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Patients by ZIP Code

PURPOSE:

The Patients by ZIP Code Table identifies patients by both their ZIP code of residence and their primary medical insurance.

CHANGES:

- There are no changes to the ZIP Code table reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

TOTAL PATIENTS: Individuals who have one or more UDS reportable visits during the reporting year.

PATIENTS BY ZIP CODE: Count of total patients according to the ZIP code on file as of the last visit.

OTHER ZIP CODE PATIENTS: Patients from ZIP codes from which 10 or fewer patients were served.

UNKNOWN RESIDENCE PATIENTS: Patients seen but with no ZIP code on record.

PRIMARY MEDICAL INSURANCE: Refer to the Table 4 Quick Fact Sheet for details about insurance categories.

HOW DATA ARE USED:

- Information is used to electronically map health center service area data and relate patients to community population and resources.
- Data are combined across health centers to enable BPHC and health centers to examine total program reach, remaining need, and to avoid service area conflicts.
- Maps and data can be accessed using an online tool, the UDS Mapper (see page 2).

TABLE TIPS:

- ZIP codes with ten or fewer patients should be aggregated and patients reported as "Other."
- For patients where ZIP code is not known, ZIP code should be reported as "Unknown."
- In general, patients with "Other" and "Unknown" should not exceed 15 percent of total patients unless there is a clear programmatic reason.
- **HOMELESS PATIENTS:** Use ZIP code of location where patient receives services if no better data exists.
- **MIGRANT PATIENTS:** Use ZIP code of the patient's temporary local housing if available or locations where patient receives service.
- **FOREIGN NATIONALS:** Use current ZIP code for people from other countries who reside in the United States either permanently or temporarily. Tourists and other people who have permanent residence outside the United States should be reported with "Other ZIP code."
- Medical insurance information must be obtained for all persons included as patients at the health center regardless of what services are provided.

CROSS TABLE CONSIDERATIONS:

Patients by ZIP Code, Tables 3A, 3B, and 4 describe the SAME PATIENTS and the totals must be equal (*shown on Table 3A Quick Fact Sheet*).

The number of patients by insurance source reported on the ZIP Code Table must be consistent with the number of patients by insurance category reported on Table 4.

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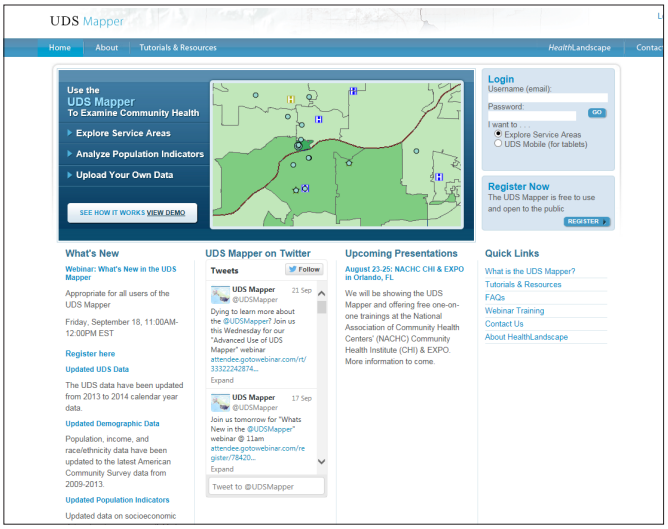
Patients by ZIP Code

PATIENTS BY ZIP CODE:

Zip Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private Insurance (e)
03301				
03302				
Other				
Unknown				

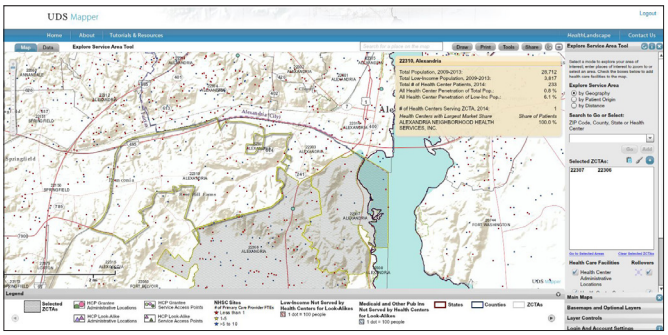
Note: This is a representation of the form. However, the actual online input process will look significantly different, as may the printed output from the EHB.



UDS MAPPER LAYERS:

MAIN MAP LAYERS

- Health center dominance
- FQHC penetration (low income/total)
- Count of health centers serving area
- Change in patients served (1 & 2 year)
- Census demographics



OPTIONAL LAYERS

- Health center locations/sites
- Other federally-linked providers
- HPSA/MUA/MUP boundaries
- Census boundaries/roads
- Background maps/satellite images

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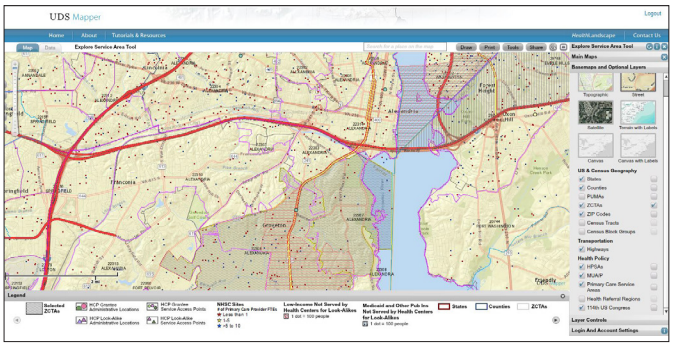
Patients by ZIP Code

USES OF UDS MAPPER TOOL:

- Visualize relationship between patients, population, and health services.
- Identify potential areas of need and quantify potential resources needed.
- Explore relationship with nearby health centers.
- Plan for growth or changes in service delivery network.
- Generate maps and data for grant applications and other presentations.

More information on the UDS Mapper Tool is available online at http://www.udsmapper.org/



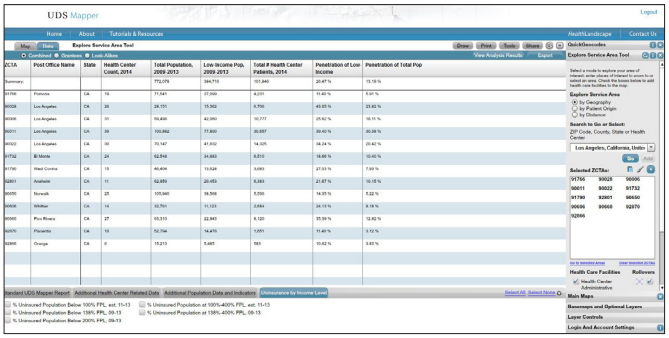


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Table 3A: Patients by Age and Sex Assigned at Birth

PURPOSE:

Table 3A is used to report the age and sex at birth of patients served by the health center. In combination with the other patient profile tables, it provides a picture of the demographics of those receiving services.

CHANGES:

- There are no changes to the Table 3A reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

TOTAL PATIENTS: Individuals who have had one or more UDS reportable visits during the reporting year.

VISIT: A documented, face-to-face contact between a patient and a provider during which the provider exercised independent, professional judgement in the provision of services.

GRANT PROGRAM PATIENTS: Individuals who have had one or more UDS reportable visits supported by one of the special population grant programs (HCH, MH, PH).

PATIENTS SEX AT BIRTH: This is normally the sex reported on a birth certificate.

TABLE TIPS:

- Table 3A is completed for the Universal Report and the grant specific report (if applicable).
- Those patients who are included on a grant specific report will also be included on the Universal Report.

TABLE 3A — PATIENTS BY AGE AND SEX ASSIGNED AT BIRTH

	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1	36	45
2	Age1	41	35
3	Age 2	30	28
4	Age 3	55	43
5	Age 4	57	48
6	Age 5	64	48
7	Age 6	63	55
8	Age 7	34	36
9	Age 8	41	42
10	Age 9	50	30
11	Age 10	48	33
12	Age 11	52	32
13	Age 12	46	44
14	Age 13	69	34
15	Age 14	62	61
16	Age 15	46	55
17	Age 16	51	64
18	Age 17	44	59
19	Age 18	42	82
20	Age 19	50	108
21	Age 20	57	97
22	Age 21	71	115
23	Age 22	91	133
24	Age 23	83	134
25	Age 24	80	119
26	Ages 25-29	362	638
27	Ages 30-34	381	586
28	Ages 35-39	347	525
29	Ages 40-44	357	535
30	Ages 45-49	448	625
31	Ages 50-54	503	628
32	Ages 55-59	396	540
33	Ages 60-64	282	377
34	Ages 65-69	165	216
35	Ages 70-74	89	136
36	Ages 75-79	53	120
37	Ages 80-84	34	48
38	Ages 85 and over	22	58
39	**Total Patients** (Sum Lines 1-38)	4,802	6,612

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

- Table 3A includes an unduplicated count of patients. This means that each patient is counted once regardless of the number of reportable visits they had during the reporting year.
- Age is calculated as of June 30th on Table 3A.

Note: For Tables 6B and 7, age is determined as of the end of the year. For this reason, and due to the fact there are additional criteria to consider when reporting universe data for other tables, the numbers are not expected to be an exact match across the tables.

CROSS TABLE CONSIDERATIONS:

- Patients by Zip Code, Table 3A (Age and Sex Assigned at Birth), 3B (Demographic Characteristics), and Table 4 (Income and Insurance) describe the same patients and the totals must equal.
- If you are reporting grant patients, the total number of patients reported on the grant table must be less than or equal to the corresponding number on the Universal Table for every cell. For example, you cannot report more migrant heath patients who are ages 30-34 than you report total patients ages 30-34.

SELECTED CALCULATIONS:

- **Children:** Patients between year 0 and 17 = sum (Lines 1 to 18) = 1,681
- **Adults:** Patients between 18 and 64 = sum (Lines 19 to 33) = 8,792
- **Older Adults:** Patients 65 and older = sum (Lines 34 to 38) = 941

Age Groups		Male Patients (a)	Female Patients (b)
1	Under age 1	36	45
2	Age1	41	35
3	Age 2	30	28
4	Age 3	55	43
5	Age 4	57	48
6	Age 5	64	48
7	Age 6	63	55
8	Age 7	34	36
9	Age 8	41	42
10	Age 9	50	30
11	Age 10	48	33
12	Age 11	52	32
13	Age 12	46	44
14	Age 13	69	34
15	Age 14	62	61
16	Age 15	46	55
17	Age 16	51	64
18	Age 17	44	59
19	Age 18	42	82
20	Age 19	50	108
21	Age 20	57	97
22	Age 21	71	115
23	Age 22	91	133
24	Age 23	83	134
25	Age 24	80	119
26	Ages 25-29	362	638
27	Ages 30-34	381	586
28	Ages 35-39	347	525
29	Ages 40-44	357	535
30	Ages 45-49	448	625
31	Ages 50-54	503	628
32	Ages 55-59	396	540
33	Ages 60-64	282	377
34	Ages 65-69	165	216
35	Ages 70-74	89	136
36	Ages75-79	53	120
37	Ages 80-84	34	48
38	Ages 85 and over	22	58

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Table 3B: Demographic Characteristics

PURPOSE:

Table 3B is used to report the Hispanic/Latino ethnicity, race, language, sexual orientation, and gender identity of the patients served by the health center. In combination with other patient profile tables, it helps us to understand the demographics of those receiving services.

