UDS: UNIFORM DATA SYSTEM

General Information

WHAT IS THE UDS?

The Uniform Data System (UDS) is a standardized reporting system that provides consistent information about health centers.

The UDS includes:

- The number and socio-demographic characteristics of people served.
- Types and quantities of services provided.
- Counts of staff who provide these services.
- Information about the quality of care provided to patients.
- Cost and efficiency data relative to the delivery of services.
- Sources and amounts of health center income.

WHY DO WE REPORT UDS?

UDS data are used to:

- Comply with legislative and regulatory requirements
- Inform HRSA, Congress, and the public of health center performance and operations
- Document program effectiveness
- Identify trends over time
- Enable comparison with national benchmarks

WHAT TABLES DO I SUBMIT?

- All health centers submit the 11 tables in the "Universal Report" the Health Information Technology (HIT) form, the Other Data Elements Form, and the new Workforce Form.

- Agencies with multiple funding streams (i.e., two or more of Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), and/or Public Housing Primary Care (PHPC)) also complete grant-specific reports:

- The Grant Report is an abbreviated version of the Universal Report (Tables 3A, 3B, 4, 6A and part of Table 5) used to report information about patients served by a special population program.

REPORTING REQUIREMENTS:

Who is requested to submit a UDS Report?

- All health center awardees, Look Alikes, and Bureau of Health Workforce (BHW) primary care clinics funded or designated before October 1 of the reporting year (including New Starts) with one or more BPHC grant (i.e., CHC, MHC, HCH, PHPC).

When do I need to report?

Complete and accurate reports must be submitted and ready for review by **February 15th**. The system will not permit changes after March 31st.

How do I report?

UDS data are submitted through the HRSA "Electronic Handbooks" (EHBs). The EHBs allows multiple users to work on a single UDS report in a collaborative manner. It also lets users complete tables as they have time, with the option to save their work and return to finish later. The EHBs provides users with a summary of which tables to submit. Additional guidance is available through the EHBs website and other training resources.

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

General Information

Table	Data Reported	Universal Report	Grant Reports
SERVICE AREA			
ZIP Code Table	**Patients by ZIP Code** — and by Health Insurance	X	Not reported for grant reports
PATIENT PROFILE			
Table 3A	**Patients by Age and Sex Assigned at Birth**	X	X
Table 3B	**Demographic Characteristics** — Patients by Hispanic/Latino Ethnicity and Race; Patients best served in a language other than English; Patients by Sexual Orientation; and Patients by Gender Identity	X	X
Table 4	**Selected Patient Characteristics** — including Patient Income, Principal Third-Party Medical Insurance, Managed Care Utilization, and Special Populations	X	X
STAFFING AND UTILIZATION			
Table 5	**Staffing and Utilization** — Profile of health center staff, the number of face-to-face and virtual visits provided, and the number of patients served. The new Selected Service Detail Addendum reports data on mental health services provided by medical providers and substance use disorder services provided by medical and mental health providers.	X	<partial>
CLINICAL			
Table 6A	**Selected Diagnoses and Services Rendered** — by number of patients and visits	X	X
Table 6B	**Quality of Care Measures** — including Prenatal Care, Childhood Immunization Status, Cervical Cancer Screening, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Preventative Care and Screening: Body Mass Index Screening and Follow-Up Plan, Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention, Use of Appropriate Medications for Asthma, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet, Colorectal Cancer Screening, HIV Linkage to Care, Preventative Care and Screening: Screening for Depression and Follow-Up Plan, and Dental Sealants for Children between 6-9 Years	X	
Table 7	**Health Outcomes and Disparities** — Deliveries and Birth Weight, Diabetes and Hypertension by race and ethnicity	X	
FINANCIAL			
Table 8A	**Financial Costs** — Accrued costs of in scope activities	X	
Table 9D	**Patient Related Revenue** — Patient related charges, collections, and adjustments	X	
Table 9E	**Other Revenue** — Reports non-patient income that support activities escribed in scope of services	X	
OTHER FORM		X	
Appendix D	**Health Center Health Information Technology (HIT) Capabilities** — HIT Capabilities and including EHR interoperability and eligibility for Meaningful Use.	X	
Appendix E	**Other Data Elements** — Medication Assisted Treatment (MAT) and telemedicine	X	
Appendix F	**Workforce** — Workforce training, staffing models to support recruitment and retention	X	

UDS | UNIFORM DATA SYSTEM

LOOK-ALIKE AND BHW PRIMARY CARE CLINICS REPORTING:

To maintain consistency with BPHC reporting, the look-alikes and BHW primary care clinics report the UDS using the tables and definitions outlined in the BPHC UDS Reporting Manual. General exceptions specific to look-alikes include:

- Fields are greyed out for elements that do not apply to look-alike reporting (*modifications are listed on the next page*).

- Look-alikes are required to complete the Universal Report only.

RESOURCES FOR ASSISTANCE:

Help and information is available year round — not just at submission time! Available resources include:

- For further information, see the PAL 2019-01 ***https://bphc.hrsa.gov/sites/default/files/ bphc/datareporting/pdf/pal201901.pdf***

- Training programs (fall through winter)

- Technical support to review submission (January–March)

- Recorded, online training webinars: ***http://bphc.hrsa.gov/datareporting/ reporting/index.html***

- An annually revised UDS Manual ***https://bphc.hrsa.gov/sites/default/files/ bphc/datareporting/reporting/2019-uds- manual.pdf***

- A telephone helpline (866-UDS-HELP)

- E-mail help: ***udshelp330@bphcdata.net***

UDS | UNIFORM DATA SYSTEM

TABLE	MODIFICATION TO TABLES FOR 2019
Grantee Profile: Patients by ZIP Code	\<none\>
Table 3A: Patients by Age and Sex Assigned at Birth	\<none\>
Table 3B: Demographic Characteristics	\<none\>
Table 4: Selected Patient Characteristics	Line 21a — Permanent Supportive Housing (330h awardees only)
Table 5: Staffing and Utilization	Addition of Virtual Visits column Addition of Selected Service Detail Addendum
Table 6A: Selected Diagnoses and Services Rendered	Selected codes have been updated
Table 6B: Quality of Care Measures	Removal of Coronary Artery Disease: Lipid Therapy Measure. Addition of the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. **CMS347v2**
Table 7: Health Outcomes and Disparities	\<none\>
Table 8A: Financial Costs	\<none\>
Table 9D: Patient Related Revenue	\<none\>
Table 9E: Other Revenue	Removal of line 1j Capital Improvement Program Grants
Appendix D: Health Center Health Information Technology (HIT) Capabilities	Form updated
Appendix E: Other Data Elements	Form updated
Appendix F: Workforce Form	New form added

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

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 2019.

