhancements videos and wiki pages**
- **E-learning modules and other resources at:**
  - UDS Training Website
  - BPHC Health Center Website



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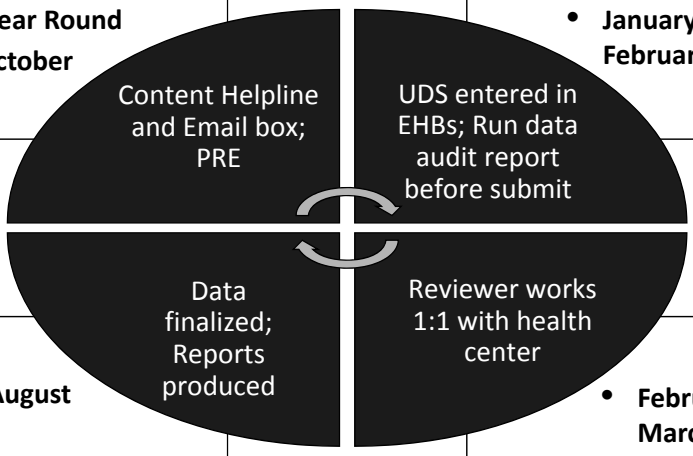
Reporting and Review Schedule

- **Help – Year Round**
- **PRE – October 2018**

- **January 1 – February 15, 2019**



- **April – August 2019**

- **February 15 – March 31, 2019**

EHBs Link

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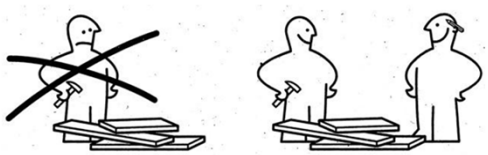
Tips for Success

- **Tables are inter-related so sit with team to agree what will be reported:**
  - Sites
  - Staff, FTEs, and roles
  - Patients and services
  - Expenses
  - Revenues



- **Adhere to definitions and instructions**
  - Refer to the manual, fact sheets, and other resources
- **Check your data before submitting**
  - Refer to last year's reviewer's letter emailed to the UDS Contact
  - Compare with benchmarks/trends
- **Address edits in EHBs by correcting or providing explanations that demonstrate your understanding**
  - *"The number is correct" is not a sufficient explanation*
- **Work with your reviewer**

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Who Uses UDS Data, and Why

- **HRSA**
  - Report to Congress
  - Program monitoring
  - Quality awards
- **Primary Care Associations**
  - Advocate for health centers
  - Identify TA/T needs
- **Health Center Controlled Networks**
  - Identify priority TA/T needs
- **Payers**
  - Assess performance
  - Incentive payments
- **Health Centers – YOU!**
  - Track performance
  - Identify QI needs
  - Assure quality care to patients

An accurate and complete UDS is important!
It is used by many stakeholders to support the Health Center Program

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Administering Program Conditions

Health centers **must** demonstrate compliance with these requirements:

- The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet Health and Human Services (HHS) reporting requirements, including those data elements for UDS reporting; and
- The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports

Source: Chapter 18: Program Monitoring and Data Reporting Systems of the Health Center Compliance Manual

Conditions will be applied to health centers who fail to comply by February 15

- **February 16-April 1**—The Office of Quality Improvement (OQI) will finalize and confirm the list of "late", "inaccurate", or "incomplete" UDS reporters
- **Mid-April**—OQI will notify the respective Health Services Offices (HSO) Project Officers of the health centers that are on the non-compliant list
- **Late April/Early May**—HSOs will issue the related Progressive Action condition

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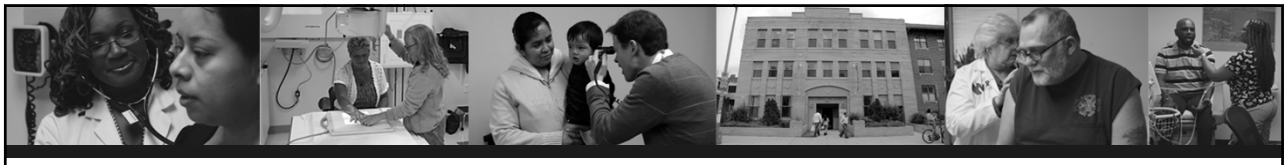

Please Complete an Evaluation!

Your input is important to us

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Contact Information

Remember to call the UDS Support Line if you have additional content questions:

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net

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