CHANGES:

- There are no changes to Table 3B reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

HOW DATA ARE USED:

Patient profile: The patient profile reports race, ethnicity, sexual orientation, gender identity, age, insurance status, and income. These factors can play a significant role in determining health outcomes by identifying and reducing health disparities and promoting culturally competent care.

Language: Identifies a critical barrier to accessing care. Languages other than English include spoken languages and sign language.

KEY TERMS:

TOTAL PATIENTS: Individuals who have one or more UDS-reportable visit(s) during the reporting year.

GRANT SPECIFIC PATIENTS: Individuals who have had one or more UDS reportable visit(s) supported by one of the special population grant programs (Health Care for the Homeless, Migrant Health Center, Public Housing Primary Care).

SEXUAL ORIENTATION: How a person describes their emotional and sexual attraction to others.

GENDER IDENTITY: A person's internal sense of gender.

TABLE TIPS:

- Table 3B is completed for the Universal Report and for grant-specific reports (if applicable).
- Count each patient only once on Table 3B regardless of volume (i.e., the number of times they received services) or scope (i.e., the number of types of services received).

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Table 3B: Demographic Characteristics

PATIENTS BY ETHNICITY:

- Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Hispanic/Latino ethnicity is self-reported by patients.
- If a patient does not indicate Hispanic/Latino ethnicity, they are to be counted as non-Hispanic/Latino in Column (b).
- For Hispanic/Latino patients who do not select a race, report these Hispanic/Latino patients on Line 7, Column (a), as "unreported" race/Hispanic or Latino ethnicity.
- If neither race nor Hispanic/Ethnicity data is provided by the patient—report on Column (c).

PATIENTS BY RACE:

- Race is self-reported by patients.
- BPHC presumes that patients are able to select multiple races. Patients who select more than one race should be included on Line 6.
- Use Line 7 (Unreported/Refused to Report) to report patients who do not specify a race or who selected a race not provided on the list.
- The total patients on Line 8 should equal the total number of patients reported on Table 3A (Line 39, Columns a and b).

PATIENTS BY LANGUAGE:

- Use Line 12 to report all patients best served in a language other than English, including persons who:
  - are served by a bilingual provider;
  - receive interpretation services,
  - use sign language; or
  - live where a language other than English is used.
- Health centers may estimate the number of Patients Served in a Language other than English if they do not maintain actual data in their EHR. Where possible, the estimate should be based on a sample.

PATIENTS BY SEXUAL ORIENTATION:

- Use Lines 13-18 to report patients' sexual orientation.
- Use Line 17 "Don't Know" when patients report that they do not know their sexual orientation. Also use this line to report patients where the health center does not know the patients' sexual orientation because the health center did not have systems in place to routinely ask about sexual orientation
- Use Line 18 "Chose Not to Disclose" if the patient chooses not to disclose their sexual orientation.
- Line 19 provides for a total for this section (Lines 13-18) and should equal Line 8D Total Patients' by Hispanic or Latino Ethnicity and Line 26A Total Patients by Gender Identity.

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Table 3B: Demographic Characteristics

PATIENTS BY GENDER IDENTITY:

- Use Lines 20-25 to report patients' gender identity.
- Use Line 24 "Other" when a person does not think that one of the four gender identity categories adequately describes them. Include in this category persons who identify as genderqueer or non-binary. Also use this category to report patients where the health center does not know patient's gender identity because the health center did not have systems in place to routinely ask about sexual identity.
- Use Line 25 "Chose Not to Disclose" if a person chooses not to disclose their gender.
- Line 26 provides a total for this section (Lines 20–25) and should equal Line 8D (Total Patients' by Hispanic or Latino Ethnicity) and Line 19A (Total Patients by Sexual Orientation).

CROSS TABLE CONSIDERATIONS:

- The same patients are described in Tables 3A, 3B, 4, and Patients by Zip Code, so total patients reported should be equal across these four tables. Specifically, Table 3A, Line 39 (a+b) = Table 3B, Lines 8D, 19A and 26A = Total Patients by Zip Code = Table 4, Line 6 Column (a).
- Tables 3B and 7 both report patients by race and Hispanic/Latino ethnicity. It is important that the data sources for identifying race and ethnicity for the two tables are the same. The number of patients listed on Table 7 by race and ethnicity cannot exceed the number of patients in the same category for Table 3B. For example, you cannot report more Asian patients with hypertension on Table 7 than total Asian patients on 3B (shown below). Additionally, the two sets of numbers should make sense when considering the prevalence of the conditions reported on Table 7. For example, if you report high rates of hypertension and diabetes but only for a small number of African Americans, it does not make sense given the prevalence of hypertension and diabetes in the African American population.
- If you submit grant tables, the total number of patients reported on the grant table must be less than or equal to the corresponding number on the Universal table for each cell. In other words, you cannot report more homeless patients who are white than total patients who are white.

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Table 3B: Demographic Characteristics

TABLE 3B — DEMOGRAPHIC CHARACTERISTICS

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	10	586		596
2a	Native Hawaiian	11	81		92
2b	Other Pacific Islander	11	615		626
2	Total Native Hawaiian/Pacific Islander (Sum Lines 2A+2B)	22	696		718
3	Black/African American	132	1,076		1,208
4	American Indian/Alaska Native	12	376		388
5	White	337	27,364		27,701
6	More than one race	54	110		164
7	Unreported/Refused to report	38,375	1139	3,996	43,510
8	Total Patients (Sum Lines 1+3+(3 to 7))	38,942	31,347	3,996	74,285

TABLE 7 — HEALTH OUTCOMES AND DISPARITIES

Section B: Hypertension by Race and Hispanic/Latino Ethnicity

Line	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Samples or EHR Total (2b)	Patients with HTN Controlled (2c)
HISPANIC/LATINO				
1a	Asian	62	-	-
1b1	Native Hawaiian	9	-	-
1b2	Pacific Islander	81	-	-
1c	Black/African American	132	-	-
1d	American Indian/Alaska Native	12	-	-
1e	White	613	-	-
1f	More than one race	16	-	-
1g	Unreported/Refused to report	19	-	-
	Subtotal Hispanic/Latino			
NON-HISPANIC/LATINO				
2a	Asian	2	-	-
2b1	Native Hawaiian	1	-	-
2b2	Pacific Islander	1	-	-
2c	Black/African American	3	-	-
2d	American Indian/Alaska Native	1	-	-
2e	White	4	-	-
2f	More than one race	2	-	-
2g	Unreported/Refused to report	135	-	-
	Subtotal Non-Hispanic/Latino			
UNREPORTED/REFUSED TO REPORT ETHNICITY				
h	Unreported/Refused to Report Race and Ethnicity	9		
i	Total			

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Table 4: Selected Patient Characteristics

PURPOSE:

Table 4 is used to report on selected patient characteristics, including income, insurance status, managed care, and membership in special populations. In combination with the other patient profile tables, it provides an understanding of the demographics of those receiving services.

CHANGES:

- There are no changes to the Table 4 reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

INSURANCE AND MANAGED CARE:

- ***Third party insurance:*** Main source of insurance for primary medical care services. Report this as of the last visit of the reporting year.
- ***Managed care member month:*** Defined as 1 member being enrolled for 1 month in a managed care plan. Total number of member months equals the sum of the monthly enrollment for the reporting year.

SPECIAL POPULATIONS:

- ***Migratory or Seasonal Agricultural Worker:*** A patient whose principal employment is agriculture on a seasonal basis. Migratory describes those who establish a temporary home for such employment. Seasonal describes those who do not establish a temporary home for such employment.
- ***Homeless Patient:*** A patient who is homeless at the time of any service provided during the reporting year.
- ***School-Based Health Center Patient:*** A patient receiving health care services at a school-based health center located on or near school grounds.
- ***Veteran:*** A patient who has been discharged from the uniformed services of the United States.
- ***Public Housing Patient:*** A patient who is served at health center sites located in or immediately accessible to public housing, regardless of whether the health center site receives PHPC funding, or the individual physically resides in public housing.

HOW DATA ARE USED:

- **Patient Characteristics:** Describes the patients by income and insurance.
- **Managed Care Utilization:** Describes managed care enrollment in terms of member months per payor.
- **Special Populations:** Provides information about special populations receiving services.

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Table 4: Selected Patient Characteristics

TABLE TIPS:

- Table 4 is completed for both the Universal Report and grant-specific report.

INCOME

- Total patients by income must equal total patients by insurance and total patients on Table 3A and 3B.
- Income should be revised annually. The patient can self-report income.
- Income must be reported by the patient. If the patient does not report income, report as unknown.
- Official poverty guidelines are available (**https://www.medicaid.gov/federal-policy-guidance/downloads/cib032417.pdf**) from CMS.

INSURANCE:

- Breast and Cervical Cancer Control Program, Workers Comp, indigent care programs, and other programs that cover only a specific service are ***not*** considered insurance.

MANAGED CARE

- Do not report enrollees in Primary Care Case Management (PCCM) programs, which pay a small monthly fee (usually less than $10 per member per month) that does not cover patient care in this section.
- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical and dental coverage (for example) is counted.

SPECIAL POPULATIONS

- All 330 Programs report the total number of homeless patients (Line 23), agricultural worker patients (Line 16), school-based patients (Line 24), veterans (Line 25), and public housing patients (Line 26) served.
- Report the patient's shelter arrangements as of the first visit during the reporting period.
- ***Homeless*** (Lines 17–22) are only reported by 330h grantees. These are patients who lack housing (regardless of family membership), including individuals whose primary residence during the night is a supervised public or private facility providing temporary living accommodations and individuals who reside in transitional housing. This information is recorded based on where they spent the previous/recent nights:
  - Homeless Shelter (Line 17)
  - Transitional (Line 18)
  - Doubling up (Line 19)
  - Street (Line 20)
  - Other (Line 21)
  - Unknown (Line 22)
- ***Migratory Agricultural Workers*** (Line 14) are usually hired laborers who are paid piecework, hourly, or daily wages and who establish a temporary home for the purposes of employment. Migratory workers who have had this work as their principle source of income within 24 months of their last visit are also reported on Line 14, as are their dependent family members who have used the center.

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Table 4: Selected Patient Characteristics

- ***Seasonal Agricultural Workers*** (Line 15) are individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers who have had this work as their principle source of income within 24 months of their last visit are reported on Line 15 as are their dependent family members who have used the center.

- ***School-Based Health Center Patients*** (Line 24) are reported by all health centers that identified a school-based health center as a service delivery site in their grant or designation application and scope-of-project description. The total number of patients who received primary health care services at the school service delivery site(s) is reported. Services may have been targeted to the students at the school or their children, siblings or parents, as well as persons residing in the immediate vicinity of the school.

- ***Veterans*** (Line 25) are patients who have been discharged from the uniformed services of the United States. They are reported by all health centers. Patients who are still in the uniformed services (including the National Guard) are not considered veterans.

