UNIFORM DATA SYSTEM

UDS Training Calendar Year 2016

Bureau of Primary Health Care

HRSA Health Center Program

Agenda

- Introduction to the Uniform Data System (UDS): Who, What, When, Where, Why
- 2016 UDS Changes and 2017 UDS Proposed Changes
- Definitions Used in the UDS Report
- Step-by-Step UDS Table Instructions
- Strategies for Successful Reporting
- Assistance Available to Help Complete the UDS

INTRODUCTION TO UDS

Who, What, When, Where, and Why

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Who Reports the UDS

- Health Center Program grantees authorized by section 330 of the Public Health Service Act
  - Community Health Center (CHC - 330(e))
  - Health Care for the Homeless (HCH - 330(h))
  - Migrant Health Center (MHC - 330(g))
  - Public Housing Primary Care (PHPC - 330(i))
- Health Center Program look-alikes
- Bureau of Health Workforce (BHW) primary care clinics

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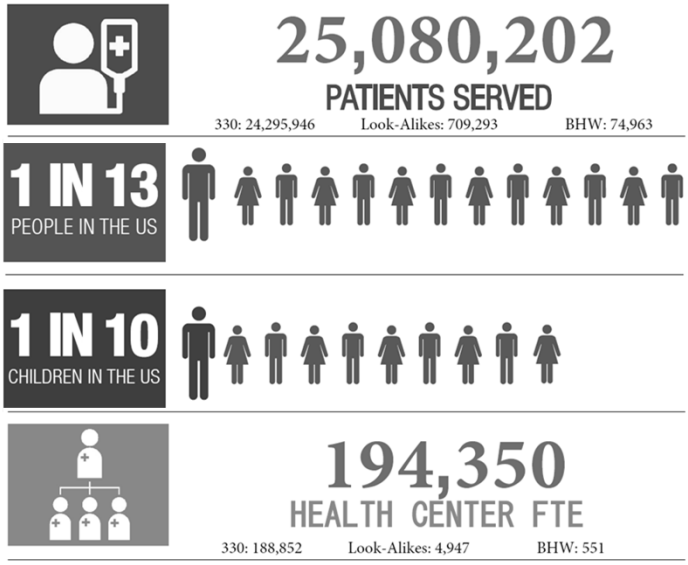
National Impact/Community Focus



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In-Scope Activities

- Report all “in-scope” activities in the health center’s Notice of Award/designation
  - All related staff, services, patients, visits, income/revenue, expenses/costs
  - Do not include sites or services which are not approved
- Report on activities that occurred during the period from **January 1, 2016 - December 31, 2016**
  - Calendar year reporting—not based on grant year or fiscal year
  - And were funded or designated before October 2016

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What is Reported

- A detailed picture of your health center using:
  - Twelve tables, which provide clinical, operational, and financial data
  - A Health Information Technology (HIT) form

What is Reported	Table(s)
Patients served and their demographic characteristics	ZIP Code, 3A, 3B, 4
Types and quantities of services provided	5, 6A
Staffing mix and tenure	5, 5A
Quality of care/health outcomes and disparities	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D, 9E
HIT capabilities, electronic health record (EHR) interoperability, Meaningful Use leveraging, telehealth, and medication-assisted treatment (MAT)	HIT Form

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Components of UDS Report

- Universal Report—Completed by all reporting health centers with data for the entire scope of the grant/designation
- Grant Report(s)—Completed by Health Center Program grantees that receive 330 grants under multiple program funding authorities

Table	Report a Universal Report if you are: 330-funded program Look-alike BHW primary care clinic	Also report Grant Report(s) if you receive 330 grants under multiple program authorities: HCH (330(h)) MHC (330(g)) PHPC (330(i))
ZIP Code	Yes	No
3A, 3B, 4	Yes	Yes
5	Yes	Yes, but patients and visits only
5A	Yes	No
6A	Yes	Yes
6B, 7, 8A, 9D, 9E	Yes	No

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Where to Report

- Report through the web-based data collection system through the Electronic Handbooks (EHB)
- Authorized staff can work on the tables
  - Multiple people can work on the UDS at the same time as long as they are in different tables
- Acknowledge that data was reviewed and validated and the accuracy verified prior to submission
  - EHB includes summary of incomplete tables and of questions about the data
- Link to UDS in EHB: https://grants3.hrsa.gov/2010/WebEPSExternal//Interface/common/accesscontrol/login.aspx

HRSA | Electronic Handbooks

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When: Important Dates

- January 1—UDS Report is available in EHB
- **February 15—Due Date**
- February 15 - March 31—Review period
  - Work with your assigned UDS reviewer
- March 31—All corrected submissions must be finalized
  - No further changes made after this date

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Why do we report the UDS?

- Comply with legislative and regulatory requirements
- Inform HRSA, Congress, and the public of health center performance and operations
- Identify trends over time
- Identify and target effective programs, services, and needed interventions
- Permit comparison with national benchmarks

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CHANGES IN UDS REPORTING

Changes by Table

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2016 Changes

- **Table 3A**: Patients are to be reported on Table 3A according to their sex at birth
- **Table 3B**: Two new sections have been added: Patients are now reported by sexual orientation and by gender identity
- **Table 4**: Line 26, Public housing patients definition stays the same, but instructions have been further clarified
- **Tables 5 and 8A**: New lines have been added to report staff and costs of dental therapists (and their patient activity), quality improvement staff, and community health workers
- **Table 5A**: New line added to report dental therapists
- **Table 6A**: Codes have completely transitioned to International Classification of Diseases, Tenth Revision ICD-10 (ICD-9 is no longer reported)

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2016 Changes Continued

- **Tables 6B and 7**: Virtually all of the UDS quality of care measures are now aligned with the Centers for Medicare & Medicaid Services (CMS) e-CQMs for Eligible Professionals
  - The June 2015 eReporting update must be used for the 2016 reporting period
  - Major differences between 2015 and 2016 reporting will be outlined later in the presentation

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Clinical Measures Aligned with e-CQMs

Table	Line	Description	e-CQM
6B	10	Childhood Immunization Status	CMS117v4
6B	11	Cervical Cancer Screening	CMS124v4
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v4
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS69v4
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v4
6B	16	Use of Appropriate Medications for Asthma	CMS126v4
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS164v4
6B	19	Colorectal Cancer Screening	CMS130v4
6B	21	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS2v5
6B	22	Dental Sealants for Children between 6-9 Years	CMS277v0
7	Part B	Controlling High Blood Pressure	CMS165v4
7	Part C	Diabetes: Hemoglobin A1c Poor Control	CMS122v4

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2016 Health Information Technology (HIT) Form Changes

- **HIT Form**: Additional questions have been added about:
  - Telehealth capacity and use
  - Medication-assisted treatment (MAT)

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2016 HIT Form Additions

12. **Medication-Assisted Treatment (MAT) for Opioid Use Disorder**

a. How many physicians, onsite or with whom the health center has contracts, had 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 with a DATA waiver working on behalf of the health center?

Note: The following ICD-10-CM code may assist in identifying MATs: ICD-10-CM F11-

13. 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.

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: _____

http://www.hrsa.gov/ruralhealth/telehealth/index.html

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2017 Proposed Changes

- **Tables 6B and 7**: Virtually all quality of care measures will align with e-CQMs for Eligible Professionals April 2016 eReporting
- **Other Data Elements Form**: The telehealth and MAT questions introduced in 2016 will be removed from the HIT Form and added to this new form
- **Other Data Elements Form**: Health centers will report the number of outreach and enrollment assists

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KEY DEFINITIONS

Visits, Patients, Providers

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Reportable Visits Defined

- Visits are used to determine who is counted as a patient on the UDS report
- To be counted as having met the visit criteria, the interaction must be:
  - Documented;
  - One-on-one contact between a patient and a licensed or credentialed provider; and
    - Exception: Group visits and telemedicine conducted by behavioral health providers only
  - By a provider who acts independently and exercises professional judgment in the provision of services to the patient

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Reportable Visits Defined Continued

- Must take place in the health center or at any other approved site or location
  - Count paid referral visits
  - Count when following current patients in a nursing home, hospital, or at home
  - Count visits provided by both paid and volunteer staff
  - If patient is first encountered at a nursing home, hospital, or similar facility that is not in approved scope, or at their home, the activity is not included in the UDS

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Reportable Visits Continued

- Count only one visit per patient, per visit type, per day
- Count only one visit per provider, regardless of the number of services provided
- Count only one visit per provider type
  - Exception: Two providers of same type at two different locations (sites) on the same day

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Patients Defined

- A patient is an individual who has at least one reportable visit during the calendar year
  - On the ZIP Code table, Table 3A, and in each section of Tables 3B and 4, count each patient once and only once, even if she or he received more than one type of service
  - Patients are reported once and only once on Tables 5 (Column C) and 6A (Column B) for each type of service or diagnosis received during the year
    - There are seven service categories: medical, dental, mental health, substance abuse, other professional, vision, and enabling services

Example: A patient seen could be counted as a medical patient AND a dental patient AND a vision patient if they had a countable visit in each service. Count the patient once on the ZIP Code Table; Tables 3A, 3B, and 4; AND once in each of the categories in which they had a countable visit on Table 5. Also count the patient on Table 6A once and only once for each diagnosis or services received.