KEY TERMS:

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

PATIENTS BY ZIP CODE: 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 for whom residence is not known and for whom a proxy is not available.

PRIMARY MEDICAL INSURANCE: A patient's primary medical insurance as of the last visit during the reporting period. The insurance plan the health center would typically bill first for medical services.

HOW DATA ARE USED:

- Information is used to 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 overlaps.

- Maps and data can be accessed using an online tool, the UDS Mapper (see page 2): **http://www.udsmapper.org/**

TABLE TIPS:

- ZIP codes with ten or fewer patients should be aggregated and patients reported as "Other."

- Patients whose ZIP code is not known should be reported as "Unknown Residence."

- In general, the total number of patients with "Other" and "Unknown" ZIP codes 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 as "Other ZIP code."

- Medical insurance information must be obtained for all health center patients, regardless of the type of services received (e.g., report a dental patient by primary medical insurance, not dental insurance).

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 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.

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

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

- Areas of Priority for Medication-Assisted Treatment (MAP for MAT)
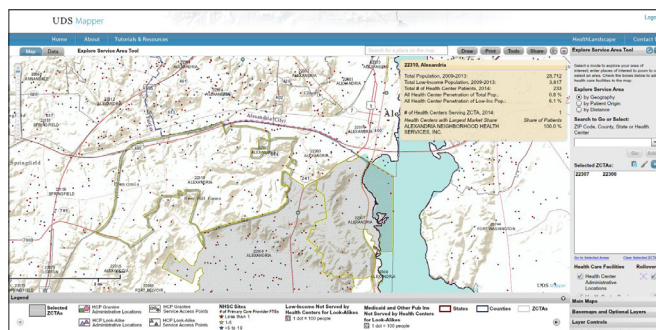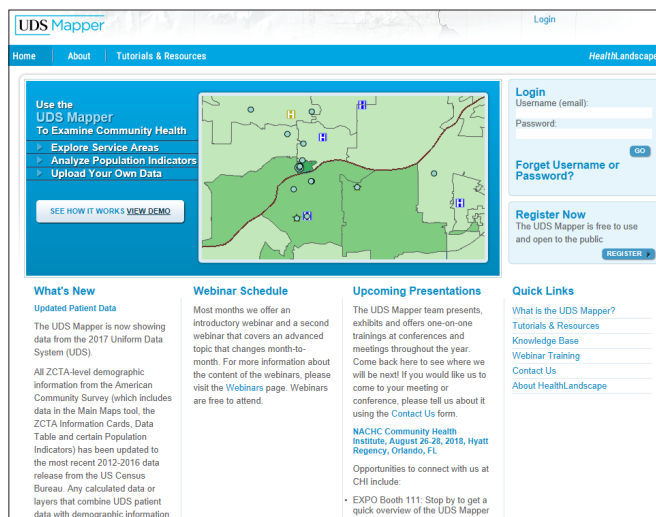
For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 25-28.
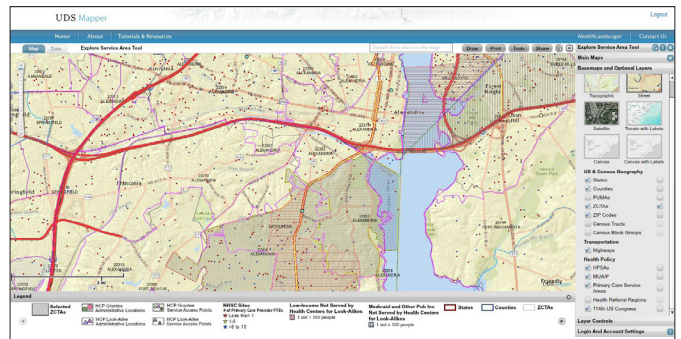
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Patients by ZIP Code

USE THE UDS MAPPER TOOL TO:

- Visualize relationships 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/

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 25-28.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

UDS: UNIFORM DATA SYSTEM

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 2019.

KEY TERMS:

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

VISIT: A documented, face-to-face or virtual contact between a patient and a provider during which the provider exercised independent, professional judgement in the provision of services. A virtual visit is provided using interactive synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.

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

PATIENTS' SEX AT BIRTH: The sex reported on a birth certificate.

UNDUPLICATED COUNT: Table 3A reflects an unduplicated count of patients, meaning that each patient is counted only once on this table regardless of the number of visits they had during the reporting year.

	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	Age 1	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

UDS | UNIFORM DATA SYSTEM

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

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.

- Age is calculated as of June 30th on Table 3A.

Note: Age is determined differently for clinical measures on Tables 6B and 7. 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 (Selected Patient Characteristics) 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 30 to 34 year old migrant heath patients 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	Age 1	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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 29 and 34.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2

UDS: UNIFORM DATA SYSTEM

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 2019.

HOW DATA ARE USED:

Patient profile: Reports race, ethnicity, sexual orientation, gender identity, age, insurance status, and income. These data can be used to identify and reduce health disparities and promote 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), including virtual visit(s), during the reporting year.

GRANT SPECIFIC PATIENTS: Individuals who have had one or more UDS-reportable visit(s), including virtual 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:

- Complete Table 3B for the Universal Report and for grant-specific reports (if applicable).

- Count each patient only once in each section of Table 3B regardless of volume (i.e., the number of times) or scope (i.e., the number of types) of services received.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 29-33 and 35.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

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 by their racial identification, 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).

- Hispanic/Latino patients who do not select race are reported 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 in areas where a language other than English is the dominant language (i.e., Puerto Rico, Pacific Islands).

- 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 whose sexual orientation is not known 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 8, Total Patients' by Hispanic or Latino Ethnicity and Line 26, Total Patients by Gender Identity.