- ***Public Housing Patients*** (Line 26) should be counted as residents of public housing if they are served at health center sites that are located in or immediately accessible to public housing, regardless of whether the health center site receives PHPC funding, or the individual physically resides in public housing. Patients who reside in scattered site Section 8 housing should be excluded.

CROSS TABLE CONSIDERATIONS:

- The total patients reported by insurance type must match on Table 4 (Lines 7–12) and Zip Code Table. For example, total Medicare patients on Table 4 (Line 9) must match the total of the Medicare Column (d) on the Zip Code Table.

- Reporting of charges and collections by payor on Table 9D relates to insurance enrollment on Table 4. For example, dividing Medicaid revenues on Table 9D, Line 3, Column (a) or Column (b) by Total Medicaid Patients on Table 4 (Line 8) equals the average charge/average collection per Medicaid Patient (see below).

- Reporting of managed care revenues on Table 9D relates to member months on Table 4. Dividing managed care capitation income by member months equals average capitation per member per month (PMPM). For example, dividing Medicaid capitated income (Table 9D, Line 2a, Column b) by Table 4, Line 13a, Column (a) equals Medicaid PMPM (see below).

SELECTED CALCULATIONS:

- **Example Calculation of Average Charge per Medicaid Patient:** $26,744,788/(20,061+15,396) = $754/Medicaid Patient

- **Example Calculation of Average Collection per Medicaid Enrollee:** $29,325,761/(20,061+15,396) = $827/Medicaid Patient
(see next page for example)

Table 4: Selected Patient Characteristics

TABLE 4 — SELECTED PATIENT CHARACTERISTICS
Reporting Period: January 1, 2016 through December 31, 2016

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

Line	Principal Third Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	**4,958**	**19,257**
8a	Regular Medicaid (Title XIX)	20,061	15,396
8b	CHIP Medicaid		
8	**Total Medicaid (Line 8a+8b)**	**20,061**	**15,396**
9a	Dually Eligible (Medicare and Medicaid)		163
9	**Medicare** (Inclusive of dually eligible and other Title XVII beneficiaries)	2	**6,860**
10a	Other Public Insurance Non-CHIP (specify:_____)	3	738
10b	Other Public Insurance CHIP		
10	**Total Public Insurance (Line 10a+10b)**	**3**	**738**
11	**Private Insurance**	**2,460**	**4,713**
12	**TOTAL** (Sum Lines 7+8+9+10+11)	**27,484**	**46,964**

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	369,658				369,658
13b	Fee-for-service Member months					
13c	**Total Member months (Sum Lines 13a+13b)**	369,658				**369,658**

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Table 4: Selected Patient Characteristics

TABLE 9D — PATIENT RELATED REVENUE								
				Retroactive, Settlements, Receipts, and Paybacks (c)				
Line	Payer category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)
1	Medicaid Non-Managed Care	5,028,253	3,890,883		1,135,473			1,166,506
2a	Medicaid Managed Care (capitated)	7,411,041	10,080,620	4,113,290		2,944,160		-2,669,579
2b	Medicaid Managed Care (fee-for-service)	14,305,494	15,354,258					-494,501
3	**Total Medicaid** (Lines 1+2a+2b)	**26,744,788**	**29,325,761**	**4,113,290**	**1,135,473**	**2,944,160**		**-1,997,574**
4	Medicare Non-Managed Care							
5a	Medicare Managed Care (capitated)							
5b	Medicare Managed Care (fee-for-service)							
6	**Total Medicare** (Lines 4+5a+5b)							
7	Other Public including Non-Medicaid CHIP (Non-Managed Care)							
8a	Other Public including Non-Medicaid CHIP (Managed Care Capitated)							
8b	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)							
9	**Total Other Public** (Lines 7+ 8a +8b)							

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Table 5: Staffing and Utilization

PURPOSE:

Table 5 identifies staff full-time equivalents (FTEs), patient visits, and total patients by service category.

CHANGES:

- There are no changes to the Table 5 reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual

KEY TERMS:

FTEs:

- "1.00 FTE" is defined as being the equivalent of one person working full-time for one year.
- Each agency defines the number of hours for "full-time work" for each position.
- FTEs are based on employment contracts for clinicians and exempt employees.
- FTEs are calculated based on paid hours for non-exempt employees (e.g., 2,080 hours/year or 1,820 hours/year).
- FTEs are adjusted for part-time work or for part-year employment.

VISITS:

To qualify as a visit, the following criteria must be met:

- Must be face-to-face between the patient and the provider (an exception is provided for behavioral health telemedicine);
- Medical and dental providers must be licensed;
- Provider must be acting independently;
- Provider must be exercising professional judgment;
- Service must be documented in the patient's chart.

PATIENTS:

- **Service Patient:** An individual who receives one or more documented "visits" of any specific service type: Medical, Mental Health, Dental, Substance Use, Other Professional, Enabling, and Vision. Patients may be counted up to once per service category.

HOW DATA ARE USED:

Table 5 is part of the Staffing & Utilization Profile for the UDS Report. The data are used to evaluate staffing of key health center leadership, clinical staff, and providers:

STAFFING RATIOS: FTEs are used to calculate staffing ratios per provider FTE.

PROVIDER PRODUCTIVITY: Visits per provider FTE.

CONTINUITY OF CARE: Visits per patient.

DENOMINATORS FOR PERFORMANCE MEASURES:

- Service cost per service patient
- Service cost per service visit
- Charges per visit
- Collections per visit
- Average costs per FTE by type

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Table 5: Staffing and Utilization

TABLE TIPS:

Table 5 is completed for the Universal Report and for grant specific reports. However, grant reports include only visits (Column b) and patients by service category (Column c); FTEs are not reported on the grant report. Appendix A of the UDS Manual contains a list of personnel categorized as providers and non-providers.

FTEs:

- Report FTEs on lines corresponding with work performed and licensure, not by job title.
- Include as FTEs: employees, contract personnel (not paid by unit of service), volunteers, and residents based on hours worked.
- Do not reduce clinical FTEs for vacation, CME, meetings, paid leave, holidays, etc.
- Do not allocate a portion of MDs' and mid-level practitioners' time to non-clinical functions, except for the medical director.

PATIENTS:

A patient is counted only once in each category in which they receive services (e.g., medical, dental, substance use, etc.) regardless of the number of visits received.

VISITS:

- Report visits on lines corresponding with staff performing the service.
- Medical visits are provided by physicians and mid-level practitioners only.
- Dental visits are provided by dentists, dental therapists, and dental hygienists only.
- Include visits provided by paid and volunteer staff; provided by a third party and paid for in full by health center, including paid managed care referrals or voucher program visits; and those performed by staff rounding on health center patients in hospital.
- One visit per patient, per service category, per day. (Exception: Two visits of the same type with two different providers at two different locations within one service category may both be counted).
- A provider counts only one visit with a patient during a day regardless of the number of services provided to that patient.

CROSS TABLE CONSIDERATIONS:

- **Tables 5 and 8A:** Costs associated with staff (FTEs) reported on Table 5 must be included in the corresponding cost center on Table 8A (example shown on next page).
- Visits and patients reported in any cell of the grant tables cannot exceed the number reported in the same cell on the Universal table.
- **Tables 5 and 9D:** Billable visits reported on Table 5 should relate to patient charges reported on Table 9D. However, non-billable visits can also be counted assuming they meet the visit criteria.
- The sum of patients on Table 5 should be greater than the total number of patients reported on Table 3A (unless only one type of service is offered). This duplicated count of patients is an indication of the comprehensiveness of care provided to health center patients.

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Table 5: Staffing and Utilization

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1-12: Medical (e.g., physicians, mid-level providers, nurses)	**1:** Medical staff
13-14: Lab and X-ray	**2:** Lab and X-ray
16-18: Dental (e.g., dentists, dental hygienists, etc.)	**5:** Dental
20a-20c: Mental Health	**6:** Mental Health
21: Substance Use	**7:** Substance Use
22: Other professional (e.g., nutritionists, podiatrists, etc.)	**9:** Other professional
22a-22c: Vision Services (e.g., ophthalmologist, optometrist, optometric assistants, other vision care)	**9a:** Vision
23: Pharmacy	**8a:** Pharmacy
24-28: Enabling (e.g., case management, outreach, eligibility) – relationship of the detail follows. Note the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.	**11a–11g:** Enabling
24: Case Managers	**11a:** Case Management
25: Patient/Community	**11d:** Patient and Community Education
26: Outreach Workers	**11c:** Outreach
27: Transportation Staff	**11b:** Transportation
27a: Eligibility Assistance Workers	**11e:** Eligibility Assistance
27b: Interpretation Staff	**11f:** Interpretation Services
27c: Community Health Workers	**11h:** Community Health Workers
28: Other Enabling Services	**11g:** Other Enabling Services
29a: Other programs/services (e.g., non-health related services including WIC, job training, housing, child care, etc.)	**12:** Other related services
29b: Quality Improvement Staff	**12a:** Quality Improvement
30a-30c and 32: Non-Clinical Patient Support (e.g., corporate, intake, medical records, billing, fiscal, and IT staff)	**15:** Administration
31: Facility (e.g., janitorial staff, etc.)	**14:** Facility

Table 5: Staffing and Utilization

SELECTED CALCULATIONS:

Dividing total cost/service by FTEs, visits, and patients for that service yields AVERAGE COSTS:

- Average cost per FTE: $5,757,876/26.59 = $216,543
- Average cost per visit: $5,757,876/25,499 = $226
- Average cost per patient: $5,757,876/10,616 = $542

TABLE 5 — STAFFING AND UTILIZATION

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
16	Dentists	8.70	21,455	
17	Dental Hygienists	2.45	4,044	
17a	Dental Therapists			
18	Dental Assistants, Aides, Techs	15.44		
19	SubTotal Dental Services (Lines 16–18)	26.59	25,499	10,616

TABLE 8A — FINANCIAL COSTS

Line	Financial Costs for Other Clinical Services	Accrued Costs (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental	3,986,773	1,771,103	5,757,876
6	Mental Health	1,356,455	652,157	2,008,612
7	Substance Abuse	446,473	217,386	663,859

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Table 5A: Tenure for Health Center Staff

PURPOSE:

Table 5A provides information on the tenure of select health center leadership staff and providers.

CHANGES:

- There are no changes to the Table 5A reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

FULL- AND PART-TIME STAFF: Full- and part-time staff are considered regular employees of the health center. These staff are employed or contracted by the health center or have another formal working arrangement.

- Full- and part-time staff are individuals who are considered regular employees of the health center. They are paid as outlined in their contract, may receive benefits, and may work different amounts of time.
- Part-year staff are individuals employed for specific periods based on recurring special needs.
- Contracted staff are individuals who work at the health center and are paid based on a regular work schedule (not by service/visit delivered in their own office).
- National Health Service Corps (NHSC) assignees are members of the National Health Service Corp who are assigned to the health center.