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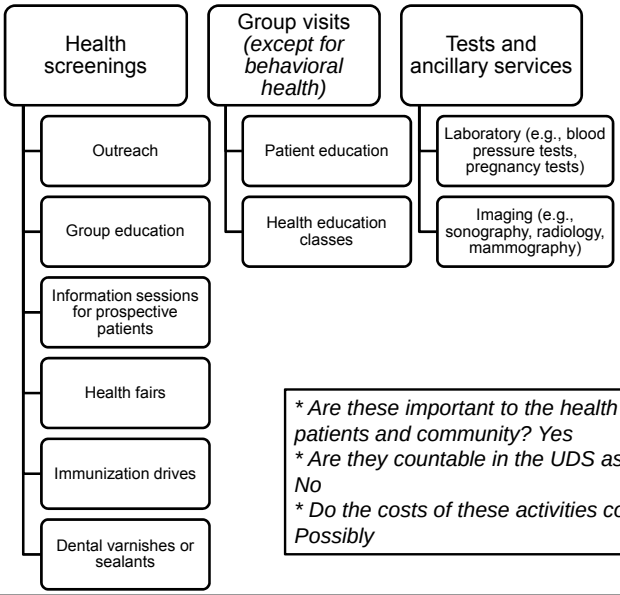
Services and Persons Not Reported



** Are these important to the health of your patients and community? Yes*
** Are they countable in the UDS as a visit? No*
** Do the costs of these activities count? Possibly*

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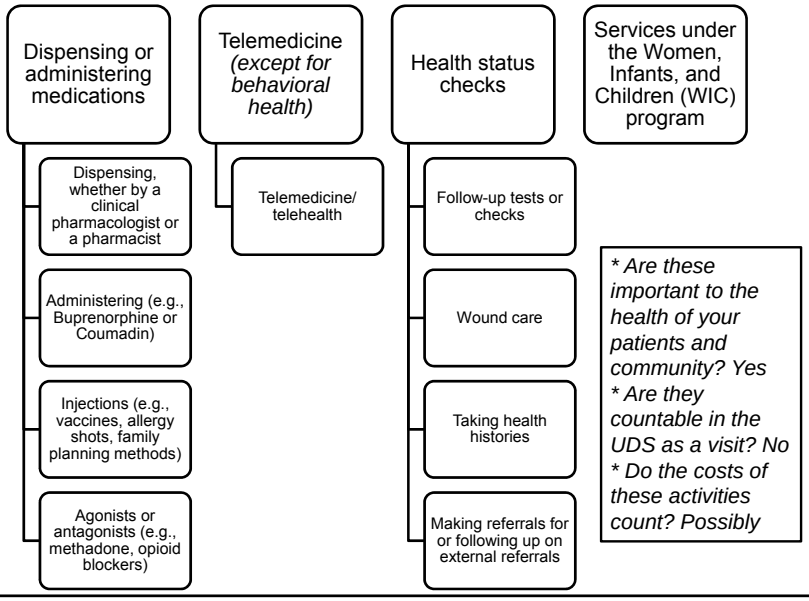
Other Services and Persons Not Reported



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Provider Defined

- A provider is defined as an individual who:
  - Assumes primary responsibility for assessing the patient and documenting services in the patient's record and
  - Exercises independent judgement regarding the services provided—which must be in their field of training (licensure and credentialing)
- Staff time should be allocated by function among major service categories
- Only those designated as "providers" in Appendix A of the UDS Manual can generate visits in the UDS
- Providers may be employees of the health center, contracted staff, or volunteers

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THE UDS TABLES

Step-by-Step Instructions

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ZIP CODE TABLE

Patients by ZIP Code

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Patients by ZIP Code and Insurance

- List all ZIP Codes with 11 or more patients in Column A
  - Aggregate ZIP Codes with 10 or fewer patients as "other"
- Report each ZIP Code by primary medical insurance
  - Use and apply same rules used for reporting patient's insurance on Table 4 (totals must be equal)

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

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Special Instructions for Reporting Patients by ZIP Code

- 330 grant funds are not a form of insurance
- Use the ZIP Code of service location if no address is obtained for a patient experiencing homelessness
- For migratory agricultural workers use the ZIP Code where the patient was housed when they received care
- Use current United States ZIP Code for persons from other countries
- These data provides current geographic service area of health centers and are updated yearly on UDS Mapper at http://www.udsmapper.org/

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TABLE 3A

Patients by Age and by Sex Assigned at Birth

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Patients by Age and Sex Assigned at Birth

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)**		

- Report the number of patients by age and by sex
- ***2016 Change***: Report patients according to their sex at birth (no longer self-reported gender)
- Calculate age on this table as of **June 30**
  - Note: The non-prenatal portions of Tables 6B and 7 define age as of December 31
- Count each patient once and only once *(regardless of number or type of visits)*
- The total (Columns A+B) on Line 39 must equal the totals from the ZIP Code Table and each section from Tables 3B and 4

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TABLE 3B

Demographic Characteristics

- Hispanic or Latino Ethnicity and Race
- Language Preference
- Sexual Orientation
- Gender Identity

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Demographic Characteristics

- Now titled “Demographic Characteristics”
- Table 3B has three sections to report patients:
  - Patients by Hispanic or Latino Ethnicity, Race, and Language: Lines 1-8 and 12 *(No change)*
  - Patients by Sexual Orientation: Lines 13-19 ***(New)***
  - Patients by Gender Identity: Lines 20-26 ***(New)***
- The total patients in each section of Table 3B (except language) must equal each other and must equal the ZIP Code Table, unduplicated patient count on Table 3A, and insurance and income sections on Table 4

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Ethnicity, Race, and Language

- Patients are to self-report ethnicity and race (Lines 1-8)
  - Patients should be able to indicate multiple races—report them on Line 6, "More than one race"
  - If a patient did not explicitly choose Hispanic/Latino BUT reported a race, report them in Column B
  - If race is unreported, report on Line 7
  - Only report patients who do not report race OR ethnicity in Column C
- Report patients best served in a language other than English on Line 12
  - Only this line may be estimated

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	

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Sexual Orientation and Gender Identity

- ***Implemented effective calendar year 2016***
- Important to identify and reduce health disparities and promote culturally competent care in health centers
  - Aligned with the Office of National Coordinator for Health Information Technology (ONC) certification program
- Self-reported by all patients or their care givers
  - Collection of this data is encouraged but not mandated from patients less than 18 years of age
  - All patients (including minors) must be reported in each section
- Health centers are to have established, routine data collection systems to capture this information

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)**	

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Special Instructions for Sexual Orientation and Gender Identity Reporting

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)**	

* If a health center is unable to report a patient's sexual orientation or gender identity, provide an explanation of the hardship experienced in Table 3B Comments of the UDS Report submission

- Line 17, "Don't Know," and Line 24, "Other"—Use to report:
  - On Line 17, patients who indicated that they do not know what their sexual orientation is
  - On Line 24, patients who indicated that they are of another gender identity than those described here (e.g., genderqueer, non-binary)
  - Missing data.* For example:
    - Patients seen prior to the health center gathering this information
    - Patients who left these sections blank on the registration or intake form
    - Minors not asked this information
- Lines 18 and 25, "Chose not to Disclose" —Use to report:
  - Patients who chose not disclose their sexual orientation or gender identity
  - Do not use this line if health center did not collect this information from patients

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TABLE 4

Selected Patient Characteristics

- Income as a Percent of Poverty Guideline
- Principal Third Party Medical Insurance
- Managed Care Utilization
- Special Populations

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Patients by Income, Lines 1-6

- Income of patients must be updated annually to qualify for sliding discounts, but should be collected from all patients. Report:
  - Most recent family income
  - On Line 5 as "unknown" if not collected within a year of their last visit
- Defined in ranges relative to the federal poverty guidelines (FPG)
- May be self-declared if consistent with Board-approved policy
- Patients who are experiencing homelessness, are migrant agricultural workers, or who are on Medicaid cannot be assumed to be 100% and below poverty
- Total patients on Line 6 must equal unduplicated patients reported on the ZIP Code Table, Table 3A, in each section of Table 3B, and the insurance section of Table 4

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

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Principal Third Party Medical Insurance, Lines 7-12

- Report primary source of medical insurance for all patients
  - No "unknowns" for insurance—must identify all patients' primary medical insurance status
- Primary medical insurance is the insurance plan that the health center would typically bill first for medical services, *regardless of whether the patient received medical care*
- Report insurance as of the last visit of the year
- Report by ages 0-17 and 18 and older
- Total patients on Line 12 must equal unduplicated patients reported on the ZIP Code Table, Table 3A (by age), in each section of Table 3B, and the income section of Table 4

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)**		

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Insurance Categories

- **Uninsured (Line 7)**
  - Patients who do not have medical insurance at the time of their last visit
  - May include patients whose services are reimbursed though a grant, contract, or uncompensated care fund
  - Do not assume and count as uninsured:
    - If a patient is experiencing homelessness or seen at a school-based clinic
    - Services not covered by insurance

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)**		

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Insurance Categories

- **Regular Medicaid (Line 8a)**
  - Include Medicaid managed care programs run by commercial insurers
  - Include those making use of Medicaid expansion
- **Children's Health Insurance Plan (CHIP) (Lines 8b or 10b)**
  - CHIP provided through Medicaid—Report on Line 8b
  - CHIP provided through commercial carrier outside of Medicaid—Report on Line 10b
  - Do not report CHIP as private insurance
  - CHIP varies from state to state—some with different names
  - If unable to distinguish between regular Medicaid and CHIP Medicaid, classify patients on Line 8a, Regular Medicaid

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)**		

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Insurance Categories Continued

- **Medicare (Line 9)**
  - Include Medicare, Medicare Advantage, MediGap, and Dually Eligible (Medicare/Medicaid)
  - In addition to reporting dually eligible patients on Line 9, also report them on Line 9a
- **Other Public Insurance Non-CHIP (Line 10a)**
  - State and/or local government insurance that covers a broad set of benefits
  - Do not include:
    - Federal or state exchanges
    - Programs with limited benefits, such as family planning; Early Prevention, Screening, Detection, and Treatment (EPDST); Breast and Cervical Cancer Control Program (BCCCP)
- **Private Insurance (Line 11)**
  - Commercial and not-for-profit company insurance
  - Include federal or state exchanges
  - Workers' compensation is a form of liability insurance
    - Report these patients according to the medical insurance they have; if they do not have medical insurance, report as uninsured on Line 7

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)**		

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Managed Care Utilization, Lines 13a-13c

- Complete only for managed care contracts where the patient must go to health center for their primary care. This includes:
  - 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
- Do NOT count as managed care:
  - Primary care case management (PCCM)
  - Patient-centered medical home (PCMH) demonstration grant
  - Patients enrolled for non-medical services only (e.g., dental, mental health)
- Report the sum of monthly enrollment for twelve months
  - A member month = one member enrolled for one month

Example: One person enrolled in a managed care plan from March - July would have five member months

- There is generally a relationship between member months, insurance (Lines 7-11), and income on the managed care lines of Table 9D

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)**					

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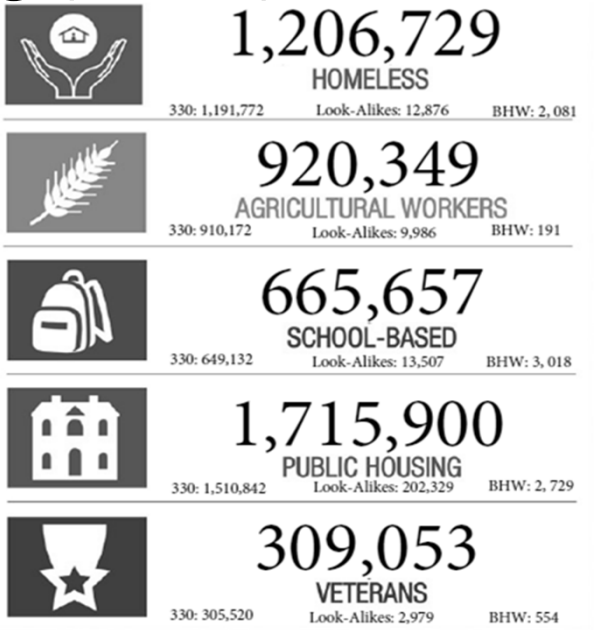
Serving Special Populations