UDS | UNIFORM DATA SYSTEM

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 whose gender identity is not know because the health center did not have systems in place to routinely ask about gender identity.

- Use Line 25 "Chose Not to Disclose" if a patient chooses not to disclose their gender.

- Line 26 provides a total for this section (Lines 20–25) and should equal Line 8 (Total Patients' by Hispanic or Latino Ethnicity) and Line 19 (Total Patients by Sexual Orientation).

CROSS TABLE CONSIDERATIONS:

- The same patients are described on the Zip Code Table, Table 3A, and each section of Tables 3B and 4, so total patients reported should be equal across these four tables. Specifically, Table 3A, Line 39 (a+b) = Table 3B, Lines 8, 19 and 26 = 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 (next page). 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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 29-33 and 35.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

UDS: UNIFORM DATA SYSTEM

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			

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 29-33 and 35.

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

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:

- Line 21a — Permanent Supportive Housing (330h awardees only). This line reports patients who are in permanent supporting housing. Permanent supportive housing usually is in service-rich environments, do not have time limits, and may be restricted to people with some type of disabling condition.

- Health centers may use criteria as defined by the Department of Housing and Urban Development to assist in defining permanent supportive housing. ***https:// www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/***

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 service delivery site in their scope of project. This includes in-scope school-based health centers located on or near school grounds that provide on-site comprehensive preventive and primary health services.

- *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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 36-45.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

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 in each section of Tables 3A and 3B.

- Income should be updated annually. The report should include the most current information available.

- Income must be reported by the patient. Do not assume income (e.g., report a Medicaid-insured patient as low-income). The patient can self-declare income as long as it is consistent with health center policies and procedures.

- Official poverty guidelines are available online at: **https://aspe.hhs.gov/2019-poverty-guidelines**.

- Use Line 5 (unknown) to report patients whose information was not collected during the calendar year.

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

- Enrollees in Primary Care Case Management (PCCM) programs, which pay a small monthly fee (usually less than $10 per member per month) that do not cover patient care, are not reported as managed care.

- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical and dental coverage (for example) is counted.

SPECIAL POPULATIONS

- All 330 programs report the total number of agricultural worker patients (Line 16), homeless patients (Line 23), 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)

  - Permanent Supportive Housing (Line 21a)

  - Unknown (Line 22)

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 36-45.

UDS | UNIFORM DATA SYSTEM

- *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. Also include on Line 14, migratory workers who have had this work as their principle source of income within 24 months of their last visit and their dependent family members who have used the center.

- *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 reported on Line 26 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 Public Housing Primary Care (PHPC) funding or the patient 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 the 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:

See next two pages for the examples described below:

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

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 36-45.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

UDS: UNIFORM DATA SYSTEM

Table 4: Selected Patient Characteristics

TABLE 4 — SELECTED PATIENT CHARACTERISTICS
Reporting Period: January 1, 2019 through December 31, 2019

Line	CHARACTERISTIC — 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**

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 36-45.

UDS | UNIFORM DATA SYSTEM

Revised October 2019 4

UDS: UNIFORM DATA SYSTEM

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)							

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

Table 5: Staffing and Utilization

PURPOSE:

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

CHANGES:

- **Addition of Column B2, Virtual Visits.** In this column you will report documented virtual (telemedicine/telehealth) contacts between a patient and a licensed or credentialed provider who exercises their independent, professional judgement in the provision of services to the patient as a visit in Column B.

- **Selected Services Detail Addendum.** The Table 5 addendum provides data on mental health (MH) services provided by medical providers as well as substance use disorder (SUD) services provided by medical providers and mental health providers. It is reported on the Universal Report only.

- 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 health center 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 as a percentage of full time 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 between the patient and the provider and can be face-to-face or virtual (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;

- Must be synchronous and/or real time.

PATIENTS:

- An individual who receives one or more documented "visits" of any service type: Medical, Mental Health, Dental, Substance Use, Other Professional, Enabling, and Vision. Patients may be counted 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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

PERFORMANCE MEASURES:

- Service cost per service patient

- Service cost per service visit

- Charges per visit

- Collections per visit

- Average costs per FTE by type

- The sum of mental health and substance use disorder services/visits reported in the main part of Table 5 and this addendum to Table 5 provide an **unduplicated** count of mental health and substance use disorder *services* across all provider types.

SELECTED SERVICE ADDENDUM

Primary care providers in health centers often provide mental health (MH) services as part of medical visits, and a wide range of both primary care and mental health providers provide substance use disorder treatment services. In the past, these mental health and substance use disorder services were not clearly captured in the UDS. As a result, the breadth of mental health and substance use disorder treatment services being provided in health centers has been understated.

The Selected Services Addendum to Table 5 asks health centers to report on health care providers who address mental health and substance use disorders, and mental health providers who address substance use disorders in order to better reflect the comprehensive, integrated model of care provided in health centers.

The information in this section only reflects providers and their mental health and substance use disorder treatment services not already reported in the mental health and substance use disorder sections on the main part of Table 5.

Examples of provider activity reported in the addendum are as follows:

- A physician who sees a patient for treatment of depression.

- A nurse practitioner seeing a patient for diabetes who is also showing signs of depression.

- A physician assistant providing MAT services to a patient with an opioid use disorder.

- A licensed clinical psychologist seeing a patient for mental health problems exacerbated by a substance use disorder.

In Column a1, report the *number* (not FTEs) of providers by type of MH and/or SUD services.

- Providers are to be counted in multiple service categories, as appropriate.

- Providers contracted on a fee-for-service basis should be counted.

In Columns b and b2, report the number of MH and/or SUD clinic or virtual visits by providers type.

- Treatment for mental health services are reported on Lines 20a01-20a04.

- Treatment for Substance use disorder services are reported on Lines 21a-21g.

- Use ICD-10 diagnostic codes associated with the visit to document/count the delivery of MH or SUD treatment services by medical and mental health providers.

- Include only visits documented with acceptable ICD-10 MH or SUD diagnosis codes.

- Exclude visits in which the only MH or SUD services provided included: screening, medication delivery or refill, patient education, referral, or case management

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2

Table 5: Staffing and Utilization

In Column c, report the number of patients seen for clinic or virtual MH and/or SUD services for each type of provider listed.