LOCUMS, ON-CALL, AND OTHER SERVICE PROVIDERS OR CONSULTANTS: Health centers often make use of individuals other than their regular staff to provide services to patients. These include locum tenens, on-call providers, volunteers, residents/trainees, off-site contract providers, and non-clinical management consultants.

CENSUS: Tenure of staff as of the last work day of the year (December 31 or the last working day).

- Include only individuals who are working on day of census or have that day off but are scheduled to return on a specific day.
- Count each individual as 1 person (Full-time equivalent (FTE) is not considered). To be included, an individual must meet one or more of the following criteria:
  - Be employed full-time.
  - Be employed part-time on a regular basis with a regular schedule.
  - Be an NHSC clinician who is assigned to the health center.
  - Be contracted on a regular basis with a regular schedule.
  - Be an on-call, locum, resident, or volunteer provider who has worked a regular schedule for at least 6 months.

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Table 5A: Tenure for Health Center Staff

TOTAL MONTHS: Months are defined here as the number of continuous months that the person has been in their current position.

- For people who have transitioned to a new position, report the number of months in their most recent position.
- For people who hold multiple positions (i.e., Pediatrician & Medical Director), report the number of months they have held each position (see examples on the next page).

HOW DATA ARE USED:

The data can be used to evaluate continuity of care, as well as staffing of key health center leadership, staff, and providers.

TABLE TIPS:

- Table 5A is completed for the Universal Report only.
- Data reported are generally available in health center personnel or human resource employment records.
- Report staff persons (not FTE) in Columns (a) and (c), on lines corresponding with work performed and licensure, consistent with Table 5.
- Report months in Columns (b) and (d), rounded up to the next whole number.

CROSS TABLE CONSIDERATIONS:

- If staff are reported on Table 5A (as head count), those staff must be reported on the corresponding lines on Table 5 (as calculated FTE). The reverse is not true however as there are likely staff on Table 5 (as calculated FTE) that are no longer with the health center at the end of the year, and therefore are not included on Table 5A.
- Staff on Table 5A reflect a head count as of the end of the measurement year, whereas Table 5 reflects staff time worked during the measurement year; therefore, number of staff are unlikely to be equal.

SELECTED CALCULATIONS:

EXAMPLE 1:

- Pediatrician hired 8/1/03, promoted to Chief Marketing Officer (CMO) on 9/15/11, and serves in both roles—Count 175 months as pediatrician and 76 months as CMO.

EXAMPLE 2:

- Chief Operating Officer (COO) is hired 11/10/89, promoted to Deputy Director 7/12/98, and then promoted to Chief Executive Officer (CEO) 6/22/14, retaining the obligations of the Deputy Director—Count 42 months as CEO only.

EXAMPLE 3:

- Chief Information Officer (CIO) hired 5/15/13 to fill the role of CIO and CFO—Count 56 months as CFO, and 56 months as CIO.

Table 5A: Tenure for Health Center Staff

TABLE 5A — TENURE FOR HEALTH CENTER STAFF					
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/Gynecologist				
5	Pediatricians	1	175		
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 Psychiatrists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer	1	42		
30a2	Chief Medical Officer	1	76		
30a3	Chief Financial Officer	1	56		
30a4	Chief Information Officer	1	56		

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Table 6A: Selected Diagnoses and Services Rendered

PURPOSE:

Table 6A is part of the clinical profile that reports on two separate sets of data: selected diagnoses and selected services rendered. It is designed to provide information on diagnoses and services using data maintained for billing purposes or electronic health record (EHR) data.

CHANGES:

- There are no changes to the Table 6A reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS. Corrections have been made to a number of ICD-10 codes.

KEY TERMS:

VISIT: To be counted as a visit in Column (a) of Table 6A for services, a service must either be delivered at the time of a visit that was counted on Table 5 or as a result of an order from a prior visit (such as a vaccination ordered for 40 days later during a well-child visit).

PATIENTS: Individuals who have one or more UDS visits during the reporting year.

HOW DATA ARE USED:

To calculate:

- The average visits per patient per year for selected chronic conditions (e.g., hypertension, diabetes, asthma, etc.).
- The average number of visits or services per patient (i.e., divide Column b by Column a).
- The frequency of acute care services by service type (e.g., well child immunizations).
- The penetration rate for routine preventative services (e.g., well child, family planning, pap tests).

CROSS TABLE CONSIDERATIONS:

- Visits and patients reported in any cell of the grant-specific tables cannot exceed the number reported on the Universal table.
- **Tables 6A and 7:** Table 6A is NOT the same as Table 7. Patients reported with diabetes or hypertension on Table 6A may not satisfy the additional criteria that must be met for inclusion on Table 7.
- **Table 6A and 6B:** Tobacco use disorder on Line 19a of Table 6A is NOT the same as patients identified as tobacco users and reported on Table 6B, Line 14a, as 6B has additional criteria.
- **Table 6A and 6B:** Number of patients with diagnosis of asthma reported in Line 5, Column (b) on Table 6A is NOT the same as number of patients with persistent asthma on 6B, Line 16, as Table 6B has additional criteria.

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Table 6A: Selected Diagnoses and Services Rendered

TABLE TIPS:

Table 6A is completed for the Universal Report and for grant specific reports.

PATIENTS AND VISITS:

- **Column a:** Total visits with diagnosis or recipient of services.
- Only services that are provided at a reportable visit are reported on Table 6A. Included in these are services attendant to a reportable visit.
- **Column b:** Unduplicated number of patients with diagnosis or having received service.
- If a patient is seen for multiple diagnoses in one visit, they can be reported once on each appropriate diagnosis line. Similarly, if a patient receives multiple services in one visit, they may be counted once on each appropriate service line.

SELECTED DIAGNOSES (LINES 1-20D):

- Report visits and patients regardless of whether or not the diagnosis is primary.
- Include follow-up services related to a countable visit. Thus, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit.

SELECTED TESTS/SCREENINGS/PREVENTATIVE SERVICES (LINES 21-26D):

- Use ICD-10 or Current Procedural Technology (CPT) codes for each line.
- On several lines, CPT codes and ICD-10 codes are provided. Health centers may use ***either*** the CPT codes ***or*** the ICD-10 codes for any specific visit, ***but not*** both.
- A single visit may be counted for multiple types of services (e.g., the same visit may include a Pap test, mammogram, and family planning service) and would be reported on each of the lines.
- A visit is counted only once for any one service code even if multiple services are given (e.g., five vaccines or two fillings in one visit are counted only once).

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Table 6A: Selected Diagnoses and Services Rendered

SELECTED CALCULATION:

Shown below, average number of Diabetes Mellitus (DM) diagnosis visits per patient per year = 30,090/9,928 = 3.0 DM visits/patient/year.

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic/ Asymptomatic HIV	B20, B97.35, O98.7, Z21	1,080	3,000
3.	Tuberculosis	A15- thru A19-	2	2
4.	Sexually transmitted infections	A50- thru A64- (Exclude A63.0), M02.3-	98	83
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	15	13
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	1,643	125
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	10,383	6,143
6.	Chronic obstructive pulmonary diseases	J40- thru J44-, J47-	2,655	2,335
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, D48.6-, N63-, R92-	148	118
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	2,130	1,078
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	30,090	9,928

Table 6A: Selected Diagnoses and Services Rendered

CROSS TABLE CONSIDERATION EXAMPLE:

Table 6A, Line 5, Column (b) (see table above): Number of patients with diagnosis of asthma in measurement year is 6,143.

Compare this to Table 6B, Section H, Line 16, Column (a): Total patients ages 5-65 with persistent asthma. This number is only 3,312 because these are patients who meet all of the following criteria:

- Diagnosed with persistent asthma;
- Last seen while between ages 5 and 64; and
- Had at least one medical visit in a health center clinic during the measurement year.

TABLE 6B: QUALITY OF CARE INDICATORS

Line	Use of Appropriate Medications for Asthma	Total Patients ages 5 - 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	**MEASURE:** Percentage of patients ages 5 through 64 years of age identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Total Universe: n=3,312	3,312	

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Table 6B: Quality of Care Measures

PURPOSE:

Table 6B reports on selected quality of care measures that are viewed as indicators of overall community health.

HOW DATA ARE USED:

Compliance rates for clinical measures and percentage of target population receiving routine or preventive service.

CHANGES:

CLINICAL QUALITY MEASURES

- To support department-wide standardization of data collection and reduce health center reporting burden, many of the specifications for Table 6B's clinical measures have been revised to align with the Centers for Medicare & Medicaid Services (CMS) electronic-specified Clinical Quality Measures (e-CQMs). A list of these measures is shown in Table 1.
- For 2017 the UDS Manual Table 6B has been updated to mirror the CMS e-CQM logic. Extensive information pertaining to e-CQMs can be found at the eCQI Resource Center: **https://ecqi.healthit.gov/ecqms**

Measure Description

- Describes the quantifiable indicator to be evaluated.

Denominator or "Universe" (also referred to as Initial Patient Population in the e-CQM)).

- Number of patients who fit the detailed criteria described for inclusion in the measure.

Numerator

- Number of patients (from the denominator) who meet the measurement standard for the measure.

Exclusions/Exceptions

- Patients who should not be included in the denominator, based on specified exclusion criteria.

Specification Guidance

- CMS measure guidance that assists with the understanding and implementation of the e-CQM.

UDS Reporting Considerations

- BPHC best practices and guidance to be applied to the measure.

Clinical quality measures aligned to an e-CQM have been updated to comply with the 2017 Addendum (January 2017): **https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ec-qms?field_year_value=2&keys=&=Apply**

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Table 6B: Quality of Care Measures

TABLE 1: 2016 TABLE 6B: CLINICAL QUALITY MEASURES		
Table 6B Reference	**2016 Measure Description**	**e-CQM**
Section C, Line 10	Childhood Immunization Status (CIS)	**CMS117v5**
Section D, Line 11	Cervical Cancer Screening	**CMS124v5**
Section E, Line 12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**CMS155v5**
Section F, Line 13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**CMS69v5**
Section G, Line 14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**CMS138v5**
Section H, Line 16	Use of Appropriate Medications for Asthma	**CMS126v5**
Section I, Line 17	Coronary Artery Disease (CAD): Lipid Therapy	No e-CQM
Section J, Line 18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	**CMS164v5**
Section K, Line 19	Colorectal Cancer Screening	**CMS130v5**
Section L, Line 20	HIV Linkage to Care	No e-CQM
Section M, Line 21	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	**CMS2v6**
Section N, Line 22	Dental Sealants for Children between 6-9 Years	**CMS277v0** (Draft e-CQM)

Table 1. For 2017 reporting period the e-CQM specifications and related materials from the 2017 Addendum (January 2017) should be used.

WHY ARE PROCESS MEASURES IMPORTANT?