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Sample Questions to Identify Agricultural Workers or Dependents

1. In the last two years, have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packinghouse, driving a truck for any type of farm work, working with farm animals such as cows, chickens, etc. Yes or No
2. In the last two years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)? Yes or No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)? Yes or No

Source: http://www.ncfh.org/administrative.html

Website: http://www.ncfh.org/

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Sample Questions to Identify Patients Experiencing Homelessness

Please check the statement which best describes your housing situation:

- ❑I live in my home which I rent, lease, or own
- ❑I am staying with a series of friends and/or extended family members on a temporary basis
- ❑I am staying in supportive or transitional housing (such as a sober living facility or recovery home)
- ❑I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility, or motel)
- ❑I have been released from an institution (such as jail or hospital) without stable housing to return to
- ❑I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation
- ❑I live in a foster care environment

Source: https://www.nhchc.org/wp-content/uploads/2016/10/ask-code-policy-brief-final.pdf

Website: https://www.nhchc.org/

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Targeted Special Populations

- **Agricultural Workers or Dependents (Lines 14-16)**
  - Migratory—An individual who establishes a temporary home for the purposes of such seasonal employment, including aged or disabled former agricultural workers
  - Seasonal—An individual who does not establish a temporary home for the purpose of seasonal employment
  - Status must be verified at least every two years
- **Homeless (Lines 17-23)**
  - Homeless—An individual who is experiencing homelessness at the time of any service provided during the year
  - Include patients in permanent supportive housing
  - Report where they are housed as of first visit during the year for housing status (Lines 17-22)
  - If institutionalized, report where the patient will spend the night after release
  - Continue to count as homeless (on Line 21) for 12 months after last visit while homeless
- ***All health centers must report total number of agricultural workers on Line 16 and total patients who are experiencing homelessness on Line 23, even if they do not receive the targeted funding for that population***

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)	

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Targeted Special Populations

- **School-Based Health Center Patients (Line 24)**
  - Report the number of patients who received primary care services at an approved (in-scope) school-based health center (on or near school)
- **Veterans (Line 25)**
  - Report the number of patients who have been discharged from the uniformed services of the United States; do not count active members
- **Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (Line 26)**
  - Report all patients seen at a site 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 330(i) funding
- ***All health centers must report total number of special population patients (if any) on Lines 24 and 25, and sites on Line 26, even if they do not receive the targeted funding for that population***

Line	Special Populations	Number of Patients (a)
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)	

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Pop Quiz: Patient Demographics

The total unduplicated patient count for a health center is 3,000 patients in 2016. When running a report of patients by insurance, there was some confusion as to insurance categories for 200 patients, as follows:

- 100 patients received services paid for by family planning funds
- 10 patients were on workers' compensation
- 60 patients had private dental insurance
- 30 patients were insured by Medicaid at their first visit but were privately insured at their last visit during 2016

How would you categorize these patients by insurance?

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2015 Patient Profile Statistics

Patient Profile Indicators	2015 National UDS Statistics	Other National Statistics
% Uninsured	24%	14%
% Medicaid/CHIP/other public	50%	18%
% Low-income (at or below <200% FPG)	92%	35%
% Racial and/or ethnic minority	62%	38%
% Hispanic or Latino	35%	18%
% Best served in another language	23%	5%
% Homeless	5%	0.2%
% Agricultural	4%	0.7%
% Served at a health center located in or immediately accessible to a public housing site	6%	N/A
% School-based	3%	N/A
% Veterans	1%	9%
% growth in total patients	6%	N/A

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TABLE 5

Staffing and Utilization

- Full-time Equivalents (FTEs)
- Visits Rendered
- Patients Served by Service Category

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Staffing and Utilization

- Column A: Staff full-time equivalents (FTEs)
- Column B: Visits by provider type
- Column C: Patients by service category
  - Medical, dental, mental health, substance abuse, vision, other professional, and enabling
- Categories on Table 5 have a direct relationship to cost categories on Table 8A
  - Will be discussed in the Table 8A section

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 (Sum lines 1-7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum 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 (Sum lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	**Total Vision Services (Sum 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 (Sum 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 (Sum lines 30a - 32)**			
34	**Grand Total (Sum lines 15+19+29+31+33+33d+33+29+29a+29b+33)**			

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Who to Include in Full-Time Equivalent (FTE) Calculation

- Report all staff providing in-scope services in terms of an annualized FTE
  - Staff includes employees, contracted staff, residents, interns, and volunteers
  - Do not include paid referral provider FTEs when working on a fee-for-service basis (paid by service, not by hours), but DO count their visits and patients!

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FTE Defined, Column A

- One full-time equivalent (FTE=1.0) describes staff who work the equivalent of full-time for one year
  - Full-time is defined by the health center
  - The majority of staff are typically non-exempt employees
    - For these individuals, divide hours paid by 2,080 for 40-hour work weeks or by appropriate amount for other work weeks
  - Based on employment contracts for clinicians and other exempt employees
  - Employee FTE is based on hours paid, including paid time off, vacation, sick time, continuing education, "admin" time, etc.
  - FTE for non-exempt staff is based on hours paid
  - FTE for volunteers and locums is based on hours worked
  - Report as FTE, not a head count, not as a census of staff as of end of year

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Calculating FTEs

- Based on:
  - The part of the year the employee works
  - Work performed, not job title
- Individuals may be allocated by function across multiple service categories, but do not parse out components of an interaction
  - Medical Director's corporate time (only) can be allocated to non-clinical support services
  - Do not allocate "administrative" time supervising clinical staff, attending clinical meeting, or writing clinical protocol

Example: A full-time medical assistant works as a laboratory technician one day a week: 0.80 FTE is reported on Line 12, Other Medical Personnel, and 0.20 FTE is reported on Line 13, Laboratory Personnel.

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Calculating FTE Examples

Regular Employee	Volunteer, Locum, etc.
One full-time staff worked for six 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	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 of 10 holidays, 12 sick days, 5 continuing medical education (CME) days, and 3 weeks vacation: 10+12+5+15=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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Specific Personnel Considerations

- See Appendix A in the manual for help determining staffing categories to report on Table 5
- **Other Medical Personnel (Line 12)**: Includes medical assistants, nurses' aides, unlicensed interns or residents
- **Dental Therapists (Line 17a) *(New)***: Only licensed in some states; visits are counted
- **Other Professionals (Line 22)**: Includes chiropractors, acupuncturists, physical, speech, and occupational therapists, nutritionists, podiatrists, etc.
- **Community Health Workers (Line 27c) *(New)***: Lay members of the community who provide outreach and education; includes promotoras, health advisors, advocates, and representatives; no visits are counted

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Specific Considerations Continued

- **Other Programs and Related Services (Line 29a)**: Includes non-health care program staff (e.g., WIC, child care, adult day health, job training, housing programs)
- **Quality Improvement (QI) Staff (Line 29b) *(New)***: Those with specific responsibility for the design and oversight of quality improvement systems; includes QI staff, data specialists, statisticians, health information technologists (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 the maintenance and operation of the computing systems, and those managing the hardware and software of an HIT
  - Include data entry, help desk, and technical assistance in the category of service they support, not IT

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Visits, Column B

- Report visits by service provider (including paid referral visits) that meet the definitions as outlined in *"key definitions"*
  - Provider must be appropriately licensed and/or credentialed to count a visit
  - Visits must be:
    - Documented
    - One-on-one (exception: group and telemedicine by behavioral health)
    - By a provider exercising independent, professional judgment
  - Not all staff can generate visits (visits are greyed out) and not all services are counted as a visit *(see "key definitions" for specifics)*
  - One visit/patient/provider type/day (Exception: If two sites)
  - A provider may deliver many kinds of services at a visit, but credit for one visit is to be reported

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 (Sum lines 1-7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum 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 (Sum lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify__)**			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	**Total Vision Services (Sum 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 (Sum 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 (Sum lines 30a - 32)**			
34	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)**			

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Patients, Column C

- Report patients by service category
- Report an unduplicated count of patients who received at least one countable visit in the service category
- A patient is an individual who had at least one reportable visit during the year *(see "key definitions" section for specifics)*
- The same patient may be counted in multiple service categories, but only once in each category

Example: A patient had two visits with the family physician, one with the optometrist, and one with a case manager during the year. She is counted <u>once</u> in Column C on each of the three lines: Line 15, Line 22d, and Line 29.

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 (Sum lines 1-7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum 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 (Sum lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify__)**			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	**Total Vision Services (Sum 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 (Sum 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 (Sum lines 30a - 32)**			
34	**Grand Total (Sum lines 15+19+20a1+20a2+20b+20c+20+21+22d+23+29a+29b+33)**			

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TABLE 5A

Tenure for Health Center Staff

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Tenure Defined

- Tenure = months of continuous employment
- Count staff employed as of December 31 of the reporting year
  - Include those who did not work on last day of the year but have a scheduled commitment for the coming year
  - Exclude anyone who is not employed at the end of the year
  - Exclude paid referral providers who work many hours, but do not have a regular schedule
- Report a head count (not FTE) in Column A and/or C and consecutive months that a person has been in current position in Column B and/or D
  - Positions align with those on Table 5
  - Months may pre-date health center grant or look-alike designation start date
- Report tenure for selected provider and management staff

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Tenure Reporting

- Staff and months are defined by two categories:
  - Full- and part-time staff (Columns A and B)
    - Employees (full- and part-time or -year), onsite contracted staff, and National Health Service Corps assignees
  - Other staff or consultants (Columns C and D)
    - Residents, locum tenens, on-call providers, volunteers, off-site contract providers paid based on time, and non-clinical consultants
- Columns A and C: Report the head count of persons in their current position as of December 31
- Columns B and D: Report the number of consecutive months of service in their current position, regardless of full- or part-time/year status *(Round up to a whole number)*
- *(New)* Dental Therapists, Line 17a, has been added to correspond with 2016 changes
- A person may appear on multiple lines

Example: A physician who has been (and remains) a pediatrician since January 1, 2013 and medical director since July 1, 2016 is credited with 48 months as a pediatrician and six months as a medical director.