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

TABLE TIPS:

Table 5 is completed for the Universal Report and for grant-specific reports. However, grant reports include only clinic and virtual visits (Column b and b2) 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, contracted personnel (not paid by unit of service), volunteers, and residents based on hours worked.

■ Do not reduce clinical FTEs for vacation, continuing education, 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.

■ A difference between the Addendum and the main part of Table 5 is that in addition to counting staff employed directly by your health center also count those contracted on an hourly basis when calculating FTEs.

■ In the column (a1) of the Addendum you are reporting the number of providers who provide services that are contracted on a fee-for-service basis, not FTEs.

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 clinic or virtual 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.

■ Mental Health visits can be provided by psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers and other mental health staff.

■ Substance use service providers do not require licenses or credentials for visits to be included on the UDS.

■ 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 the 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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Table 5: Staffing and Utilization

VIRTUAL VISITS

- A virtual visit is one that meets all other requirements of a UDS visit except that it is not an in-person interaction between a patient and provider. Just as with in-person visits, not all virtual visits are countable.

- Virtual visits must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.

- Virtual visits should use telemedicine-specific CPT or HCPCS codes with:

    - GT — Via interactive audio and video telecommunications systems

    - .95 — Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

- State and Federal telehealth definitions and regulations regarding acceptable modes of care delivery, types of providers, informed consent, and location of patient are not applicable in determining virtual visits for UDS reporting.

- See What Counts as a Virtual Visit on page 8

- See **_Mental Health/Substance Use Disorder Services Detail Handout_**

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.

- Total patients on Table 5 should be greater than total number of patients reported on Table 3A (unless only one type of service is offered).

- All medical patients on Table 5 are eligible for inclusion in clinical quality measures on Tables 6B and 7.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   5

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   6

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

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
	TABLE 5 — STAFFING AND UTILIZATION				
16	Dentists	8.7	21,422	33	
17	Dental Hygienists	2.45	4,044		
17a	Dental Therapists				
18	Other Dental Personnel	15.44			
19	Total Dental Services (Lines 16–18)	25.59	25,466	33	10,616

Line		Accrued Costs (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	TABLE 8A — FINANCIAL COSTS			
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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Table 5: Staffing and Utilization

WHAT COUNTS AS A VIRTUAL VISIT?

THE FOLLOWING VIRTUAL VISITS WILL COUNT ON THE UDS:

- Health center provider provides in-scope services via telemedicine to a patient not physically present in the same location as the provider.

- A patient at the health center is provided services by a non-health center provider not physically present at the health center through telemedicine, and the health center covers the cost of the services by the other provider.

THE FOLLOWING VIRTUAL VISITS WILL NOT COUNT ON THE UDS:

- Health center provider provides out-of-scope services via telemedicine to a patient not physically present in the same location as the provider.

- A patient at the health center is provided services by a non-health center provider not physically present at the health center through telemedicine, and the health center does not pay for the services.

- A provider at the health center confers with a provider at a different health center via video chat regarding a patient's care.

- A patient and a provider discuss a patient's health concerns via a secure email through the EHR.

- A staff member at the health center takes a photograph of a patient's skin condition and sends it through the portal to a provider not physically present at the health center for diagnosis (i.e., "telederm" or "store and forward" model).

- A patient at the health center is provided services through telemedicine by a provider not physically present at the health center and who does not have access to the health center's HIT/EHR. The health center pays for the services.

- Interaction is not coded or charged as telehealth services.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

8

UDS: UNIFORM DATA SYSTEM

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 2019.

- Updated with current codes. A list of updated codes can be found at **http://bphcdata.net/docs/table_6a_code_changes.pdf**.

KEY TERMS:

VISIT: For a service to be counted as a visit in Column (a) on Table 6A, it must either be delivered at the time of a visit that was counted on Table 5 (include clinic visits — column b and virtual visits — column b2) 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-reportable visits (clinic or virtual) during the reporting year.

HOW DATA ARE USED:

To calculate:

- The average visits per patient per year for a particular condition and/or service — divide Column b by Column a (e.g., number of diabetes visits per diabetic patient per year).

- The frequency of acute care services by service type (e.g., well child immunizations).

- The penetration rate for routine preventative services (e.g., children who received well child visits, women 15-44 who received contraceptive services, and women 23-64 who received PAP tests).

CROSS TABLE CONSIDERATIONS:

- Visits and patients reported in any cell of the grant-specific tables cannot exceed the number reported in the same cell of any table on the Universal Report.

- **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. Similarly, some patients counted on Table 7 may not have had a reported visit on Table 6A.

- **Table 6A and 6B:**

  - Tobacco use disorder on Table 6A (Line 19a) is NOT the same as patients identified as tobacco users on Table 6B (Line 14a) because Table 6B has additional inclusion criteria.

  - Number of patients diagnosed with asthma on Table 6A (Line 5, Column b) is NOT the same as number of patients with persistent asthma on Table 6B (Line 16) because Table 6B has additional criteria to be considered.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 62-69.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

UDS: UNIFORM DATA SYSTEM

Table 6A: Selected Diagnoses and Services Rendered

TABLE TIPS:

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

Please note: Clinic and Virtual visits, as reported on Table 5 are both included everywhere that visits are referred to on this page.

PATIENTS AND VISITS:

- **Column a:** Total visits with a specific diagnosis (Lines 1–20) or service (Lines 21–34) indicated.

- Table 6A reports on services that were provided during a UDS-reportable visit only. Included in these services attendant to a reportable visit (e.g., vaccinations ordered by a provider and given on a different day).

- **Column b:** Unduplicated number of patients with diagnosis or having received service.

- If a patient is seen for multiple diagnoses in one visit, they must be reported once on each appropriate diagnosis line. Similarly, if a patient receives multiple services in one visit, they must 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 include multiple types of services (e.g., Pap test, mammogram, and family planning service) and would be reported once on each of the specified service 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).

UDS | UNIFORM DATA SYSTEM

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.

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED				
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-, O98.0-	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, O98.4-	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, D05-, D48.6-, D49.3, N60-, N63-, R92-	148	118
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	2,130	1,078
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	30,090	9,928

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 62-69.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

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 <u>persistent</u> asthma;

- Last seen while between ages 5 and 64; and

- Had at least one medical visit in a (clinic or virtual) clinic during the measurement year.