If patients receive timely routine and preventive care, then we can expect improved health status. For example, we know that:

- *Children who receive vaccinations are less likely to contract preventable diseases;*
- *Women who receive Pap tests are more likely to be treated earlier and less likely to suffer adverse outcomes from HPC and cervical cancer; and*
- *Timely follow-up care for patients who test positive for HIV reduces morbidity and mortality and the risk of further transmission.*

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Table 6B: Quality of Care Measures

TABLE TIPS:

In Sections C through N, report the findings of your review of services provided to targeted populations:

- **Column a: Number of Patients in the Universe (or denominator).** This will equal the number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.
- **Column b: Number of Charts Sampled.** This will equal the number of patients from the universe (column a) for whom data have been reviewed. Three options are available:
    1. All patients who fit the criteria for the clinical measure (same as universe in column a); **OR**
    2. A number equal to or greater than 80%* of all patients who fit the criteria (≥ 80% of the universe reported in column a); **OR**
    3. A random sample 70 patients selected from the universe (column a).

    ***NOTE:** If you choose Option 2 (80% of column a) the sample cannot be restricted by any variable related to the clinical measure.
- **Column c (measurement standard).** This will equal the number of charts (from Column B) whose clinical record indicates that the measure has been met.

Childhood Immunization Status (Line 10), CMS117v5

Measure Description

Percentage of 2-year-old children who received the following vaccines by their 2nd birthday:

- 4 diphtheria, tetanus and acellular pertussis (DTaP);
- 3 polio (IPV), one measles, mumps and rubella (MMR);
- 3H influenza type B (HiB);
- 3 hepatitis B (Hep B);
- 1 chicken pox (VZV);
- 4 pneumococcal conjugate (PCV);
- 1 hepatitis A (Hep A);
- 2 or 3 rotavirus (RV); and
- 2 influenza (flu).

Denominator or "universe" (Columns a & b)

Children who turned 2 years of age* and had a medical visit during the measurement period.

Born on or after January 1, 2015 and on or before December 31, 2015

Numerator (Column c)

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

Exclusions/Exceptions

- None

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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Table 6B: Quality of Care Measures

Cervical Cancer Screening (Line 11), CMS124v5

Measure Description

Percentage of women screened for cervical cancer using either of the following criteria :

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

Denominator or "universe" (Columns a & b)

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

Born on or after January 1, 1953 and on or before December 31, 1993

Numerator (Column c)

Women with one or more of the following screenings for cervical cancer:

- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test;
- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test.

Exclusions/Exceptions

Women who have had a hysterectomy with no residual cervix are **excluded from the denominator (or "universe")**.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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

Measure Description

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

Denominator (Universe) (Columns a & b)

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

Born on or after January 1, 2000 and on or before December 31, 2013

Numerator (Column c)

Children and adolescents who have had:

- Their BMI **percentile** (not just BMI or height and weight) recorded during the measurement period; ***and***
- Counseling for nutrition ***and*** physical activity during a visit that occurred during the ***measurement*** period.

Exclusions/Exceptions

Patients who had a diagnosis of pregnancy during the measurement period are **excluded from** the **denominator (or "universe")**.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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Table 6B: Quality of Care Measures

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

Measure Description

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

*NORMAL PARAMETERS: Age 18 years and older BMI greater than or equal to 18.5 and less than 25 kg/m2.

Denominator (Universe) (Columns a & b)

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

**Born on or before December 31,1998, and were 18 years of age or older on date of last visit*

Numerator (Column c)

Patients with:

- A documented BMI (not just height and weight) during their most recent visit ***or*** during the previous six months of that visit, ***and***
- When the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the current visit.
- INCLUDE patients with a normal BMI documented in column c. Those with a normal BMI do not require a documented follow-up plan to be included in the numerator (column c).

Exclusions/Exceptions

Exclude from the denominator:

- Pregnant patients (ages 18-64 only),
- Patients receiving palliative care;
- Those who refuse measurement of height and/ or weight or refuse follow-up; or
- Who had a documented medical reason, including:
- Elderly patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as: *illness or physical disability; mental illness, dementia, confusion; nutritional (vitamin or mineral) deficiency;* or
- In an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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Table 6B: Quality of Care Measures

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

Measure Description

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

Denominator (Universe) (Columns a & b)

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

**Born on or before December 31, 1998*

Numerator (Column c)

Patients who:

- Were screened for tobacco use at least once within 24 months before the end of the measurement period; **and**
- Received tobacco cessation intervention if identified as a tobacco user.
- Column c INCLUDES **patients with a negative screening as well as** those with a **positive screening who received cessation intervention**.

Exclusions/Exceptions

Exclude from the denominator patients with a documented medical reason for not being screened for tobacco use (e.g., limited life expectancy or other medical reason).

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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

Measure Description

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

Denominator (Universe) (Columns a & b)

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

**Born on or after January 1, 1953 and on or before December 31, 2011*

Numerator (Column c)

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

Exclusions/Exceptions

Exclude from the denominator, patients diagnosed with emphysema, chronic obstructive bronchitis, cystic fibrosis, or acute respiratory failure during or prior to the measurement period.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

Table 6B: Quality of Care Measures

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

Measure Description

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

Denominator (Universe) (Columns a & b)

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

Born on or before December 31, 1998

Numerator (Column c)

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

Exclusions/Exceptions

Exclude from the denominator:

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

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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

Measure Description

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

Denominator (Universe) (Columns a & b)

- Patients 18 years of age and older* with a medical visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had an active diagnosis of IVD during the measurement year.

Born on or before December 31, 1998

Numerator (Column C)

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

Exclusions/Exceptions

Exclude from the **denominator**, patients who **had documented use of anticoagulant medications** at some point during the measurement year.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

Table 6B: Quality of Care Measures

Colorectal Cancer Screening (Line 19), CMS130v5

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

Denominator (Universe) (Columns a & b)

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

Born on or after January 1, 1942 and on or before December 31, 1966

Numerator (Column c)
Patients with one or more of the following screenings for colorectal cancer:

- Fecal occult blood test (FOBT), including fecal immunochemical test (FIT) (during the measurement period)
- Flexible sigmoidoscopy (during the measurement period or the four years prior to the measurement period)
- Colonoscopy (during the measurement period or the nine years prior to the measurement period)

Exclusions/Exceptions
Exclude from the denominator, patients with a diagnosis of colorectal cancer or history of total colectomy.

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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

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

Denominator (Universe) (Columns a & b)

- Patients first diagnosed with HIV by the health center between October 1, 2016 and September 30, 2017, **and** who had at least one medical visit during 2016 or 2017.

Numerator (Column c)

- Patients newly diagnosed with HIV who received treatment within 90 days of diagnosis.
- Include patients who: *were newly diagnosed by your health center provider and had a medical visit with your health center provider (or with a referral resource) who initiates treatment for HIV.*

Exclusions/Exceptions

- None

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

Table 6B: Quality of Care Measures

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

Measure Description

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

Universe (Denominator) (Columns a & b)

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

Patients born on or before December 31, 2004

Numerator (Column c)

Patients who:

- Were screened for depression on the date of the visit using an age-appropriate standardized tool; and
- If screened positive for depression, had a follow-up plan documented on the date of the positive screen.
- Column c INCLUDES patients with a negative depression screening. Those with a negative screening do not require a documented follow-up plan to be included in the numerator.

Exclusions/Exceptions

Exclude from the denominator, patients:

- With an active diagnosis of depression or a diagnosis of bipolar disorder
- Who refuse to participate
- Who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status
- Whose functional capacity or motivation to improve may impact the accuracy of results

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

Table 6B: Quality of Care Measures

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

Measure Description

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

NOTE: CMS277v0 is a draft e-CQM that currently reflects 5 through 9 years of age but will be corrected to use age 6 through 9 as measure steward intended.

Denominator (Universe) (Columns a & b)

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

**Born on or after January 1, 2008 and on or before December 31, 2010*

Numerator (Column c)

- Number of children who received a sealant on a permanent first molar tooth during the measurement period.

Exclusions/Exceptions

- Exclude from the denominator, children for whom all first permanent molars are non-sealable (i.e., molars are decayed, filled, currently sealed, or un-erupted/missing)

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

TABLE AND CROSS TABLE CONSIDERATIONS:

Table 3A, 5, and 6B: The relationship between the universes on Table 6B should be verified as reasonable when compared to the total number of patients by age on Table 3A and the percentage of patients by service category on Table 5.

In this example, Table 3A shows a total of 1,550 patients (age 2) and the universe for childhood immunizations is also 1,550.

Reporting of the universe of patients for childhood immunizations and cervical cancer screening must be reasonable (as must all universe selections) given total patients by age on 3A and/ or the percentage of patients who are medical patients on Table 5.

Table 6B: Quality of Care Measures

SECTION C — CHILDHOOD IMMUNIZATION				
Line	**Childhood Immunization**	**Total Number of Patients with 2nd Birthday During Measurement Year (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Immunized (c)**
10	**MEASURE:** Children who have received age appropriate vaccines prior to their 2nd birthday during measurement year (on or prior to December 31)	1,550	1,550	1,395
SECTION D – CERVICAL CANCER SCREENINGS				
Line	**Cervical Cancer Screening**	**Total Female Patients 23 through 64 Years of Age (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Tested (c)**
11	**MEASURE:** Percentage of women 23–64 years of age, who received one or more Pap tests to screen for cervical cancer	26,778	26,778	19,767

TABLE 3A — PATIENTS BY AGE AND GENDER			
Line	**Age Groups**	**Male Patients (a)**	**Female Patients (b)**
3	Age 2	20	14
4	Age 3	766	750
24	Age 23		901
25	Age 24		973
26	Ages 25-39		7,762
27	Ages 30-34		3,719
28	Ages 35-39		3,149
29	Ages 40-44		2,845
30	Ages 45-49		2,737
31	Ages 50-54		2,582
32	Ages 55-59		2,110

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Table 7: Health Outcomes and Disparities

PURPOSE:

Table 7 reports data on selected clinical quality measures by race and Hispanic/Latino ethnicity that are commonly seen as indicators of community health. Birth outcome information is discussed on a separate fact sheet.

HOW DATA ARE USED:

Compliance rates for clinical measures and percentage of target population receiving routine or preventive service.

These data will be used to calculate:

- Disparities in health outcomes by race and ethnicity (national level).
- Prevalence rates for Hypertension (HTN) and Diabetes Mellitus (DM).

CHANGES:

CLINICAL QUALITY MEASURES

To support department-wide standardization of data collection and reduce health center reporting burden, many of the specifications for the clinical measures in Table 7 have been revised to align with the Centers for Medicare & Medicaid Services (CMS) electronic-specified Clinical Quality Measures (e-CQMs).

For 2017 the UDS Manual Table 7 has been updated to mirror the CMS e-CQM logic. Extensive information pertaining to e-CQMs can be found at the eCQI Resource Center: **https://ecqi.healthit.gov/ecqms**

Measure Description

- Describes the quantifiable indicator to be evaluated.

Denominator or "Universe" (also referred to as Initial Patient Population in the e-CQM).

- Number of patients who fit the detailed criteria described for inclusion in the measure.

Numerator

- Number of patients (from the denominator) who meet the measurement standard for the measure.

Exclusions / Exceptions

- Patients who should not be included in the denominator, based on specified exclusion criteria.

Specification Guidance

- CMS measure guidance that assists with the understanding and implementation of the e-CQM.

UDS Reporting Considerations

- BPHC best practices and guidance to be applied to the measure.