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				

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2015 Service Delivery Statistics

Service Delivery Indicators	2015 National UDS Statistics
Primary care physicians average years of tenure	5.3
Non-clinical/facility/service support FTEs as % of total FTEs	36%
% total patients receiving medical services	85%
% total patients receiving dental services	21%
Average medical visits/medical patient (excl. nurses)	3.14

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TABLE 6A

Selected Diagnoses and Services Rendered

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Selected Diagnoses and Services

- Two separate sets of data:
  - **Selected Diagnoses (Lines 1-20d)**
    - Use applicable ICD-10 codes
    - Note: ICD-9 is no longer used
  - **Selected Services (Lines 21-34)**
    - Use applicable ICD-10 or Current Procedural Terminology (CPT) or American Dental Association (ADA) codes
    - Report the selected tests, screenings, and preventative services on Lines 21-26d
    - Report the selected dental services on Lines 27-34
- Column A: Report the number of visits with the selected service or diagnosis
  - If a patient has more than one reportable service/diagnosis during a visit, count each
  - The same patient can have multiple visits during the year
  - Do not report multiple services in the same category (e.g., different immunizations, such as DPT and MMR, at the same visit)
- Column B: Report the number of unduplicated patients receiving the service or with the diagnosis

	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 HIV, Asymptomatic HIV	B20, B97.35, O98.7-, Z21		
3.	Tuberculosis	A15- through A19-		
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-		
4a..	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51		
4b..	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52		
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-, R92-		
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820		
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I26- through I28-, I30- through I52-		
11.	Hypertension	I10- through I15-		
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)		
13.	Dehydration	E86-		
14.	Exposure to heat or cold	T33.XXXX, T34.XXXX, T67.XXXX, T68.XXXX, T69.XXXX		
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-		

* Excerpt from Table 6A

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Considerations and Example

- Special considerations:
  - If the health center staff make the diagnosis, it is counted
  - If the health center orders and performs the service, it is counted
  - Only report services that are conducted as part of a countable visit
  - Do not report referrals, unless it is a contracted paid referral

Example: A patient had three visits during 2016:

- First visit was with the family physician who diagnosed the patient with hypertension. The patient also received a flu shot. (Report the activity on Line 11 [Hypertension] and Line 24a [Flu vaccine])
- Second visit was with the nurse practitioner who further evaluated the patient for hypertension and a diagnosis of tobacco use was made. The patient received cessation counseling. (Report this activity on Lines 11, 19a, and 26c)
- Final visit was with the dentist for an emergency dental procedure on two teeth. (Report the activity on Line 27)

Note: This patient is counted only once on each of the demographic tables, once as a medical patient on Table 5, and once as a dental patient on Table 5.

	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 I15-	2	1
Selected Mental Health and Substance Abuse Conditions				
19a.	Tobacco use disorder	F17-	1	1
	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				
24a.	Seasonal Flu vaccine	**CPT-4:** 90654 through 90662, 90672, 90673, 90685 through 90688	1	1
26c.	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II**: 4000F, 4001F	1	1
	Service Category	**Applicable ADA Code**	**Number of Visits (a)**	**Number of Patients (b)**
Selected Dental Services				
27.	I. Emergency Services	**ADA:** D9110	1	1

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Calculating Visits per Patients

- Calculating the average number of visits per patient for the selected diagnoses and services is one way to learn more about your patients and to identify potential errors in the report
  - Calculate by taking the value on each line in Column A (Visits) and dividing by Column B (Patients)
- Here are a few averages using UDS 2015 national data
  - How does your health center compare?

Line	Diagnosis or Service	Average Visit per Patient
5	Asthma	1.84
9	Diabetes mellitus	3.37
11	Hypertension	2.57
21	HIV test	1.12
22	Mammogram	1.10
23	Pap test	1.07
26	Health supervision or child or infant	1.54
28	Restorative services (dental)	1.96

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TABLES 6B AND 7

Quality of Care and Health Outcomes and Disparity Measures

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Clinical Measure Reporting

- Most UDS clinical measures now align with other national reporting ***(New)***:
  - Many of the clinical quality measures are aligned with CMS' e-CQMs for Eligible Professionals
  - Only use the June 2015 eReporting measures for 2016 reporting
  - eReporting specifications can be found at the CMS' eCQI Resource Center https://ecqi.healthit.gov/ep
- Each measure is written out to identify:
  - **Performance Measure**: A quantifiable indicator used to evaluate how well the health center is achieving standards
  - **Universe (Denominator)**: The number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated
  - **Numerator**: The number of records (a subset of the denominator) that meet the measurement standard for the specified measure
  - **Exclusions or Exceptions**: Patients not to be considered or included in the denominator (exclusions) or removed if identified (exceptions)
- Specifically assesses the health center's current medical patients (dental patients for the dental sealant measure)
- Note: Codes are included in the manual to help identify universes, exclusions, and numerators, but are not all-inclusive

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Column Logic Instructions (For Non-Prenatal and Delivery Measures)

- **Column A = Universe (Denominator)**
- **Column B = Records sampled or EHR total**
  - This becomes the denominator in calculating the measure
  - Report in Column B:
    - All patients who fit the criteria; same number as reported in Column A; *or*
    - A number equal to or greater than 80 percent of all patients who fit the criteria, no less than 80 percent of Column A; *or*
    - A random sample of 70 patient charts who fit the criteria, only if health centers do not have at least 80 percent of all patient records in the HIT/EHR for any given measure or if the missing cases would bias the findings
  - Note: Report here the universe count from Column A if value is 70 or less
- **Column C = Records meeting the measurement standard**
  - This number (numerator) divided by the number in Column B determines the percentage of patients meeting the measurement standard

Example: Section C - Childhood Immunization Status

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

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Considerations

- Each measure has a unique universe or denominator
  - Be sure to include patients seen at all of your sites, at all programs, and by all providers
  - The universe criteria for each measure may be based on a specific:
    - Age range
    - Sex
    - Diagnosis or condition
    - Type of visit—All measures (except the dental measure) require that the patient had a medical visit during the reporting year
- Note: The birth weight and diabetes measures look at the number of records that do NOT meet the performance standard.

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Table 7 Disparities Format

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**

On Table 7 in each Section (Births [A], Hypertension [B], and Diabetes [C]) outcome data are reported by race and ethnicity. Report:

- Hispanic/Latino patients in the first part
- Patients who are not Hispanic/Latino in the second part
- Patients who do report a race nor an ethnicity are reported in the third part

- Note: Patients who report a race but no ethnicity are assumed to be non-Hispanic.
- Table 7 race and ethnicity categories **must** align with Table 3B
  - Use to check prevalence—follow up on unusual numbers

Example: On Table 3B, 200 patients who are Asian and Hispanic were reported. On Table 7, 100 of the same race/ethnicity were reported in the diabetes section; resulting in 50% prevalence. This should be investigated.

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TABLE 6B

Quality of Care Measures

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Quality of Care Measures

- Report on quality of care measures
- These *"process measures"* serve as a proxy for good long-term health outcomes:

  If patients receive timely acute and/or preventive care, we can expect improved health status.

Example: If patients are routinely asked about their tobacco use and provided with cessation counseling, then the probability of cancer, asthma, emphysema, and other tobacco-related illnesses will be reduced

76

Measures to Report

Line	Description	e-CQM
7-9	Early Entry into Prenatal Care	No e-CQM
10	Childhood Immunization Status	CMS117v4
11	Cervical Cancer Screening	CMS124v4
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v4
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS69v4
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v4
16	Use of Appropriate Medications for Asthma	CMS126v4
17	Coronary Artery Disease (CAD): Lipid Therapy	No e-CQM
18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS164v4
19	Colorectal Cancer Screening	CMS130v4
20	HIV Linkage to Care	No e-CQM
21	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS2v5
22	Dental Sealants for Children between 6-9 Years	CMS277v0

77

TABLE 6B

Characteristics of Prenatal Care Patients

78

Prenatal Patients by Age

0	Prenatal Care Provided by Referral Only (Yes or No)	

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	
5	Ages 45 and over	
6	**Total Patients (Sum lines 1-5)**	

Section A, Lines 1-6

- Report all prenatal care patients, by age group, who were:
  - Provided all prenatal care by the health center, including delivery
  - Provided all prenatal care by the health center, but referred for delivery
  - Provided some prenatal care, but were later referred for care and delivery
  - Diagnosed and referred with no prenatal care provided by the health center
- Report regardless of whether they began prenatal care at health center or were referred to it
  - Note: Age is as of June 30

Prenatal Care by Referral Only: Mark if your health center provides prenatal care to patients through direct ***referral only***

Include women who began or were referred for prenatal care in the:

- Previous year, continued care, and delivered in the current reporting period
- Current year and who delivered during the current reporting year
- Current year, but will not deliver until the next reporting period

Note: Do not include patients who only had tests, vitamins, assessments, or education and did not have a prenatal care physical exam with a provider unless they were referred out

79

Early Entry into Prenatal Care

No e-CQM

Section B, Lines 7-9

- **Universe (Denominator)**: Report the trimester women began prenatal care and whether it was at your health center or referred by your health center (Column A) or with another provider who referred her to you (Column B)
- **Numerator**: The number of women who began prenatal care during their first trimester (Line 7, Columns A+B)
- Women who were referred by the health center for all their prenatal care must be counted in Column A
  - Report the trimester when prenatal care began, not when the referral was made
- Note: Total women by trimester of entry on Lines 7-9, Columns A + B, must equal the total prenatal women reported on Line 6, Column A.