In other words, the number on Table 6B is smaller because Table 6A includes some patients age 65 or older and some patients with intermittent asthma.

	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	

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 62-69.

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

Table 6B: Clinical Quality Measures

PURPOSE:

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

HOW DATA ARE USED:

Compliance rates for clinical measures and percentage of target population receiving routine or preventive service are calculated and reviewed by the Health Resources and Services Administration (HRSA).

CHANGES:

CLINICAL QUALITY MEASURES

■ To support HHS 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 2019, the UDS Manual's Table 6B has been updated to mirror the CMS e-CQM logic for those variables which are aligned. Extensive information pertaining to e-CQMs can be found at the eCQI Resource Center: **https://ecqi.healthit.gov/ecqms**.

■ Elimination of line 17: Coronary Artery Disease (CAD): Lipid Therapy

■ Addition of line 17a: Statin Therapy of the Prevention and Treatment of Cardiovascular Disease

Measure Description
■ The quantifiable indicator to be evaluated.

Denominator or "Universe" (also referred to as Initial Patient Population in the e-CQM).
■ Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Numerator
■ Records (from the denominator) that meet the measurement standard for the specified measure.

Exclusions/Exceptions
■ Patients who should not be considered and removed from the denominator.

Specification Guidance
■ CMS measure guidance that assists with the understanding and implementing eCQMs.

UDS Reporting Considerations
■ BPHC requirements and guidance to be applied to the specific measure and may differ from or expand on the eCQM specifications.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. The majority of the UDS clinical measures are aligned with CMS 2019 Performance Period Eligible Professional/Eligible Clinical eCQMs. Use the most current CMS-issued eCQM specifications for the version numbers referenced in the UDS Manual for 2019 reporting and measurement period. Although there are other updates available from CMS, they *are not to be used* for 2019 reporting.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

UDS: UNIFORM DATA SYSTEM

Table 6B: Clinical Quality Measures

		TABLE 1: 2019 TABLE 6B: CLINICAL QUALITY MEASURES	
Table	Line	2019 Measure Description	e-CQM
6B	10	Childhood Immunization Status (CIS)	**CMS117v7**
6B	11	Cervical Cancer Screening	**CMS124v7**
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**CMS155v7**
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**CMS69v7**
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**CMS138v7**
6B	16	Use of Appropriate Medications for Asthma (**no longer e-specified**)	
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**CMS347v2**
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	**CMS164v7**
6B	19	Colorectal Cancer Screening	**CMS130v7**
6B	21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	**CMS2v8**
6B	22	Dental Sealants for Children between 6–9 Years	**CMS277v0**
7	Part B	Controlling High Blood Pressure	**CMS165v7**
7	Part C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	**CMS122v7**

Table 1. For 2019 reporting period, use the latest electronic specifications available for 2019 Performance Period.

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 HPV 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.*

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   2

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).** Number of patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

- **Column b: Number of Charts Reviewed.** 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); See sample of page 11. **OR**

  3. A random sample 70 patients selected from the universe (column a).

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

- **Column c: Measurement Standard.** Number of charts (from Column B) whose clinical record indicates that the measure has been met.

Childhood Immunization Status (Line 10), CMS1175v7

Measure Description

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

- 4 diphtheria, tetanus and acellular pertussis (DTaP);
- 3 polio (IPV);
- 1 measles;
- 1 mumps;
- 1 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).

Universe (Column a)

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

Born on or after January 1, 2017 and on or before December 31, 2017

Denominator (Column b)

Number of records reviewed.

Numerator (Column c)

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

Exclusions/Exceptions

Denominator

Patients who were in hospice care during the measurement period.

Numerator

Not applicable.

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

Cervical Cancer Screening (Line 11), CMS124v7

Measure Description

Percentage of women 21*–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21*–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.

Universe (Column a)

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

> *Born on or after January 1, 1955 and on or before December 31, 1995*
>
> *Note: Use age 23 as the initial age to include in assessment. See the UDS Manual for further detail.*

Denominator (Column b)

Number of records reviewed.

Numerator (Column c)

Women with one or more of the following screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

- Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test;

- Cervical cytology/HPV co-testing performed during the measurement period or the 4 years prior to the measurement period for women who are at least 30 years old at the time of the test.

Exclusions/Exceptions

Denominator

- Women who had a hysterectomy with no residual cervix or a congenital absence of cervix.

- Women who were in hospice care during the measurement period.

Numerator

Not applicable.

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), CMS155v7

Measure Description

Percentage of patients 3–17 years old who had an outpatient medical visit, and who had evidence of height, weight, **and** body mass index (BMI) percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement period.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

4

Table 6B: Clinical Quality Measures

Universe (Column a)

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

> *Born on or after January 1, 2002 and on or before December 31, 2015

Denominator (Column b)

Number of records reviewed.

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**

- Counseling for physical activity during the measurement period.

Exclusions/Exceptions

Denominator

- Patients who have a diagnosis of pregnancy during the measurement period.

- Patients who were in hospice during the measurement period.

Numerator

Not applicable.

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

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan (Line 13), CMS69v7

Measure Description

Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit **and** when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit.*

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

Universe (Column a)

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 31,2000, and were 18 years of age or older on date of last visit

Denominator (Column b)

Number of records reviewed.

Numerator (Column c)

Patients with:

- A documented BMI (not just height and weight) during their most recent visit **or** during the 12 months prior to that visit, **and**

- When the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the 12 months prior to 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).

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

5

Exclusions/Exceptions

Denominator

- Patients who were pregnant during the reporting period;

- Patients receiving palliative care during or prior to the visit;

- Patients who refuse measurement of height and/or weight or refuse follow-up during the visit; or

- Patients who had a documented medical reason, during or within 12 months of the visit, 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

  - Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health.

Numerator

Not applicable

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

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v7

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 who received cessation counseling intervention if identified as a tobacco user.

Universe (Column a)

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, 2000

Denominator (Column b)

Number of records reviewed.

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

Denominator

Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cession intervention (e.g., limited life expectancy, other medical reason).

Numerator

Not applicable.