Updated specifications (2017 Addendum) for the following measures can be found at: **https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=2&keys=&=Apply**

- Section B: Controlling High Blood Pressure has been revised to align with **CMS165v5**
- Section C: Diabetes: Hemoglobin A1c Poor Control has been revised to align with **CMS122v5**

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Table 7: Health Outcomes and Disparities

KEY TERMS:

INTERMEDIATE OUTCOME MEASURES:
Documentation of measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes. For example:

- **Controlling High Blood Pressure**: There will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life, *if there is less uncontrolled hypertension*.
- **Diabetes: Hemoglobin A1c Poor Control**: There will be fewer long-term complications such as amputations, blindness, and end-organ damage, *if there is less poorly-controlled diabetes*.

TABLE TIPS:

In Section B (Controlling High Blood Pressure) and Section C (Diabetes: Hemoglobin A1c Poor Control), health centers will report on the findings of their reviews of services provided to targeted populations:

- **Column a: Number of Patients in the Universe (or denominator).** This will equal the number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.
- **Column b: Number of Charts Sampled.** This will equal the number of patients from the universe (column a) for whom data have been reviewed. Three options are available:

    1. All patients who fit the criteria for the measure (same as universe in column a); **OR**
    2. A number equal to or greater than 80%* of all patients who fit the criteria (≥80% of the universe reported in column a); **OR**
    3. A random sample of 70 patients selected from the universe (column a).

    ***NOTE:** If you choose Option 2 (80% of column a), the sample cannot be restricted by any variable related to the clinical measure.

- **Column c: Measurement Standard.** This will equal the number of charts (from column b) whose clinical record indicates that the measure rules and criteria have been met.

    NOTE: All age requirements for this table are as of January 1st.

REPORTING RACE & ETHNICITY

- Patients who report their race but do not indicate they are Latino/Hispanic are assumed to be non-Hispanic and reported on lines 2a-2g.
- Patients for whom ethnicity and race are not known are reported as "Unreported/Refused to Report Race and Ethnicity" on line h.
- The data source for reporting patients by race and ethnicity for Table 3B and Table 7 must be consistent for accurate reporting.

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Table 7: Health Outcomes and Disparities

CONTROLLING HIGH BLOOD PRESSURE (COLUMNS 2A-2C), CMS165V5

Measure Description

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

Denominator or "universe (Columns 2a and 2b)

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

**Patients born on or after January 1, 1932 and on or before December 31, 1998*

Numerator (Column 2c)

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

Exclusions/Exceptions

Exclude from the **denominator,** patients with:

- Evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period
- A diagnosis of pregnancy during the measurement period

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%) (COLUMNS 3A-3F), CMS122V5

Measure Description

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

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

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

**Patients born on or after January 1, 1942 and on or before December 31,1998*

Numerator (Column 3f)

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

Exclusions/Exceptions

- Exclude from the **denominator,** patients with **a diagnosis of secondary diabetes due to another condition.**

**Please refer to the UDS Manual for detailed Specification Guidance and UDS Reporting Considerations.*

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Table 7: Health Outcomes and Disparities

SELECTED CALCULATIONS (SHOWN ON FOLLOWING PAGES)

- **Compliance rate** is calculated by dividing Table 7, Column (2c) by Column (2b)

  Example: HTN for White/Non-Hispanic 93/176 = 52% patients with controlled HTN

- **Percent medical patients with diagnosis** is calculated by dividing total patients by diagnosis by total medical patients.

  Example: 8,651 medical patients with HTN [Table 7, Line i, Column (2a)] / 67,919 total medical patients [Table 5, Line 15, Column c] = 13%

- **Total White/Non-Hispanic patients with HTN** ages 18 – 85 with two or more medical visits = 4,494 [Universe on Table 7, Line 2e, Column 2a].

NOTE:

- Must not exceed total patients ages 18 – 75 on Table 3A. (Lines 19-35)
- Must not exceed total medical patients on Table 5.
- Must not exceed total White/Non-Hispanic patients on Table 3B.

Comparison of patients in universe on Table 7 with estimated total patients who meet reporting criteria:

- Total White/Non-Hispanic patients with Hypertension (HTN) ages 18-75 with two or more medical visits = 4,494 [Universe on Table 7, Line 2e, Column 2a].
- Cannot exceed total medical patients on Table 5 = 67,919.
- Cannot exceed total White/Non-Hispanic patients on Table 3B = 27,364.

Assuming an equal distribution of medical patients by race and ethnicity and age:

- Estimated maximum number of patients in universe for White/Non-Hispanic HTN patients = Total patients ages 18-84 (31,900) x 0.91 (percentage of patients who are medical) x 0.37 (percentage of patients who are White / Not Hispanic) = 10,741. Note: Example not shown but data is drawn from Tables 3A and 5.
- **CHECK:** Universe of medical patients on Table 7 (4,494) does not exceed estimated maximum number of patients meeting criteria (10,741).

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Table 7: Health Outcomes and Disparities

SECTION B: CONTROLLING HIGH BLOOD PRESSURE

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
HISPANIC/LATINO				
1a	Asian	2	2	1
1b1	Native Hawaiian	1	1	0
1b2	Other Pacific Islander	0	0	0
1c	Black/African American	9	9	5
1d	American Indian/Alaska Native	0	0	0
1e	White	15	15	11
1f	More than One Race	3	3	2
1g	Unreported/Refused to Report Race	3,397	3,397	2,380
	Subtotal Hispanic/Latino	3,427	3,427	2,399
NON-HISPANIC/LATINO				
2a	Asian	61	61	35
2b1	Native Hawaiian	9	9	5
2b2	Other Pacific Islander	137	137	83
2c	Black/African American	176	176	93
2d	American Indian/Alaska Native	16	16	10
2e	White	4,494	4,494	2,845
2f	More than One Race	11	11	8
2g	Unreported/Refused to Report Race	85	85	54
	Subtotal Non-Hispanic/Latino	4,989	4,989	3,133
UNREPORTED/REFUSED TO REPORT				
h	Unreported/Refused to Report Race and Ethnicity	235	235	146
i	***Total***	8,651	8,651	5,678

PERCENT OF PATIENTS WHO ARE MEDICAL =

Medical patients/total patients:

- Total medical patients = Table 5, Line 15, Column (c) = 67,919
- Total patients = Table 4, Line 6 = 74,285 *(Not shown)*
- 67,919/74,285 → 91% of patients are medical patients.

TABLE 5: STAFFING AND UTILIZATION

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
15	Total Medical (Lines 8+10a through 14)	172.35	250,064	67,919

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Table 6B and Table 7: Prenatal Care

PURPOSE:

Tables 6B and 7 include sections that report data on prenatal care measures and other commonly seen indicators of healthy pregnancies and babies.

CHANGES:

- There are no changes to the Tables 6B and 7 reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

WHY ARE PRENATAL MEASURES IMPORTANT?

By improving these "intermediate outcome" measures, long-term negative health outcomes will be less likely for both the baby and mother.

- **Normal birth weight:** If there are children born at a normal birth weight, then there will be fewer children who suffer mental or physical delays or organ damage.
- **Early entry into care:** If a woman enters care in her first trimester, she will be less likely to suffer adverse birth outcomes.

HEALTH PEOPLE 2020 GOALS:

- The Healthy People 2020 Goal: 77% of females will receive prenatal care in the first trimester.
- The Healthy People 2020 Goal: reduce the percentage of low birth-weight, live births to 8%.

HOW DATA ARE USED:

These data will be used to calculate:

- Normal birth weight rates
- National disparities in health outcomes by race and ethnicity
- Prenatal risk factors

TABLE TIPS — Table 6B Entry into Prenatal Care

SECTION A: Age of Prenatal Care Patients

- Report ***all*** prenatal patients, regardless of whether services provided by the health center or by another through a referral from the health center during the year, regardless of whether they delivered.
- **Include:** Women whose only service in the reporting year was their delivery, women who transferred or were "risked out," women who were delivered by another provider.
- Do ***not*** include patients who had a pregnancy test but did not have a clinical visit.

SECTION B: Early Entry into Prenatal Care

- Entry into prenatal care begins with a visit to a physician nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) provider who initiates prenatal care with a *physical exam* (i.e., not a pregnancy test, nurse assessment, etc.)
- The patient is reported on the row corresponding to the trimester when they began their prenatal care.

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Table 6B and Table 7: Prenatal Care

TABLE TIPS — Table 6B (Continued):

- Women who begin prenatal care with the health center are reported in column (a). Women who begin care at another provider and transfer are reported in column (b).
- **Line 7 – First Trimester:** Includes women whose "first visit" occurred when she was estimated to be pregnant anytime through the end of the 13th week after conception.
- **Line 8 – Second Trimester:** Includes women whose "first visit" occurred when she was estimated to be between the start of the 14th week through the 26th week after conception.
- **Line 9 – Third Trimester:** Includes women whose "first visit" occurred when she was estimated to be 27 weeks or more after conception.
- Obstetricians commonly count time from last reported menstrual period (LMP). Since this is two weeks earlier than conception, if counting this way, then the first trimester would be considered up through 15 weeks post-LMP. The second trimester is through 28 weeks post-LMP. Trimester may be based on other data if LMP data are not available.
- The sum of the numbers in the six cells of lines 7 through 9 in section B must equal the number reported on line 6 in section A.

TABLE AND CROSS TABLE CONSIDERATIONS:

- **Table 6B Sections A and B:** Total prenatal patients (Line 6) must equal total prenatal patients by trimester of entry [Lines 7-9 columns (a) and (b)]. (See graph on next page.)
- **Tables 6B and 7:** Number of prenatal patients should exceed number of women delivering because not all prenatal patients deliver in reporting year (example on next page).

TABLE TIPS — Table 7 Birth Weight

- Beginning in the 2014 reporting year, all health centers will complete section A.
- With the exception of lines 0 and 2, data is reported by race and ethnicity.
- **Line 2**: Report the total number of deliveries ***performed by health center providers*** including those of non-health center patients.
- **Column (1a):** Report all prenatal patients from Table 6B who were known to have delivered during the year, even if the delivery was done as the result of a referral to a non-health center provider.
- **Columns (1b) through (1d):** Report all live births born to health center patients during the reporting year by weight, including multiples (e.g. birth weight for each baby), regardless of who performed the delivery.
- Health Center is expected to obtain birth weight information for all pregnant prenatal patients who deliver even if their providers do not perform the delivery.
- Birth mothers should be reported on the line corresponding to their unique race/ethnicity (which may differ from babies).

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Table 6B and Table 7: Prenatal Care

CONSIDERATIONS DEMONSTRATED:

Table 6B (see table on next page): Section A, ***total prenatal patients*** (Line 6) must equal Section B, ***total prenatal patients*** by trimester of entry [Lines 7-9 columns (a) and (b)].

CHECK: Line 6 = 2,388
Lines 7-9, Column a + Column b = 2388

Total prenatal care patients (Table 6B, Line 6) should be greater than prenatal care patients that delivered during the year
(Table 7, Line i, column 1a)

CHECK: 2,388 > 1,304

SELECTED CALCULATIONS:

- **Percent Deliveries Low Birth Weight:** (Total live births < 1500 g + Total live births 1500 – 2499 g)/(Total live births (Table 7, Columns 1b through 1d, Line i)).