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		

80

Early Entry into Prenatal Care Major Differences from Last Year

- There are no major differences

81

TABLE 6B

Clinical Measures, Lines 10-22

82

Childhood Immunization Status (CIS), Line 10

CMS117 v4

Universe (Denominator), 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
  - Born between January 1, 2014, and December 31, 2014
  - Includes children seen for acute or chronic conditions (not just those seen for well-child care)

Exclusions: None

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

83

Childhood Immunization Status Measurement Standard

Numerator, Column C: Number of children who were fully immunized by their second birthday

- Notes in the discharge record that the patient received the immunization "at delivery" or "in the hospital" may be counted as evidence of meeting parts of the measurement standard
- A note that patient is "up to date" that does not list the date of each immunization and provider is not sufficient evidence
- "Good faith efforts" to get a child immunized that fail do not meet the measurement standard, including:
  - Failure to bring in patient for appointment
  - Refusal for personal or religious reasons
  - Refusal because of beliefs about vaccines

84

Childhood Immunization Status Required Vaccinations

- A child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or history of illness for ALL of the following:
  - 4 diphtheria, tetanus, and acellular pertussis (DTP/DTaP)
  - 3 polio (IPV)
  - 1 measles, mumps, rubella (MMR)
  - 3 H influenza type b (Hib)
  - 3 Hepatitis B (Hep B)
  - 1 chicken pox VZV (Varicella)
  - 4 pneumococcal conjugate (PCV)
  - 1 Hepatitis A (Hep A)
  - 2 or 3 rotavirus (RV)
  - 2 influenza (flu) vaccines

85

Childhood Immunization Status Major Differences from Last Year

- **Denominator**
  - Children 2 years of age (previously 3 years of age)
- **Exclusions**
  - No longer permits exclusion of patients not seen ever prior to turning 2
- **Numerator**
  - Adds 1 Hepatitis A (Hep A), 2 or 3 rotavirus (RV), and 2 influenza (flu) vaccines

86

Cervical Cancer Screening, Line 11

CMS124 v4

Universe (Denominator), Columns A and B: Women 23-64 years of age with a medical visit during the measurement period

- Were born between January 1, 1952, and December 31, 1992, ***and***
- Were first seen by health center prior to their 65th birthday
- Had at least one medical visit in a clinical setting during the measurement year

Exclusions: Women who have had a hysterectomy and who have no residual cervix

Line	Cervical Cancer Screening	Total Female Patients 23-64 Years of Age (a)	Number Charts Sampled or EHR total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer			

87

Cervical Cancer Screening Measurement Standard

Numerator, Column C: Women with one or more Pap tests during the measurement year or during the two calendar years prior to the measurement year

- Documentation in the medical record must include the date of the Pap test, who performed the test, and the test result
- Do not count:
  - Referrals to third parties without documentation of results
  - Statements from patient that it was done—without documentation
  - Refusal of patient to have the test

88

Cervical Cancer Screening Major Differences from Last Year

- **Denominator**
  - Women age 23 through 64 years (previously age 24 through 64 years)
- **Exclusions**
  - No major differences
- **Numerator**
  - No longer includes concurrent human papillomavirus (HPV) and Pap test for those age 30 and older

89

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Line 12

CMS155 v4

Universe (Denominator), Columns A and B: Patients 3 through 17 years of age with at least one medical visit during the measurement period

- Born between January 1, 1999, and December 31, 2012
- Were first seen ever by the health center prior to their 18th birthday
- Had at least one medical visit in a clinical setting during the measurement year

Exclusions: Patients who have a diagnosis of pregnancy during the measurement period

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.			

90

Childhood Weight Assessment and Counseling Measurement Standard

Numerator, Column C: Patients who had their body mass index percentile (not just BMI or height and weight) documented during the measurement period ***and*** who had documentation of counseling for:

- Nutrition ***and***
- Physical activity

- Documentation must show all **three** elements occurred during 2016

91

Childhood Weight Assessment Major Differences from Last Year

- There are no major differences
- Note: e-CQMs indicate that the denominator is to be limited to outpatient visits with a primary care physician (PCP) or obstetrician/ gynecologist (OB/GYN), but this reporting will not be limited to only those providers

92

Body Mass Index Screening and Follow-Up, Line 13

CMS69 v4

Universe (Denominator), Columns A and B: Patients who were 18 years of age or older with a medical visit during the measurement year

- Born on or before December 31, 1997
- Last seen by the health center after their 18th birthday
- Had at least one medical visit during the measurement year

Exclusions:

- Patients who are pregnant (age 18-64 only)
- Patient is receiving palliative care
- Patient refuses measurement of height and/or weight
- Patient is in an urgent or emergent medical situation where time is of the essence
- Other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Total Patients 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 aged 18 and older with (1) BMI documented *and* (2) follow-up plan documented *if* BMI is outside normal parameters			

93

Body Mass Index (BMI) Screening and Follow-Up Measurement Standard

Numerator, Column C:

1. Patients with a documented BMI (not just height and weight) during their most recent visit ***or*** during the six months prior to the most recent visit, ***and***
2. For those patients with a BMI outside of normal parameters, a follow-up plan is documented during the visit or within six months of the current visit

Normal BMI parameters:

- Age 18-64 years ***and*** BMI was greater than or equal to 18.5 and less than 25
- Age 65 years and older ***and*** BMI was greater than or equal to 23 and less than 30

94

BMI Screening and Follow-Up Major Differences from Last Year

- **Denominator**
  - Does not include visits where the patient is receiving palliative care, refuses measurement of height and/or weight, or is in an urgent or emergent medical situation, or if there are other reasons documented in the medical record
- **Exclusions**
  - Does not exclude if services conducted outside of clinical setting
- **Numerator**
  - No major differences

95

Tobacco Use: Screening and Cessation Intervention, Line 14a

CMS138 v4

Universe (Denominator), Columns A and B: Patients aged 18 years and older seen for at least two visits in the measurement year or at least one preventive visit during the measurement period

- Born on or before December 31, 1997
- Were last seen by health center after their 18th birthday
- Had at least one preventive medical visit during the measurement year ***or***
- Had at least two medical visits during the measurement year

Exclusions: Patient records with documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

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 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			

96

Tobacco Use Screening and Cessation Measurement Standard

Numerator, Column C: Patients screened for tobacco use at least once within 24 months of the most recent visit ***and***

- Include patients asked about tobacco use (all forms of tobacco) at most recent visit or a visit within 24 months of the last visit and found to not be a tobacco user, ***and***
- Include patients that were found to be a tobacco user who received tobacco use cessation services, including:
  - Received a prescription or a recommendation to purchase an over-the-counter smoking cessation medication
  - Were found to be on (using) a smoking cessation agent

97

Tobacco Use Screening and Cessation Major Differences from Last Year

- **Denominator**
  - Includes patients seen twice for medical care or at least once for a preventive visit
- **Exclusions**
  - Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
- **Numerator**
  - No major differences

98

Use of Appropriate Medications for Asthma, Line 16

CMS126 v4

Universe (Denominator), Columns A and B: Patients age 5 through 64 years with a diagnosis of persistent asthma who had at least one medical visit during the measurement period

- Born on or after January 1, 1952, and on or before December 31, 2010
- Diagnosed with ***persistent*** asthma ***or*** have persistent asthma as a current diagnosis on a chronic illness form or template
- Were last seen by the health center while they were age 5 through 64 years
- Had at least one medical visit during the measurement year

Exclusions: Patients with emphysema, chronic obstructive pulmonary disease, cystic fibrosis, or acute respiratory failure during or prior to the measurement period

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 prescribed medication during the measurement period			

99

Use of Appropriate Medications for Asthma Measurement Standard

Numerator, Column C: Patients who were dispensed at least one prescription for a preferred therapy during the measurement period

- 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

100

Appropriate Medications for Asthma Major Differences from Last Year

- **Denominator**
  - Patients age 5 through 64 years (previously age 5 through 40 years)
  - Eligibility not limited to individuals with two medical visits ever
- **Exclusions**
  - Additional exclusions: Patients with emphysema, chronic obstructive pulmonary disease, cystic fibrosis, or acute respiratory failure during or prior to the measurement period
  - Patients with allergic reactions to asthma medications are no longer excluded from the measure denominator
- **Numerator**
  - No major differences

101

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

No e-CQM

Universe (Denominator), Columns A and B: Patients 18 years of age and older with CAD, myocardial infarction (MI), or who had cardiac surgery in the past, with at least one medical visit during the measurement period and had at least two medical visits ever

- Born on or before December 31, 1997
- Have an active diagnosis of CAD ***or*** diagnosed as having had MI ***or*** had cardiac surgery
- Were last seen by health center after their 18th birthday
- Had at least one medical visit during the measurement year
- Had at least two medical visits ever

Exclusions:

- Patients whose last low-density lipoprotein (LDL) lab test during the measurement year was less than 130 mg/dL
- Individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL-lowering medications

Note: Patients with no record of LDL lab test must be included in the universe and evaluated.

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

102

CAD: Lipid Therapy
Measurement Standard

- **Numerator, Column C**: Patients who received a prescription for or were provided or were taking lipid-lowering medications during the measurement period
  - Do not count patients who are receiving a form of treatment other than pharmacologic treatment (e.g., therapeutic lifestyle changes)

103

CAD: Lipid Therapy
Major Differences from Last Year

- There are no major differences

104

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic, Line 18

CMS164 v4

Universe (Denominator) Columns A and B: Patients 18 years of age and older with a medical visit during the measurement period who had an active diagnosis of IVD or who were discharged alive for acute myocardial information (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

- Born on or before December 31, 1997
- Had an active diagnosis of IVD or who had been discharged alive after AMI, CABG, PCI during the 12 months prior to the measurement period
- Were last seen by the health center while they were 18 years of age or older
- Had at least one medical visit during the measurement year

Exclusions: None

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	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 Antithrombotic Therapy (c)
18	MEASURE: Percentage of patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antithrombotic therapy			

105

IVD: Use of Aspirin or Another Antithrombotic Measurement Standard

Numerator, Column C: Patients who had documentation of use of aspirin or another antithrombotic during the measurement period

106

IVD: Aspirin or Another Antithrombotic Major Differences from Last Year

- There are no major differences
- Note: Revised to PCI, which includes percutaneous transluminal coronary angioplasty (PTCA)

107

Colorectal Cancer Screening, Line 19

CMS130 v4

Universe (Denominator), Columns A and B: Patients who were aged 50 through 75 with a medical visit during the measurement period

- Born between January 1, 1941, and December 31, 1965
- Had at least one medical visit during the measurement year

Exclusions: Patients with a diagnosis or past history of colorectal cancer or colectomy

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 age 50 through 75 years of age who had appropriate screening for colorectal cancer			

108

Colorectal Cancer Screening Measurement Standard

Numerator, Column C: Patients with one or more screenings for colorectal cancer

- Appropriate screenings include any one of the following:
  - a colonoscopy during the measurement period or the nine years prior to the measurement period (January 1, 2007 or later)
  - a flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period (January 1, 2012 or later)
  - a fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test, *during* the measurement period
- Note: DNA (deoxyribonucleic acid) colorectal cancer screening tests, such as Cologuard, do not meet the measurement standard

109

Colorectal Cancer Screening Major Differences from Last Year

- **Denominator**
  - Patients age 50 through 75 (previously 51 through 74)
- **Exclusions**
  - No major differences
- **Numerator**
  - No major differences