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

6

Use of Appropriate Medications for Asthma (Line 16), (No longer e-specified)

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

Universe (Column a)
- 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, 1955 and on or before December 31, 2013

Denominator (Column b)
Number of records reviewed.

Numerator (Column c)
- Patients who were ordered at least one prescription for a preferred therapy during the measurement period.

Exclusions/Exceptions
Denominator
- Patients with a diagnosis of emphysema, chronic obstructive pulmonary disease, obstructive chronic bronchitis, cystic fibrosis, or acute respiratory failure that overlaps the measurement period.

Numerator
Not applicable.

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

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v2

Measure Description
Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period:

- Patients 21 years of age or older previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); or
- Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or
- Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.

Universe (column a)
Patients 21* years of age and older who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a medical visit during the measurement period.

  Include patients who were born on or before December 31, 1997

Denominator (column b)
Number of records reviewed.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

7

Numerator (column c)

Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period.

Exclusions/Exemptions

Denominator

- Patients who have a diagnosis of pregnancy.

- Patients who are breastfeeding.

- Patients who have a diagnosis of rhabdomyolysis.

- Patients with adverse effect, allergy, or intolerance to statin medication.

- Patients who are receiving palliative care.

- Patients with active liver disease or hepatic disease or insufficiency.

- Patients with end-stage renal disease (ESRD).

- For patients 40 through 75 years of age with diabetes who have the most recent fasting or direct LDL-C laboratory test result less than 70 mg/dL and are not taking statin therapy.

Numerator

Not applicable

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), CMS164v7

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.

Universe (Column a)

- 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 a diagnosis of IVD overlapping the measurement period.

  Born on or before December 31, 2000

Denominator (Column b)

Number of records reviewed.

Numerator (Column C)

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

Exclusions/Exceptions

Denominator:

- Patients who had documentation of use of anticoagulant medications overlapping the measurement year.

- Patients who were in hospice care during the measurement period.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

8

Numerator

Not applicable

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

Colorectal Cancer Screening (Line 19), CMS130v7

Measure Description

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

Universe (Column a)

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

  Born on or after January 1, 1944 and on or before December 31, 1968

Denominator (Column b)

- Number of records reviewed.

Numerator (Column c)

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT), during the measurement period
- Fecal Immunochemical Test (FIT) deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to 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
- Computerized Tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period

Exclusions/Exceptions

Denominator

- Patients with a diagnosis of colorectal cancer or history of total colectomy;
- Patients who were in hospice care during the measurement period.

Numerator

Not applicable

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.

Universe (Column a)

- Patients first diagnosed with HIV by the health center between October 1, 2018 and September 30, 2019, **and** who had at least one medical visit during 2018 or 2019.

Denominator (Column b)

- Number of records reviewed.

Numerator (Column c)

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

9

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v8

Measure Description

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

Universe (Column a)

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

  *Patients born on or before December 31, 2006

Denominator (Column b)

- Number of records reviewed.

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 and those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

Denominator:

- Patients with an active diagnosis of depression or a diagnosis of bipolar disorder

- Patients who refuse to participate

- Patients who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status

- Patients whose functional capacity or motivation to improve may impact the accuracy of results

Numerator

Not applicable.

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

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

Measure Description

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

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.

Universe (Column a)

- 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, 2010 and on or before December 31, 2012

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

10

Denominator (Column b)

Number of records reviewed.

Numerator (Column c)

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

Exclusions/Exceptions

Denominator

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

Numerator

Not applicable.

*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 the example on the next page, 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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

11

Table 6B: Clinical Quality Measures

SECTION C — CHILDHOOD IMMUNIZATION STATUS

Line	Childhood Immunization STATUS	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	**MEASURE:** Percentage of children 2 years of age who received age appropriate vaccines by thier 2nd birthday)	1,550	1,550	1,395

SECTION D — CERVICAL CANCER SCREENING

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-95.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

12

UDS: UNIFORM DATA SYSTEM

Table 7: Health Outcomes and Disparities

PURPOSE:

Table 7 reports data on hypertension and diabetes quality measures by race and Hispanic/Latino ethnicity. These measures are commonly seen as indicators of community health. (Birth outcome information, also on Table 7, is discussed on a separate fact sheet.)

HOW DATA ARE USED:

These data are used to calculate compliance for hypertension and non-compliance for diabetes.

They can also 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, the specifications for the clinical measures on Table 7 continue to be revised to align with the Centers for Medicare & Medicaid Services (CMS) electronic-specified Clinical Quality Measures (e-CQMs).

For 2019 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
- The quantifiable indicator to be evaluated.

Denominator or "Universe" (also referred to as Initial Patient Population in the e-CQM).
- Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Numerator
- Records (from the denominator) that meet the measurement standard for the specified measure.

Exclusions/Exceptions
- Patients who should not be considered and removed from the denominator.

Specification Guidance
- CMS measure guidance that assists with the understanding and implementing eCQMs.

UDS Reporting Considerations
- BPHC requirements and guidance to be applied to the specific measure and may differ from or expand on the eCQM specifications.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. The majority of the UDS clinical measures are aligned with CMS 2019 Performance Period Eligible Professional/Eligible Clinical eCQMs. Use the most current CMS-issued eCQM specifications for the version numbers referenced in the UDS Manual for 2019 reporting and measurement period. Although there are other updates available from CMS, they *are not to be used* for 2019 reporting.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-73 and 96-104.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   1

UDS: UNIFORM DATA SYSTEM

Table 7: Health Outcomes and Disparities

KEY TERMS:

INTERMEDIATE OUTCOME MEASURES:
Measurable outcomes of clinical intervention are used as a surrogate for good long-term health outcomes.

- **Controlling High Blood Pressure:** There will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life, *if there is more controlled 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).** The number of patients who fit the detailed criteria for inclusion in the specific measure to be evaluated.

- **Column b: Number of Charts Reviewed.** 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 **OR**

  3. A random sample of 70 patients selected from the universe (column a).

     ***NOTE:** If you report based on Option 2 (80% of Column a), the universe cannot be restricted by any consistent variable (for example, cannot exclude only elderly patients).

- **Column c: Measurement Standard.** 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 of the reporting year.

REPORTING RACE & ETHNICITY

- Patients who report their race but do not report their ethnicity are assumed to be non-Hispanic and are reported on lines 2a-2g.