  For example: (11+55)/(11+55+1,251) * 100 = 5.0% of live births are low birth weight.

- **Percent Early Entry into Prenatal Care:** (Total women having first visit with health center in 1st trimester + total women having first visit with another provider in 1st trimester)/(Total prenatal patients (Table 6B, Line 6))

  For example: (1,757 + 44)/(2,388)* 100 = 75.4% of women entered prenatal care in 1st trimester.

- **Percent Teen Prenatal Patients:** Prenatal patients less than 15 years old + Prenatal Patients Ages 15 to 19 (Table 6B, Lines 1+2)/ Total prenatal patients (Table 6B, Line 5)

  For example: ((12+340)/2,388)* 100 = 14.7% of prenatal patients who are teenagers.

TABLE 7: HEALTH OUTCOMES AND DISPARITIES

Section B: Hypertension by Race and Hispanic/Latino Ethnicity

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

#	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)
HISPANIC/LATINO		
1a	Asian	9
1b1	Native Hawaiian	
1b2	Other Pacific Islander	
1c	Black/African American	57
1d	American Indian/Alaska Native	
1e	White	163
1f	More than One Race	39
1g	Unreported/Refused to Report Race	164
NON-HISPANIC/LATINO		
2a	Asian	67
2b1	Native Hawaiian	2
2b2	Other Pacific Islander	
2c	Black/African American	243
2d	American Indian/Alaska Native	42
2e	White	265
2f	More than One Race	87
2g	Unreported/Refused to Report Race	64
UNREPORTED/REFUSED TO REPORT ETHNICITY		
h	Unreported/Refused to Report Race and Ethnicity	102
i	***Total***	1,304

Table 6B and Table 7: Prenatal Care

TABLE 6B: QUALITY OF CARE INDICATORS			
Section A: Age Categories for Prenatal Patients			
Demographic Characteristics of Prenatal Care Patients			
LINE	**AGE**	**NUMBER OF PATIENTS (a)**	
1	Less than 15 years	12	
2	Ages 15-19	340	
3	Ages 20-24	865	
4	Ages 25-44	1,167	
5	Ages 45 and Over	4	
6	Total Patients (sum lines 1-5)	2,388	
Section B: Trimester of Entry into Prenatal Care			
LINE	**Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year**	**Women Having First Visit with Health Center (a)**	**Women Having First Visit with Another Provider (b)**
7	First Trimester	1,757	44
8	Second Trimester	429	31
9	Third Trimester	114	13

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Table 8A: Financial Costs

PURPOSE:

Table 8A reports accrued costs by cost center. By reviewing the data reported on Table 8A, one can understand the total cost associated with activities which are within the scope of the programs supported.

CHANGES:

- There are no changes to the Table 8A reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

ACCRUED COSTS (Column A): The direct costs incurred during the reporting period associated with the cost centers and services listed.

ALLOCATION (Column B): The direct costs of the facility and non-clinical support services (line 16) distributed across the programs and program related services. Details of the methodology are shown in the box below.

ALLOCATION OF FACILITY AND NON-CLINICAL SUPPORT SERVICES IN COLUMN B (traditional method):

FACILITY COSTS on line 14 are allocated based on the amount of square footage utilized for Medical, Medical Lab & X-Ray, Dental, Mental Health, Substance Abuse, Pharmacy, Vision, Other Professional Services, Enabling, Other Program Related Services, QI, and Administration.

- **Note:** Health centers may use an alternative allocation method that effectively distributes facility costs (approved or used by your auditors), but be sure to save back-up paperwork for review and explain the methods used in the table comments section.

NON-CLINICAL SUPPORT SERVICES COSTS on line 15 are allocated after facility costs have been allocated. Allocate administrative costs that can be assigned to specific services and then allocate the balance of costs based on the proportion of total cost (excluding administrative cost) that is attributable to each service category.

HOW DATA ARE USED

Data are used to calculate:

- Total cost per total patient
- Medical cost per medical patient, etc.
- Medical cost per medical visit, etc.
- Percent facility and non-clinical support costs
- Cash flow analysis (Table 8A costs compared
- with cash revenues on 9D and 9E)
- Charge-to-cost ratio

TABLE TIPS:

In column (a), report Accrued Costs:

- Include direct costs for each cost center consistent with FTEs reported on Table 5
- Exclude bad debt
- Include depreciation

Table 8A: Financial Costs

TABLE TIPS (continued):

In column (b), report the Allocation of Facility and Non-Clinical Support costs for each cost center. Distribute total facility and non-clinical support costs (line 16, column (a)) to the appropriate cost center and report in column (b). The total amounts entered in column (b) will equal the amount reported on line 16, column (a).

In column (c), report the Total Cost:

- Sum of direct and indirect expenses
- Report the value of donated ("in-kind") services on line 18 only

MEDICAL CARE COSTS

- On line 1, report salaries and benefits for medical personnel (hired and contracted) listed on Table 5, lines 1 – 12.
- On line 2, report all medical (not dental!) lab and x-ray costs including supplies, lab staff, etc.
- On line 3, report all other direct medical costs, including dues, supplies, depreciation, travel, CME, EHR system, etc.

OTHER CLINICAL SERVICES COSTS

On lines 5, 6, 7, 9, and 9a, include all personnel (hired or contracted) and "other" direct expenses for the service.

PHARMACY COSTS

- On line 8b, report only the cost of pharmaceuticals. On line 8a, report all other costs related to pharmacy including, pharmacy systems, staff, equipment, and non-pharmaceutical supplies, etc., related to pharmacy.
- If you cannot separate non-drug cost from total cost (contract or pre-pack arrangements), report all costs on line 8b – "pharmaceuticals."
- All facility and non-clinical support costs for pharmacy is reported on line 8a.
- Do not include donated pharmaceuticals on either line. (Report these on Line 18.)

OTHER PROGRAM RELATED SERVICE & QI COSTS

- Lines 11a-11g report all direct costs for the provision of enabling services.
- On line 12, report direct costs for the provision of non-health care services (e.g., WIC, childcare centers, adult day care, HeadStart, employment training programs, etc.) Include any "pass through" funds on line 12 (more information can be found on Table 9E).
- On line 12a, report all direct costs for the quality improvement (QI) program, including all personnel dedicated to the QI program and/or HIT/EHR system development and analysis.

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Table 8A: Financial Costs

CROSS TABLE CONSIDERATIONS:

Table 5, column (a) and Table 8A: Comparison of Staff FTEs reported by service on Table 5 should be consistent with costs reported on Table 8A by cost center unless staff are volunteers.

- Table 5, column (c) and Table 8A: Comparison of visits and patients by service on Table 5 should be consistent with costs by service on Table 8A unless donated.
- Tables 8A and Table 9D: Total costs for billable services on 8A should be related to total charges on Table 9D if fees are calculated to cover costs.
- Tables 8A, 9D, and 9E: Cash income on Tables 9D and 9E should be related to total costs on Table 8A unless experiencing a profit on cash flow problem or deficit.
- **Note:** See 2017 UDS Manual Instructions for Table 8A—Financial Costs for further explanation and examples.

SELECTED CALCULATIONS:

Dividing Total cost/service by FTEs, visits, and patients for that service category yields average costs (Shown on Table 5):

Average salary and benefits per medical FTE: Divide Table 8A, line 1, column (a) by Table 5, lines 8 +10a + 11 + 12, column (a).

- $20,287,757/(46.85 + 12.10 + 7.71 + 99.00) = $139,282

Average medical cost per medical visit: Divide total medical costs less lab and X-ray costs (Table 8A, line 4 – line 2) by medical visits less nursing visits (Table 5 line 15 – line 11) = $23,126,832/(250,064-0) = $92.48

Average medical cost per medical patient: Divide total medical costs less lab and X-ray costs (Table 8A, line 4 – line 2) by total medical patients (Table 5, line 15) = $23,126,832/67,919 = $340.50

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Table 8A: Financial Costs

TABLE 5: STAFFING AND UTILIZATION				
Line	**Personnel by Major Service Category**	**FTEs (a)**	**Clinic Visits (b)**	**Patients (c)**
1	Family Physicians	24.55	115,843	
2	General Practitioners	0.75	2,922	
3	Internists	5.20	24,838	
4	Obstetrician/Gynecologists	5.70	22,729	
5	Pediatricians	8.15	44,659	
7	Other Specialty Physicians	2.50	9,291	
8	**Total Physicians (Lines 1-7)**	46.85	220,282	
9a	Nurse Practitioners	4.85	11,061	
9b	Physician Assistants	6.85	17,615	
10	Certified Nurse Midwives	0.4	1,106	
10a	**Total NP, PA, and CNM's (Lines 9a-10)**	12.10	29,782	
11	Nurses	7.71		
12	Other Medical personnel	99.00		
13	Laboratory personnel			
14	X-ray personnel	6.69		
15	**Total Medical (Lines 8a+10a through 14)**	172.35	250,064	67,919

TABLE 8A: FINANCIAL COSTS				
Line		**Accrued Cost (a)**	**Allocation of Facility and Non-Clinical Support Services (b)**	**Total Cost After Allocation of Facility and Non-Clinical Support (c)**
Financial Costs for Medical Care				
1	Medical Staff	20,287,757	9,741,909	30,029,666
2	Lab and X-ray	1,302,135	662,268	1,964,403
3	Medical/Other Direct	2,839,075	1,329,591	4,168,666
4	**Total Medical Care Services (Sum Lines 1 through 3)**	24,428,967	11,733,768	36,162,735

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Table 9D: Patient Related Revenue

PURPOSE:

Table 9D collects information on charges, collections, retroactive settlements, allowances, self-pay sliding discounts, and self-pay bad debt write-off.

CHANGES:

- There are no changes to the Table 9D reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

HOW DATA ARE USED

These data are used to calculate average charge per visit, payer mix, and charge-to-cost ratio.

KEY TERMS:

FULL CHARGES: The entire gross charges to a payer for a billable service according to your fee schedule.

COLLECTIONS: The entire gross receipts for the year from a payer regardless of the period for which the service was rendered.

FORM OF PAYMENT:

MANAGED CARE CAPITATED: Capitation fees paid to the health center (usually monthly) regardless of whether services were delivered or not.

MANAGED CARE FEE-FOR-SERVICE: Charges and collections for patients assigned to the health center under managed care arrangement and seen on a fee-for-service basis.

PAYERS:

MEDICAID: Includes all routine Medicaid and EPSDT under any name; Medicaid part of Medi-Medi or crossovers; CHIP if paid through Medicaid; may include fees for other state programs paid by the Medicaid intermediary.

MEDICARE: Includes all routine Medicare; Medicare Advantage; Medicare portion of Medi-Medi or crossovers. If your system uses both the G-code charge and actual charge, you can remove G-code charges by running a report to get the total for G-code charges for the year, then subtract this number from total charges and report the difference in Column A.