110

HIV Linkage to Care, Line 20

No e-CQM

Universe (Denominator), Columns A and B: Patients who were never before diagnosed with HIV who were first diagnosed with HIV *by the health center* between October 1 of the prior year through September 30 of the current measurement year who had at least one medical visit during the measurement period or prior year

- Diagnosed with HIV for the first time ever by the health center between October 1, 2015, and September 30, 2016
- Had at least one medical visit during 2016 or 2015

Exclusions: None

- Note that the identification of patients for this measure crosses years and may include prior year patients
- Patients first diagnosed with HIV are those who received a reactive initial HIV test confirmed by a positive supplemental HIV (blood) test

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			

111

HIV Linkage to Care Measurement Standard

Numerator, Column C: Patients who were never before diagnosed with HIV who received treatment within 90 days of diagnosis

- Include patients who:
  - Were newly diagnosed by your health center providers
  - Had a medical visit with your health center provider who initiated treatment for HIV within 90 days of testing
  - Had a visit with a referral resource which initiated treatment for HIV within 90 days of testing
- *Medical treatment must be initiated* within 90 days of HIV diagnosis, not just a referral made, education provided, or retesting conducted

112

HIV Linkage to Care
Major Differences from Last Year

- There are no major differences

113

Screening for Clinical Depression and Follow-up Plan, Line 21

CMS2 v5

Universe (Denominator), Columns A and B: Patients aged 12 years and older with at least one medical visit during the measurement period

- Born on or before December 31, 2003
- Had at least one medical visit during the measurement year

Exclusions:

- Patients who refuse to participate or who are in urgent or emergent situations
- Patients whose functional capacity or motivation to improve impacts the accuracy of results
- Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Note: Patients who are in ongoing treatment for depression are not included in the universe

Line	Preventive Care and Screening: Screening for Clinical 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 aged 12 and older who were (1) screened for depression with a standardized tool, *and* if screening was positive (2) had a follow-up plan documented.			

114

Screening for Clinical Depression and Follow-Up Plan Measurement Standard

Numerator, Column C: Patients screened for clinical 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

- Include patients with screening test results:
  - That were negative
  - That were positive **and** had a follow-up plan documented

115

Screening for Clinical Depression and Follow-Up Plan Major Differences from Last Year

- **Denominator**
  - Exclude patients who refuse to participate, urgent or emergent situations, or if the patient's functional capacity or motivation to improve impacts the accuracy of results
- **Exclusions**
  - No major differences
- **Numerator**
  - No major differences

116

Dental Sealants for Children between 6-9 Years, Line 22

CMS277 v0

Universe (Denominator), Columns A and B: Children 6 through 9 years of age who had a dental visit in the measurement period who had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the measurement period

- Born between January 1, 2007, and December 31, 2009
- Had a dental visit with the health center or with another dental provider through a paid referral
- Had at least one oral assessment or comprehensive or periodic oral evaluation visit during the measurement period
- Were at moderate to high risk for caries

Exclusions: Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/ missing)

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: Children aged 6 through 9 years, at moderate to high risk of caries, who received a sealant on a first permanent molar			

117

Dental Sealants for Children Measurement Standard

Numerator, Column C: Children who received a sealant on a permanent first molar tooth during the measurement period

118

Dental Sealants for Children Major Differences from Last Year

- There are no major differences
- Note: Although measure title is age 6 through 9 years, draft e-CQM reflects age 5 through 9 years—health centers should continue to use age 6 through 9 years, as measure steward intended

119

TABLE 7

Health Outcomes and Disparities

120

Intermediate Outcome Measures

- Report on selected health outcome and disparities measures
- These *"intermediate outcome measures"* serve as a proxy for good long-term health outcomes:

  If measurable outcomes are improved, then later negative outcomes will be less likely

Example: *If* there is less uncontrolled hypertension, *then* there will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life

121

Measures to Report

Part	Description	e-CQM
Part A	Low Birth Weight	No e-CQM
Part B	Controlling High Blood Pressure	CMS165v4
Part C	Diabetes: Hemoglobin A1c Poor Control	CMS122v4

122

HIV Positive Pregnant Women and Total Deliveries by Health Center Providers

- **Line 0**: Report HIV positive pregnant women served by the health center, regardless of whether or not the health center provided them with prenatal care or HIV treatment
- **Line 2**: Report total women who had deliveries performed by health center clinicians, including deliveries to non-health center patients (e.g., on-call, emergency deliveries)

0	**HIV Positive Pregnant Women**	
2	**Deliveries Performed by Health Center's Providers**	

123

Low Birth Weight, Section A

No e-CQM

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)

Universe (Denominator), Columns 1b + 1c + 1d: Babies born during the measurement year

- Also report women who had a delivery in Column 1a
- Report babies according to their birth weight in grams
  - Very low birth weight (Column 1b) = Birth weight less than 1,500 grams
  - Low birth weight (Column 1c) = Birth weight 1,500 grams through 2,499 grams
  - Normal birth weight (Column 1d) = Birth weight 2,500 grams or greater

Exclusions:

- Stillbirths (mother is counted on Table 6B, delivery is counted on Table 7, but birth weight is not counted)
- Miscarriages (mother is counted only on Table 6B)

124

Low Birth Weight
Measurement Standard

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)

Numerator, Columns 1b + 1c: Babies born with a birth weight below normal (under 2,500 grams)

- Report mothers who had deliveries once, regardless of number of babies born to them, in Column 1a
- Report all live births by weight (count multiple babies born to the same mother separately) in Columns 1b, 1c, or 1d
- Report the race and ethnicity of the mother and baby separately
- Report mothers and babies who received prenatal care, even if the prenatal care and/or delivery was done by a non-health center provider
- Note: Prenatal Women ≠ Deliveries ≠ Birth Outcomes
- Unlike other measures, the higher the percentage of babies born with low birth weight, the poorer the outcome

125

Low Birth Weight
Major Differences from Last Year

- There are no major differences

126

Controlling High Blood Pressure, Section B

CMS165 v4

Universe (Denominator), Column 2a: Patients 18 through 85 years of age with a diagnosis of essential hypertension (HTN) within first six months of or prior to the measurement period and had a medical visit during the measurement period

- Born between January 1, 1931, and December 31, 1997
- Diagnosed with essential hypertension before June 30 of the measurement year
- Had at least one medical visit during the measurement year

Exclusions: Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period; also exclude patients with a diagnosis of pregnancy during the measurement period

Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)

127

Controlling High Blood Pressure Measurement Standard

Numerator, Column 2c: Patients whose blood pressure at the most recent visit during the measurement period is adequately controlled

- Adequate control is defined as systolic blood pressure (BP) lower than 140 mm Hg and diastolic BP lower than 90 mm Hg
- Patients with no test during the year are included in the universe but do not meet the measurement standard
  - Report these patients in Columns 2a and 2b, but do not count them in Column 2c

Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)

128

Controlling High Blood Pressure Major Differences from Last Year

- **Denominator**
  - Age 18 through 85 years (previously age 18 through 84 years)
  - Eligibility no longer limited to patients with at least two medical visits during the measurement year
  - A diagnosis of essential hypertension is required
- **Exclusions**
  - Exclude patients with dialysis or renal transplant before or during the measurement period and chronic kidney disease, Stage 5 (in addition to evidence of end-stage renal disease), and patients with a diagnosis of pregnancy during the measurement period
- **Numerator**
  - No major differences

129

Diabetes: Hemoglobin A1c (HbA1c) Levels, Section C

CMS122 v4

Universe (Denominator), Column 3a: Patients 18 through 75 years of age with diabetes who had a medical visit during the measurement period

- Born between January 1, 1941, and December 31,1997
- Have a diagnosis of Type 1 or Type 2 diabetes
  - Report on patients with diabetes regardless of when they were first diagnosed
- Had at least one medical visit during the measurement year

Exclusions: Gestational or steroid-induced diabetes; patients with a diagnosis of secondary diabetes should not be included

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)

130

Diabetes: HbA1c Levels Measurement

Numerator, Column 3f: Patients whose most recent HbA1c level during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period

Report HbA1c levels as follows:

- HbA1c less than 8 percent (Column 3d1)
- HbA1c greater than 9 percent or no test during the year (Column 3f)

- Unlike other measures, the higher the percentage of Hba1c, the poorer the outcome
- Note: Usually Columns 3d1 + 3f ≠ 3b

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)

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Diabetes: HbA1c Levels Major Differences from Last Year

- **Denominator**
  - Age 18 through 75 years (previously age 18 through 74)
  - Eligibility no longer limited to patients with at least two medical visits during the measurement year
- **Exclusions**
  - No major differences
- **Numerator**
  - No major differences

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Pop Quiz: Clinical Measures

Main Street CHC served 200 total children that turned two during 2016. This total consists of:

- 40 who had dental visits only
- 20 who had a medical emergency visit only and received no vaccinations
- 120 who had a well-child care visit only with the pediatrician
- 20 who had both a dental visit and a medical visit

How many of the 200 2-year-olds should be reported as the universe count for the Childhood Immunization Status measure (Table 6B, Line 10, Column A)?