- Patients whose race and ethnicity are not known are reported as "Unreported/Refused to Report Race and Ethnicity" on line h.

- The data source used to report race and ethnicity data must be the same one used for both Tables 3B and 7.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-73 and 96-104.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2

CONTROLLING HIGH BLOOD PRESSURE (COLUMNS 2A-2C), CMS165V7

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, 1934 and on or before December 31, 2000

Numerator (Column 2c)
- Patients whose blood pressure at the most recent visit was adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg) during the measurement period.

Exclusions/Exceptions

Denominator
- Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period.
- A diagnosis of pregnancy during the measurement period.
- Patients who were in hospice care 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), CMS122V7

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 or "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, 1944 and on or before December 31,2000

Numerator (Column 3f)
- Patients whose most recent HbA1c level performed during the measurement year is greater than 9.0 percent and patients who had no test conducted during the measurement period.

Exclusions/Exceptions

Denominator
- Patients who were in hospice care during the measurement period.

Numerator
Not applicable.

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-73 and 96-104.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

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 18–85 on Table 3A. (Lines 19–37)

- 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 18–85 with at least one medical visit = 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, ethnicity and age the following calculations can be done to check for reasonableness:

- Estimated maximum number of patients in universe for White/Non-Hispanic HTN patients = Total patients ages 18–85 (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).

These estimates may be distorted if there are large numbers of non-medical patients served at your health center or services are not distributed equally across age groups.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-73 and 96-104.

UDS | UNIFORM DATA SYSTEM

Revised October 2019
4

UDS: UNIFORM DATA SYSTEM

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

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 70-73 and 96-104.

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

Table 6B and Table 7: Prenatal Care

PURPOSE:

Tables 6B and 7 include sections that report data on indicators of healthy pregnancies and babies, such as prenatal care and birth outcome measures.

CHANGES:

- There are no changes to the reporting requirements for the prenatal and birth outcome portions of Tables 6B and 7 for the 2019 reporting period.

WHY ARE PRENATAL MEASURES IMPORTANT?

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

- **Normal birth weight:** If there are children born at a normal birth weight, there is less risk of mental or physical delays or organ damage.

- **Early entry into care:** This is an accepted strategy to improve health outcomes of pregnancy for mothers and infants.

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

- Health outcome disparities by race and ethnicity

TABLE TIPS — Table 6B Entry into Prenatal Care

SECTION A: Age of Prenatal Care Patients

- Report all prenatal patients served during the year, regardless of whether you provided services directly or by referral to another provider and regardless of whether or not they had delivered by the end of the year.

- **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; and women who were still pregnant at the end of the year.

- Do **not** include patients who had a pregnancy test but did not have a clinical visit.

SECTION B: EARLY ENTRY INTO PRENATAL CARE

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

Universe (Line 7 + Line 8 + Line 9, columns a + b)
- Women seen for prenatal care during the year.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 76-78, and 97-99.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

1

TABLE TIPS — Table 6B (Cont.):

Numerator (Line 7, Columns A + B)
- Women beginning prenatal care at the health center or with a referral provider (Column A), or with another prenatal provider (Column B), during their first trimester.

Exclusions/Exemptions
- Not applicable

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

- Entry into prenatal care begins with a visit to a physician, nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) 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 prenatal care.

- Women who begin prenatal care with the health center are reported in column (a). Women who began care with another provider, then transferred to the health center are reported in column (b).

- **Line 7 — First Trimester:** Report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after their last menstrual period.

- **Line 8 — Second Trimester:** Report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.

- **Line 9 — Third Trimester:** Report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after their last menstrual period.

- The sum of the numbers in the six cells of lines 7-9 represents the total number of women who received prenatal care from the health center during the calendar year and is equal to the number reported on line 6.

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 DELIVERIES & BIRTH OUTCOMES

- With the exception of lines 0 and 2, data are reported by race and ethnicity.

- **Line 0** reports how many pregnant women with HIV were seen by your health center during the year regardless of whether or not you provided them with prenatal care.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 76-78, and 97-99.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2

TABLE TIPS — Table 7 Birth Weight (cont.)

- **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 performed by a non-health center provider.

- **Columns (1b) through (1d):** Report all live births born to women receiving prenatal care at (or through referral from) your health center during the reporting year by weight, including each twin or triplet, etc. regardless of who performed the delivery.

- Health center is expected to obtain birth weight information for all babies 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).

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
	Subtotal Hispanic/Latino	432
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
	Subtotal Non-Hispanic/Latino	770
UNREPORTED/REFUSED TO REPORT ETHNICITY		
h	Unreported/Refused to Report Race and Ethnicity	102
i	*Total*	1,304

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 76-78, and 97-99.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

Table 6B and Table 7: Prenatal Care

CONSIDERATIONS DEMONSTRATED:

Table 6B (see table on next page): Section A, *total prenatal patients by age* (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 who delivered during the year. (Table 7, Line i, column 1a).

> **CHECK:** 2,388 > 1,304

SELECTED CALCULATIONS:

- **Percent Deliveries Low Birth Weight:**

  $$\frac{\text{Table 7, Line I, columns 1b + 1c}}{\text{Table 7, Line I, columns 1b+1c+1d.}}$$

  For example: (11+55)/(11+55+1,251) = 0.05 (or 5%) 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) (Table 6B, line 7, Columns a+b)/(Total prenatal patients (Table 6B, Line 6))

  For example: (1,757 + 44)/(2,388)= 0.754 (or 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) = 0.147 (or 14.7%) of prenatal patients who are teenagers.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 76-78, and 97-99.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

4

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: Early 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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 76-78, and 97-99.

UDS | UNIFORM DATA SYSTEM

Revised October 2019 5

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 2019.

- 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.

ALLOCATION OF FACILITY AND NON-CLINICAL SUPPORT SERVICES IN COLUMN B (recommended multi-step 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 Use Disorder, Pharmacy, Vision, Other Professional Services, Enabling, Other Program Related Services, QI, and Administration.

- **Note:** Health centers may use an alternative allocation method (approved or used by your internal auditors) that effectively distributes facility costs 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:

- Understand the full costs incurred to provide in-scope services.