OTHER PUBLIC: Includes state or other public insurance; Non-Medicaid CHIP; state-based programs which cover a specific service or disease such as BCCCP, Title X, Title V, TB. Does not include indigent care programs.

PRIVATE: Includes private and commercial insurance; Medi-gap programs, Tricare, Trigon, Workers Comp, etc.; contracts with schools, jails, Head Start, etc. Insurance purchased through state or federal exchanges are reported as "private" unless you can identify them as being enrolled through purchased subsidies from a Medicaid Expansion program (in which case, report as Medicaid).

SELF-PAY: Charges for which patients are responsible and all associated collections. Includes payments for indigent care program services.

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Table 9D: Patient Related Revenue

TABLE TIPS:

CHARGES (COLUMN A)

- Undiscounted, unadjusted charges based on fee schedule, for services provided in the measurement year.
- Do not include "charges" where no collection is attempted or expected, such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid be used as full-charged (i.e. FQHC should never be reported as charges).

COLLECTIONS (COLUMN B)

- Amount collected as payment for, or related to, the provision of services on a cash basis, including payments from third party payers, capitation payments, payments from patients, and collections for services provided in a prior year.

ADJUSTMENTS (COLUMNS C1 – C4)

- Columns (c1) and (c2) include payments for FQHC or S-CHIP settlements (difference between established per-visit rate and initial payments) and reconciliations (submission of a cost report) for current or prior year.
- Column (c3) or "Other Retroactive Payments" includes risk pools, incentives, PFP, and withholds.
- These amounts are also included in column (b).

ALLOWANCES (COLUMN D)

- Reductions in payment by a third party based on a contract.
- Reduce the allowance in column(d) by the amount of FQHC adjustments (c1-c4).
- Allowances do not include:
  - non-payment for services not covered by the third party
  - non-payment of bills which were not submitted in a timely fashion or properly signed / submitted.
  - deductibles or co-payments that are not paid by a third party and not collected from patient.
  - For capitated insurance only, the allowance is calculated as the difference between total charges and collections unless there are early or late capitation payments (column d = column a – column b).

SLIDING DISCOUNTS (COLUMN E)

- Reduction in the amount due or paid for services rendered based solely on the patient's documented income and family size as it relates to federal poverty level.
- May be applied to co-payments, deductibles, and non-covered services for insured patients when the related charge has been moved to the self-pay line.
- Self-pay line only.

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Table 9D: Patient Related Revenue

BAD DEBT (COLUMN F)

- Amounts considered to be uncollectable from the patient and formally written off during the calendar year, regardless of when the service was provided.
- *Only self-pay bad debt* is reported, third-party bad debt is not reported.

RECLASSIFYING CHARGES:

- Co-payments and deductibles as well as charges for non-covered services rejected by third parties should be moved to the payer responsible for the charge.
- It is essential to reclassify these charges and portions of charges appropriately.
- Show collections of these reclassifications on the appropriate line.

REPORTING CHARGES AND COLLECTIONS FOR PHARMACEUTICALS DISPENSED AT CONTRACT PHARMACIES

- Charges are reported by payer in column (a)
- The amount received from the patient (Line 13) or insurance company (Line 10) is reported in column (b).
- The amount written off for an insurance company is reported in column (d).
- The amount written off for a patient as a sliding discount is reported in column (e).

CROSS TABLE CONSIDERATIONS:

- Table 4, lines 7-12 and Table 9D: Reporting of charges and collections by payer on Table 9D relates to insurance enrollment on Table 4. (Shown on Table 4)
- Table 4, lines 13a-b and Table 9D: Reporting of capitated managed care revenues on Table 9D divided by capitated member months on Table 4 should approximate PMPM. (Shown below.)
- Table 5 and Table 9D: Billable visits on Table 5 should relate to charges on 9D (charge per visit).
- Table 8A and Table 9D: Reimbursable costs should relate to gross charges if fee schedule is designed to cover costs.
- Table 9D, line 13, column (e) and Table 9E, line 6a, column a: If indigent care funds on Table 9E reimburse for services delivered to uninsured patients in the current year, they should not exceed sliding fee discount on Table 9D.

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Table 9D: Patient Related Revenue

TABLE 9D (Part II of II) — PATIENT RELATED REVENUE (Scope of Project Only)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (C)		
				Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retroactive Payments Including Risk Pool/ Incentive/Withhold (c3)
14	**TOTAL** (Lines 3+6+9+12+13)	52,440,869	41,010,494	4,113,290	1,306,596	2,944,160

TABLE 8A – FINANCIAL COSTS				
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	20,287,757	9,641,909	30,029,666
2	Lab and X-ray	1,302,135	662,268	1,964,403
3	Medical/Other Direct	2,839,075	1,329,591	4,168,666
4	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 through 3)	**24,428,967**	**11,733,768**	**36,162,735**
FINANCIAL COSTS FOR OTHER CLINICAL SERVICES				
5	Dental	3,986,773	1,771,103	5,757,876
6	Mental Health	1,356,455	652,157	2,008,612
7	Substance Use	446,473	217,386	663,859
8a	Pharmacy not including pharmaceuticals	1,587,276	790,340	2,377,616
8b	Pharmaceuticals	2,177,064		2,177,064
9	Other Professional (Specify_____)	555,819	280,298	83,618
9a	Vision	1,111,640	560,597	167,236
10	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9A)	11,221,500	4,271,881	13,235,881

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Table 9E: Other Revenue

PURPOSE:

Table 9E collects information on non-patient related cash receipts for the reporting period that supported activities described in the scope of project(s) covered by any BPHC grant program, the look-alike program, or the BHW primary care clinic program.

CHANGES:

- There are no changes to the Table 9E reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

LAST PARTY RULE: Grant and contract funds should always be reported based on the entity from which the health center received them, regardless of their origin.

DRAW DOWNS: The cash amount drawn down during the reporting year – not the award amount.

OTHER FEDERAL GRANTS: Grants received directly from the Federal Government except BPHC.

STATE: Includes grants which are not tied to service delivery (WIC, prevention, outreach, etc.).

INDIGENT CARE PROGRAMS: Includes state and local programs that pay for health care for the uninsured based on a current or prior level or service, though not on a specific fee for service.

FOUNDATION OR PRIVATE GRANTS: Includes funds received from foundations or private organizations (including funds received from another health center).

OTHER REVENUES: Includes contributions, fundraising income, rents and sales, patient record fees, etc.

HOW DATA ARE USED

- Tables 9D and 9E: Numerator for calculating revenues per health center, per provider FTE, per visit, etc.
- Tables 9D and 9E versus 8A: Cash collections compared with accrued costs as indicator of cash flow.
- Tables 9D and 9E: Diversification of funding.

TABLE TIPS:

- Report non-patient service income.
- Cash basis — amount received/drawn down during reporting year.
- Report based on "last party" to handle funds before you receive them (e.g., Federal dollars received through the state are reported as "state;" grants passed through another health center are reported as "private").

BPHC GRANTS

- The amounts shown on the BPHC Grant Lines should reflect direct funding only.
- Enter draw-downs during the reporting period for all BPHC Section 330 grants in the primary care cluster.

OTHER REVENUES

Line 3: Other Federal Grants

- Do not report Ryan White Part A or Part B unless you are a governmental entity that receives them directly.
- Do not report Ryan White Part C funds from another health center.
- Do not include IHS funds for compacted and contracted services (these are considered "safety net" and are reported on line 6a).

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Table 9E: Other Revenue

Line 3a: Medicare and Medicaid EHR Incentive Grants for Eligible Providers

- Documents incentives provided to eligible providers for the adoption, implementation, upgrading, and meaningful use of certified EHRs.

Line 6: State Grants and Line 7: Local Grants

- Includes grants that pay for line items rather than products.
- Are not "product sensitive" — won't be reduced if you under-produce or be increased if you over-produce.

Line 6a: Indigent Care Programs

- May be a lump sum or based on a pre-set "*per-visit*" fee.
- All of the associated charges, sliding, discounts, and bad debt write-offs are reported on the self-pay line.
- Do not include state ***insurance*** plans.

REVENUES NOT REPORTED ON 9E

- Do not report payments from a 340(b) pharmacy program anywhere on Table 9E. All patient pharmacy income is reported on Table 9D, all pharmacy expenses are reported on Table 8A. For more detail, see Appendix B in the UDS Manual.
- Do not include the value of donated services, supplies, or facilities.
- Do not include capital received as a loan.
- Do not include patient-related revenues (e.g., pharmacy, BCCCP, etc.), as these are reported on 9D.

CROSS TABLE CONSIDERATIONS:

- Tables 5, 8A, and 9E: Activity related to grants and contracts reported on Table 9E are reported on Table 5 and 8A (e.g., if WIC FTEs are reported on Table 5, a WIC grant should be reported on Table 9E).
- Table 8A, 9D, and 9E: Cash revenues reported on Tables 9D and 9E should relate to costs on Table 8A unless health center is reporting a deficit or having cash flow problems.

If funds are passed through to another agency:

- Report the **patients** on Tables 3A, 3B, 4, and 5, the **staff and visits** on Table 5, and **costs** by service category on Table 8A.
- On 9E, report the total amount of *direct funding* to you. Do not reduce the amount by money the health center passed through to other centers (i.e., sub-grantees or sub-recipients).
- Costs (usually equal to the grant amount) are usually reported as "other" on Table 8A.
- Table 9D, line 13, column (e) and Table 9E, line 6a, column (a): If indigent care funds on Table 9E reimburse for services delivered to uninsured patients in the current year, they normally do not exceed sliding fee discount on Table 9D.
- For the Medicare and Medicaid Electronic Health Record Incentive Program grants on line 3a, if payments are made directly to provider, any amount kept by the provider as compensation should be reflected on this line and Table 8A, line 1.

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Table 9E: Other Revenue

TABLE 8A: FINANCIAL COSTS				
Line		Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support (c)
17	**TOTAL ACCRUED COSTS (Sum Lines 4+10+13+16)**	54,244,560		
18	Value of Donated Facilities, Services, and Supplies (specify:_____)			
19	**TOTAL WITH DONATIONS (Sum Lines 17 and 18)**			

TABLE 9D — PATIENT RELATED REVENUE (Scope of Project Only)							
				RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (C)			
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retroactive Payments Including Risk Pool/Incentive/ Withhold (c3)	Penalty/ Payback (c4)
14	**TOTAL (Lines 3+6+9+12+13)**	52,440,869	41,010,494	4,113,290	1,306,596	2,944,160	

SELECTED CALCULATIONS:

- **Surplus/Deficit:** Compares accrued costs on Table 8A with cash revenues from Tables 9D and 9E. A deficit suggests a cash flow problem.
- ***Total accrued costs*** on Table 8A (Line 17) = ***$54,244,560***
- ***Cash revenues*** = collections from patient services (Table 9D, Line 14, Column (b) = $41,010,494) + draw-downs from grants and contracts (Table 9E, Line 11 = $14,336,510) = ***$55,347,004***
- ***Cash revenues*** > Total accrued costs, resulting in a surplus.

TABLE 9E — OTHER REVENUES		
Line		
11	**Total Revenue (Lines 1+5+9+10)**	14,336,510