A. 120
B. 160
C. 180
D. 200

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2015 Statistics on Clinical Performance

Quality of Care Indicators	2015 National UDS Statistics	Other National Statistics
% Early access to prenatal care	73%	78%
% Low birth weight	8%	8%
% Childhood immunizations	78%	80%
% Weight assessment and counseling for children and adolescents	58%	N/A
% Adult weight screening and follow-up	59%	N/A
% Tobacco use screening and cessation services	83%	N/A
% Depression screening and follow-up	51%	N/A
% Cervical cancer screening	56%	93%
% Colorectal cancer screening	38%	71%
% HIV linkage to care	75%	49%
% Controlled hypertension	64%	61%
% Uncontrolled diabetes	30%	16%
% Dental sealants	42%	28%

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TABLE 8A

Financial Costs

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Financial Costs

- **Column A**: Report **accrued** direct costs
  - Include costs of staff, fringe benefits, supplies, equipment, depreciation, related travel
  - Exclude bad debt
- **Column B**: Report allocation of facility and non-clinical support services
  - Requires allocation to all other cost centers
  - Line 16, Column A must equal the sum of Column B
- **Column C**: Sum of costs in Column A plus allocation in Column B

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Financial Costs for Medical Care				
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services (Sum lines 1-3)**			
Financial Costs for Other Clinical Services				
5	Dental			
6	Mental Health			
7	Substance Abuse			
8a	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9	Other Professional (Specify: ___)			
9a	Vision			
10	**Total Other Clinical Services (Sum lines 5-9a)**			
Financial Costs of Enabling and Other Program Related Services				
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (Specify: ___)			
11h	Community Health Workers			
11	Total Enabling Services Cost (Sum lines 11a-11h)			
12	Other Related Services (Specify:___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services (Sum lines 11, 12, and 12a)**			
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)**			

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Line Definitions

- Separate medical staff (Line 1) from medical lab and X-ray (Line 2), and from other direct medical costs (Line 3)
  - This is the only category that separates costs within the same service category
  - Include paid medical interns or residents and vouchered or contracted medical services on Line 1
  - Exclude staff dedicated to HIT/EHR design and QI (report on Line 12a)
  - But include the cost of an HIT/EHR *system* on Line 3 (include depreciation on the software and hardware, training costs, and licensing fees)
- Report all direct expenses including personnel (hired and contracted), benefits, supplies, and equipment together on all remaining service category lines

Line	Cost Center
Financial Costs for Medical Care	
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	**Total Medical Care Services (Sum lines 1-3)**
Financial Costs for Other Clinical Services	
5	Dental
6	Mental Health
7	Substance Abuse
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: ___)
9a	Vision
10	**Total Other Clinical Services (Sum lines 5-9a)**
Financial Costs of Enabling and Other Program Related Services	
11a	Case Management
11b	Transportation
11c	Outreach
11d	Patient and Community Education
11e	Eligibility Assistance
11f	Interpretation Services
11g	Other Enabling Services (Specify: ___)
11h	Community Health Workers
11	Total Enabling Services Cost (Sum lines 11a-11h)
12	Other Related Services (Specify:___)
12a	Quality Improvement
13	**Total Enabling and Other Services (Sum lines 11, 12, and 12a)**
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)**

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Specific Line Considerations

- Separate Pharmacy Costs (Line 8a) from Pharmaceutical Costs (Line 8b)
  - Report pharmacy assistance program as Eligibility Assistance, Line 11e, not as pharmacy
  - Report dispensing fee on Line 8a
  - 340b price of pharmacy is included on Line 8b
- Include rented out space in the health center, adult day health care, WIC, or a retail pharmacy to non-patients as Other Related Services (Line 12)
- Report staff dedicated to the QI program and/or HIT/EHR system development and analysis on Line 12a, not including hardware support

Line	Cost Center
Financial Costs for Medical Care	
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	**Total Medical Care Services (Sum lines 1-3)**
Financial Costs for Other Clinical Services	
5	Dental
6	Mental Health
7	Substance Abuse
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: ___)
9a	Vision
10	**Total Other Clinical Services (Sum lines 5-9a)**
Financial Costs of Enabling and Other Program Related Services	
11a	Case Management
11b	Transportation
11c	Outreach
11d	Patient and Community Education
11e	Eligibility Assistance
11f	Interpretation Services
11g	Other Enabling Services (Specify: ___)
11h	Community Health Workers
11	Total Enabling Services Cost (Sum lines 11a-11h)
12	Other Related Services (Specify:___)
12a	Quality Improvement
13	**Total Enabling and Other Services (Sum lines 11, 12, and 12a)**
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)**

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Considerations

- Report all facility expenses—including the health center's rent or depreciation, mortgage interest payments, utilities, security, janitorial services, maintenance, etc.—on Line 14
  - Do not report total FIP/CIP costs
- Report non-clinical support services costs on Line 15
  - Include corporate administration, billing, collections, medical records, intake staff, facility and liability insurance, legal fees and their direct support costs (travel, supplies, etc.)
  - Do not include malpractice insurance here; include in the service categories
- Report donations ("in-kind") on Line 18 only, including services, facilities, and supplies
  - Include donated pharmaceuticals and volunteers

Line	Cost Center
Financial Costs for Medical Care	
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	**Total Medical Care Services (Sum lines 1-3)**
Financial Costs for Other Clinical Services	
5	Dental
6	Mental Health
7	Substance Abuse
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: ___)
9a	Vision
10	**Total Other Clinical Services (Sum lines 5-9a)**
Financial Costs of Enabling and Other Program Related Services	
11a	Case Management
11b	Transportation
11c	Outreach
11d	Patient and Community Education
11e	Eligibility Assistance
11f	Interpretation Services
11g	Other Enabling Services (Specify: ___)
11h	Community Health Workers
11	Total Enabling Services Cost (Sum lines 11a-11h)
12	Other Related Services (Specify: ___)
12a	Quality Improvement
13	**Total Enabling and Other Services (Sum lines 11, 12, and 12a)**
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)**

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Allocation of Facility, Column B

- Facility costs reported on Line 14, Column A, are to be distributed to each cost center in Column B
  - Base the allocation on the amount of usable square footage utilized for each of the cost centers
    - Do not include common spaces, unless dedicated to a specific service area
  - Capture differences in costs per building, such as improvements, donated space, etc.
  - Allocate each building separately, if possible
  - Do not allocate areas leased or rented to third parties in facility cost

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Allocation of Non-Clinical Support, Column B

- Non-clinical support costs reported on Line 15, Column A, are to be distributed to each cost center in Column B
  - Allocate after facility costs have been allocated to it
  - Allocate based on actual use or straight line method (proportion of net costs to each service category)
- Contracted services would normally have a lower allocation of overhead charge, although those arrangements do consume some administrative costs

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Match Staff and Services to Costs

- Make sure staff and services reported on Table 5 corresponds with costs reported on Table 8A
- Also be sure the **new** lines align:

Table 5	Table 8A
Line 17a: Dental Therapists	Line 5: Dental Costs
Line 27c: Community Health Workers	Line 11h: Community Health Workers
Line 29b: Quality Improvement Staff	Line 12a: Quality Improvement

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Table 5 and 8A Crosswalk

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 Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists)	9: Other Professional
22a–22c: Vision Services (ophthalmologists, optometrists, optometric assistants, other vision care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling (e.g., case management, outreach, eligibility)	11a–11h: Enabling *Note that the 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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2015 Cost of Services Statistics

Cost of Services Indicators	2015 National UDS Statistics
Medical cost per medical patient	$554
Medical cost per medical visit	$177
Dental cost per dental patient	$463
Dental cost per dental visit	$183

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TABLE 9D

Patient-Related Revenue

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Patient-Related Revenue

- Report charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off
  - Report 2016 charges and cash income for patient services on a ***cash*** basis
  - Report by payer: Medicaid, Medicare, other public, private, and self-pay
  - Report each by subcategory: Non-managed care, capitated, managed care, and fee-for-service managed care

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

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Payment Types

- Each third-party payer category has three forms of payment
  - **Non-Managed Care, Fee-for-Service**: Payment for each charge (or global fee) on the charge slip, encounter form, or bill
  - **Managed Care, Capitated**: Payment for each month the patient is enrolled in the program, regardless of whether or not any services were rendered during the month
    - In public programs, includes reconciliations to some prospective payment system (PPS) rates
  - **Managed Care, Fee-for-Service**: Patient is assigned to doctor or clinic, but payment is only made when a charge is reported
    - Reconciliation to PPS rates occur in some public programs
    - Some carved out charges and collections for capitated patients are reflected here, too

1	Medicaid Non-Managed Care
2a.	Medicaid Managed Care (capitated)
2b.	Medicaid Managed Care (fee-for-service)
3	**Total Medicaid (Sum lines 1+2a+2b)**
4	Medicare Non-Managed Care
5a.	Medicare Managed Care (capitated)
5b.	Medicare Managed Care (fee-for-service)
6	**Total Medicare (Sum lines 4+5a+5b)**
7	Other Public, including Non-Medicaid CHIP (Non-Managed Care)
8a.	Other Public, including Non-Medicaid CHIP (Managed Care Capitated)
8b.	Other Public, including Non-Medicaid CHIP (Managed Care fee-for-service)
9	**Total Other Public (Sum lines 7+8a+8b)**
10	Private Non-Managed Care
11a.	Private Managed Care (capitated)
11b.	Private Managed Care (fee-for-service)
12	**Total Private (Sum lines 10+11a+11b)**

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Payer Considerations

- Revenues relate to patient enrollment on Table 4
- Exceptions and other considerations include:
  - Medicaid expansion programs are to be reported as Medicaid, Lines 1-3
  - State or federal exchanges are reported as Private, Lines 10-12
  - State-based programs which cover a specific service or disease (e.g., BCCCP or Title X Family Planning) are reported as Other Public, Lines 7-9
  - State revenues from contracts with schools, jails, head start, tribes, and workers' compensation as reported as Private, Lines 10-12
  - Include portion of charges paid by each payer to the appropriate payer categories (e.g., Medi-Medi, co-payments, deductibles)
  - Do not include state or local indigent care programs as Other Public, instead report as Self-pay, Line 13

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

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Full Charges this Period, Column A

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

Report Full Charges in Column A by payer source

- Some unpaid charges should be reclassified to other payers

Full Charges means:

- Undiscounted, unadjusted, gross charges for services based on the fee schedule; include only those charges for services billed
  - Include all service charges (e.g., medical, dental, mental health, vision, contract 340b pharmacy)
  - Do not include "charges" where no collection is attempted or expected, such as charges for enabling services, donated pharmaceuticals, or free vaccines
  - Do not include capitation rate as charge amount

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Collections this Period, Column B

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

Report Collections by payer in Column B

- Include all
  - Payments received in 2016 for services rendered to patients, including capitation payments, payments from patients, third party insurance, federally qualified health center (FQHC) reconciliations, and wrap-around payments
  - Pay for performance, other incentive payments, contract payments, and quality bonuses
- Do not include "meaningful use" payments from Medicaid and Medicare

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Retroactive Payments and Paybacks, Columns c1 - c4

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

Report prospective payment system (PPS) reconciliations, wrap-around payments, managed care pool distributions, pay for performance (P4P) payments, quality bonuses, and paybacks to federally-qualified health center (FQHC) payers or health maintenance organizations (HMOs) in Columns C1 through C4

- **Columns (C1) and (C2)**: Report reconciliation payments (based on filing of cost report) and wrap-around payments (additional amounts per visit to bring payment up to FQHC level) (Report in C1 if payment received are for current year; C2 for prior years)
- **Column (C3)**: Report other retroactive payments, including risk pools, incentives, P4P, quality bonuses, withholds, and court-ordered payments
  - Do *not* include eligible provider payments from CMS for implementing electronic health records
- **Column (C4)**: Report amounts which are returned to or deducted by a third party due to overpayments collected earlier (Report C4 as positive number)
- Amounts reported in C1 – C4 are included in Column B, <u>but do not equal Column B</u>