- 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

- Include depreciation

- Exclude bad debt

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 105-115.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

1

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** lab and x-ray costs, including supplies, lab staff, etc. Do not include any dental lab/x-ray costs associated on this line.

- 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

- Line 8a includes staff, facility and non-clinical support costs related to pharmacy; including: pharmacy systems, staff, equipment, non-pharmaceutical supplies, etc.

- Line 8b is used to report the cost of pharmaceuticals.

- If you cannot separate non-drug costs (contract or pre-pack arrangements) from total cost — report all costs on line 8b (pharmaceuticals).

- Donated pharmaceuticals are reported on line 18 (value of donated facilities, services, & supplies). Do not include them in the amounts reported on lines 8a or 8b.

OTHER PROGRAM RELATED SERVICE & QI COSTS

- Lines 11a–11h 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.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 105-115.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2

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, cash flow problem, or deficit.

- **Note:** See 2019 UDS Manual Instructions for Table 8A for further details, including a table showing the relationship between Tables 5 and 8A (in Appendix B).

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 (see next page for example).

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 105-115.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

3

TABLE 5: STAFFING AND UTILIZATION

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	24.55	115,461	382	
2	General Practitioners	.075	2,895	27	
3	Internists	5.20	24,723	115	
4	Obstetrician/Gynecologists	5.70	22,729	0	
5	Pediatricians	8.15	43,918	741	
7	Other Specialty Physicians	2.50	9,248	43	
8	Total Physicians (Lines 1–7)	46.85	218,974	1,308	
9a	Nurse Practitioners	4.85	11,001	60	
9b	Physician Assistants	6.85	17,273	342	
10	Certified Nurse Midwives	.04	1,106	0	
10a	Total NPs, PAs, and CNMs (Lines 9a–10)	12.10	29,380	402	
11	Nurses	7.71			
12	Other Medical Personnel	99.00			
13	Laboratory Personnel				
14	X-ray Personnel	6.69			
15	Total Medical (Lines 8 + 10a through 14)	172.35	248,354	1,710	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 of 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 of Lines 1 through 3)	24,428,967	11,733,768	36,162,735

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 105-115.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

4

UDS: UNIFORM DATA SYSTEM

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-offs.

CHANGES:

- There are no changes to the Table 9D reporting requirements for 2019.

- Many of the requirements have been further clarified in this version of the UDS Manual.

HOW DATA ARE USED

- The data from Table 9D are used to understand health center patient service revenue and payer mix.

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

KEY TERMS:

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

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

FORM OF PAYMENT:

MANAGED CARE CAPITATED: Capitation fees paid, per patient or per assigned member, to the health center (usually monthly) regardless of whether services were rendered or not.

MANAGED CARE FEE-FOR-SERVICE: Charges and collections for patients assigned to the health center under a 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.

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., that are paid by the organization and based on patient visits. Insurance purchased through state or federal exchanges are reported as "private", even if subsidies are used to support that purchase.

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

UDS | UNIFORM DATA SYSTEM

UDS: UNIFORM DATA SYSTEM

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 enter "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 charges (e.g., FQHC rate or PPS rate should not be reported as charges).

- For Medicare charges, 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.

COLLECTIONS (COLUMN B)

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

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. These are often referred to as wrap payments.

- Column (c3) or "Other Retroactive Payments" includes risk pools, incentives, Pay for Performance (P4P), and withholds.

- These amounts are also included in column (b).

- Column (c4) or "Penalty/Payback" enter payments made by the health center to payers because of overpayments collected earlier. This could include ACO downside risk payments.

ALLOWANCES (COLUMN D)

- Allowances are payment reductions granted as part of an agreement with a third-party payer.

- 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 a 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). This does not apply for fee-for-service payers.

UDS | UNIFORM DATA SYSTEM

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.

- Line 13 — self-pay line only.

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 is reported in column (b).

- The amount written off for a third-party payer 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: Table 4 reports primary medical insurance and Table 9D includes all charges and collections including those for other services such as dental. Charges and collections by payer type on Table 9D relate to insurance enrollment on Table 4.

- Table 4, lines 13a–b and Table 9D: Capitated managed care revenue on Table 9D divided by capitated member months on Table 4 should approximate PMPM.

- 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 (see sample tables on next page).

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 116-125.

UDS | UNIFORM DATA SYSTEM

Revised October 2019   3

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 Payments: P4P, Risk Pools, etc. (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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 116-125.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

4

UDS: UNIFORM DATA SYSTEM

Table 9E: Other Revenues

PURPOSE:

Table 9E collects and reports information on non-patient income received during the reporting period that supported activities described in the scope of project(s) covered by the Health Center program grants, the Look-alike program or the HRSA Bureau of Health Workforce (BHW) primary care program.

CHANGES:

- Line 1j Capital Improvement Grants has been removed from this table.

- 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 revenue.

TABLE TIPS:

- Report only non-patient service income.
- Report on a cash basis — the amount received and/or 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 Government Grants & Contracts — line 6;" grants passed through another health center are reported as "Foundation/Private Grants & Contracts — line 8").
- Look-alikes and BHWs will file this table but will have no income from the BPHC Health Center Grant Program on line 1.

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 on this line (they are considered "safety net" and are reported on line 6a).

UDS | UNIFORM DATA SYSTEM

Table 9E: Other Revenues

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

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 126-131.

UDS | UNIFORM DATA SYSTEM

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

- 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

- Grants that pay for line items rather than products.

- Grant funds reported on these lines are not related to productivity (e.g., 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 of Table 9D.

- Do not include state *insurance* plans.

REVENUES NOT REPORTED ON 9E

- Do not report payments from a 340(b) pharmacy program on Table 9E. All patient pharmacy income is reported on Table 9D and all pharmacy expenses are reported on Table 8A. For more detail on reporting contract pharmacy, see Appendix B in the UDS Manual.

- Do not include the value of donated services, supplies, or facilities (those are reported on Table 8A, line 18).

- 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 reported on Tables 5 and 8A are related to grants and contracted reported on Table 9E (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.

- 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 discounts 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.

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).

- Report the amount passed through as a cost on Table 8A, either in cost center categories or on Line 12 (other related services) if it is a lump sum.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 126-131.

UDS | UNIFORM DATA SYSTEM

Revised October 2019

2