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Allowances, Column D

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

Report allowances in Column D

- Allowances are agreed upon reductions/write-off in payment by a third party payer
  - Must be reduced by the amount of retroactive settlements and receipts (Columns C1, C2, and C3) and paybacks (Column C4) must be added to allowances
  - May result in a negative number
- <u>Do not</u> include as allowances amounts that are to be reclassified to a secondary payer; these include:
  - Non-payment for services that are not covered by or rejected by the third party
  - Deductibles or co-payments due from the patient
- For managed care capitated lines (Lines 2a, 5a, 8a, and 11a) only, which do not typically carry an account receivable, allowances equal the difference between charges and collections (Column D = Column A – Column B)

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Sliding Discounts, Column E

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation /Wrap-Around Current Year (c1)	Collection of Reconciliation / Wrap-Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			
13	Self Pay	$200	$20						$180	

Report reductions in patient charges based on their ability to pay as a sliding discount in Column E

- Only patients may be granted a sliding discount and reported on Line 13
- Sliding discounts:
  - Are based solely on the patient's documented income and family size, at the time of service, as it relates to the federal poverty guidelines
  - May be applied to insured patients' co-payments, deductibles, and non-covered services only when the charge has been moved/reclassified from the original charge line to self-pay
  - May not be applied to past due amounts

Example: A patient's service had a full charge of $200. The patient was uninsured and the health center, in advance of service, determined that the patient qualified for a nominal fee based on sliding discount program policies. The patient owed $20, which was paid on the day of the visit. The handling of this service is reflected above.

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Bad Debt Write-Off, Column F

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

Report patient bad debt in Column F

- Only patient bad debt may be reflected (*not* third party payer bad debt) and is to be reported on Line 13
  - Third party payer bad debt is not reported anywhere in the UDS
- Include amounts owed by patients that are considered to be uncollectable and formally written off during 2016, regardless of when the service was provided
- Bad debt cannot be changed 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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Reclassification of Charges

- It is essential to reclassify charges which are unpaid in whole or in part by one payer if another payer is responsible for the service charges
  - Do not reclassify allowances
- Include co-payments and deductibles, as well as charges for non-covered services rejected by third party payers
- Show collections received by payer on the appropriate line

How to Reclassify Charges:

- Deduct unpaid charges or portion of charge from original payer line (Medicaid, Medicare, Private, or Other Public)
- Add the portion of charges due from the next payer to the appropriate line (i.e., to Self-pay line for co-pays and deductibles, or to a secondary (or tertiary, etc.) payer)

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Example of Reclassifying Charges

Reclassify Charge

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation /Wrap Around Current Year (c1)	Collection of Reconciliation /Wrap Around Previous Years (c2)	Collection of Other Retroactive Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			
10	Private Non-Managed Care	~~$200~~ $170	$120					$50		
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	Total Private (Sum lines 10+11a+11b)									
13	Self Pay	$30								

Example: A patient received services with a full charge of $200. The patient had private insurance and the patient's insurance had a contractual allowance with the health center of $50 for the type of service (reflected in Column D), leaving a net of $150 owed for the service. The insurance company pays $120 (reflected in Column B). The insurance did not cover the $30 co-pay and the patient does not have a secondary insurance. Therefore, the $30 is the patient's responsibility. Reclassify the $30 to self-pay charges as follows:

- Reduce the initial charge of $200 to private insurance by $30, which is owed by the patient. Private payer charge = $170
- Add $30 to self-pay charges

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TABLE 9E

Other Revenue

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Other Revenue

Report non-patient income received during 2016

- Report on a cash basis
- Include income that supported activities described in scope
- Use "last party rule"
  - Report funds from the entity from which you received them, not the original source of funds
- Most lines include a field to specify the grants or contracts reported

Example: Your center received funds from another health center who received the funds from SAMHSA. Report these on Line 8, Foundation/Private.

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center (Sum lines 1a through 1e)**	
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1	**Total 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 (Sum lines 1+5+9+10)**	

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BPHC Grants

BPHC Grants, Lines 1a-1k

Report BPHC grants drawn down during 2016

- Report funds received directly from BPHC regardless of their end use, including:
  - Health Center Program grants by type
  - Capital improvement program grants
  - Capital development grants
- Include funds received from BPHC and passed through to another agency

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center (Sum lines 1a through 1e)**	
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1	**Total 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 (Sum lines 1+5+9+10)**	

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Federal Sources

Other Federal Grants, Lines 2-3a

Ryan White Part C Funds, Line 2

- Report only Part C here
  - Part A is usually reported on Line 7, Local
  - Part B is usually reported on Line 6, State

Other Federal Grants, Line 3

- Report grants received directly from the federal government, other than BPHC
- Include grants which are paid directly from the U.S. Treasury (e.g., SPRANS, HUD, SAMHSA)

Medicare and Medicaid EHR Incentive Payments for Eligible Providers, Line 3a

- Report Meaningful Use funds
- Include funds paid directly to providers and turned over to the health center (this is the only exception to the last party rule)

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center (Sum lines 1a through 1e)**	
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1	**Total 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 (Sum lines 1+5+9+10)**	

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State, Local, Private and Other Revenue

Non-Federal Grants or Contracts, Lines 6, 7,8, and 10

State, Line 6; and Local, Line 7

- Report amounts received from state or local governments on Line 6 and 7, respectively
- Report non-health service delivery grants (e.g., WIC, outreach)
- Do not include indigent care programs
- Do not include fee-for-service payments (e.g., BCCCP, FP)—report these on Table 9D

Foundation/Private, Line 8

- Funds received from foundations or private organizations (e.g., funds from another health center, a Primary Care Association)

Other Revenue, Line 10

- Report other cash, non-charge-based income
- Include contributions, fundraising income, rents, sales, interest income, patient record fees, pharmacy sales to the public (i.e., non-health center patients), etc.

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center (Sum lines 1a through 1e)**	
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1	**Total 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 (Sum lines 1+5+9+10)**	

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State/Local Indigent Care Programs

State/Local Indigent Care Programs, Line 6a

Report funds received from state and local programs that subsidize/pay for health care (in general) services rendered to the uninsured

- Based on a current or prior level of service or on a flat fee per visit (not fee-for-service)

Report across tables as follows:

- Report patients as uninsured on Table 4 (not under other public insurance or state insurance plans)
- Report full charges, collections, bad debt (if any) for these services on the Self-pay line on Table 9D; everything not owed by the patient is written off as a sliding discount
- Report amounts provided by the programs subsidizing these services and IHS PL 93-638 Compact funds allocated to the health center on Table 9E, Line 6a
  - Private contracts with tribes are to be reported as Private, on Table 9D
- Do not report these funds on both Tables 9D and 9E

Patient is uninsured **Table 4, Line 7**

Record charge and collections (if any) as self-pay, balance as sliding fee **Table 9D, Line 13**

Report indigent care funds **Table 9E, Line 6a**

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Pop Quiz: Financial Reporting

Main Street CHC has a sliding discount program to help individuals who cannot afford care. In 2016, the combined total of self-pay collections, sliding discounts, plus bad debt = $125,000. Self-pay charges were $75,000. When the health center ran the Data Audit Report (required prior to UDS-submission), the system provided the following edit check:

More collections and write-offs are reported than total self-pay charges, reported on Table 9D, Line 13

What could be the possible cause for this scenario?

A. Co-pays and/or deductibles were not properly reclassified from third party payers down to the Self-pay line
B. The health center reported the adjusted amount (after discounts) as a self-pay charge instead of full charges
C. Significant prior year(s) patient account balances owed were collected
D. A large amount of patient bad debt was written off
E. All of the above

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2015 Statistics on Health Center Income

Income Indicators	2015 National UDS Statistics
% income from patient services	65%
% of patient charges managed care	35%
Sliding discounts as a % of self-pay charges	62%
Allowances as a % of insured charges	24%

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HEALTH INFORMATION TECHNOLOGY FORM

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Health Information Technology Form

- Report on a series of questions on health information technology (HIT) capabilities, including electronic health record (EHR) interoperability, leverage for Meaningful Use, telehealth, and medication-assisted treatment
  - Includes the implementation of EHR, certification of systems, how widely adopted the system is throughout the health center and its providers, and national and/or state quality recognition (accreditation or primary care medical home [PCMH])
- New questions have been added regarding telehealth capacity and use and medication-assisted treatment (MAT) for opioid use disorder

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STRATEGIES FOR SUCCESS

Parting Instructions

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Strategies for Success

- Work as a team
  - *Tables are interrelated*
- 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 EHB 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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Reminders

- **Who**: Health centers funded or designated prior to October 1
- **What**: Activities in scope of project; Reporting period of January 1, 2016 – December 31, 2016
- **Where**: Through EHB, which opens January 1, 2017
- **When**: *February 15, 2017* with a review period between February 15, 2017 – March 31, 2017

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Available Assistance

- Regional in-person UDS trainings
- Online training modules, manual, fact sheets, webinars, other health center data and technical assistance materials, including PALs
  - http://www.bphcdata.net
  - http://bphc.hrsa.gov/datareporting/index.html
- Telephone and email support line for reporting questions and use of UDS data
  - 866-UDS-HELP (866-837-4357) or email: udshelp330@bphcdata.net
- Technical support from a UDS Reviewer during the review period

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Additional Resources

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

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References for Performance Measures

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

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Other References

- Health information technology
  - Health Information Technology, Evaluation, and Quality (HITEQ): hiteqcenter.org
- Public housing
  - Community Health Partners for Sustainability: http://www.chpfs.org
  - National Center for Health in Public Housing: http://www.nchph.org
- Sexual orientation/gender identity
  - National LGBT Health Education Center: http://www.lgbthealtheducation.org
- Oral health
  - National Network for Oral Health Access: http://www.nnoha.org
- Agricultural workers
  - Migrant Clinicians Network: http://www.migrantclinician.org
  - National Center for Farmworker Health: http://www.ncfh.org
- Homeless
  - National Health Care for the Homeless Council: http://www. nhchc.org
  - Corporation for Supportive Housing: http://www.csh.org

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Discussion

- Are there issues that you have encountered related to UDS that you would like to share (state-specific reporting, consensus on handling issues, etc.)?
- Are there any final questions that you would like to discuss before we leave today?
- Remember to call the UDS Support Line if you have additional content questions at:

1-866-UDS-HELP or 1-866-837-4357

udshelp330@bphcdata.net

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Thank you!

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

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