Module 1:

1. Why is the UDS important?

Data are used by BPHC to demonstrate the 330 program's effectiveness
Data are used by project officers to monitor program performance
Data are used by grantees to develop baselines and report progress on SAC and BPR applications
BPHC uses the data to make funding decisions
All of the above

[The correct response to Question 1 is "All of the above".]

2. What kinds of technical assistance and support are available to assist you with preparing your 2009 UDS report?

Telephone help-line available year round
E-mail help available year round
UDS Manual with step-by-step instructions
Review of your tables by expert consultants
On-line training modules
Regional trainings
All of the above

[The correct response to Question 2 is "All of the above".]

3. What is the initial due date for your UDS data?

February 15, 2010
March 31, 2010
June 30, 2010

[The correct response to Question 3 is "February 15, 2010".]

4. Your 2009 UDS Report summarizes your activities for:

All your organizations activities for your fiscal year
All in-scope project activities for the period January 2009 – December 2009
All funded activities for the calendar year

[The correct response to Question 4 is "All in-scope project activities for the period January 2009 – December 2009".]

5. You may revise your UDS report after March 31, 2010.

True
False

[The correct response to Question 5 is “False”. You may not revise your UDS report after March 31, 2010.]

Module 2:

1. What is meant by an "unduplicated count" of total patients?

Each patient counts only once regardless of the number of visits they have.
Each patient is counted once each time they are seen by a physician.
Each patient is counted once each time they are seen by a different type of service provider (e.g. medical, dental, mental health, etc.).

[The correct response to Question 1 is "Each patient counts only once regardless of the number of visits they have".]

2. Patients are characterized by race AND ethnicity on the UDS. Which of the following is an acceptable method for obtaining this information?

Health center staff can make a best guess of a patient's race if the patient does not provide the information.
Race and Ethnicity are self reported by patients
Use census data to proportionally allocate patients to race and ethnicity categories

[The correct response to Question 2 is "Race and Ethnicity are self reported by patients".]

3. Patients who do not indicate that they are Hispanic are assumed to be non-Hispanic for purposes of reporting ethnicity on the UDS.

True
False

[The correct response to Question 3 is "True". If a patient does not indicate that they are Hispanic or Latino, you should assume that they are not when reporting ethnicity on the UDS report.]

4. Which one of the following types of information or methods can NOT be used to determine patient income for reporting on the UDS?

Patients can self report income on the registration form.
An eligibility assistance worker can determine a patient's income using approved documentation.
A patient's insurance can be used as a proxy for income.
If the patient has not provided income information, the patient must be reported as having unknown income.

[The correct response to Question 4 is "A patient's insurance can be used as a proxy for income". This is not a valid method for reporting UDS data, insurance should never be used as a proxy for income.]

5. In reporting patients by primary medical insurance, which one of the following is NOT considered to be a type of primary medical insurance coverage?

Medicaid
Workers Compensation
Medicare
SCHIP

[The correct response to Question 5 is “Workers Compensation”. Workers Compensation is not considered to be a type of primary medical insurance as it does not provide broad coverage, only coverage for work related illnesses or injuries.]

6. How many member months are reported for a patient who is enrolled in a capitated managed care plan for half the year?

1 month
6 months
12 months

[The correct response to Question 6 is “6 months”.]

7. Primary care case management is an example of reportable managed care.

True
False

[The correct response to Question 7 is “False”. Primary Care Case Management is not considered to be Managed Care.]

8. You must report the number of homeless persons, migrant farmworkers, school-based clinic patients and veterans you serve regardless of whether you receive targeted funding for special populations.

True
False

[The correct response to Question 8 is “True”. You must report the number of patients that you see from each of these special population categories regardless of whether or not targeted funding is received.]

9. Patients reported by age and gender (Table 3A), race and Latino identity (Table 3B), income (Table 4) and medical insurance (Table 4) must be equal.

True, because you are reporting the same patients by different characteristics
False, because each table describes the patients differently

[The correct response to Question 9 is “True”. The number of patients reported on each of these tables must be equal as you are describing the same patient population in different ways.]

Module 3:

1. A full-time equivalent (FTE) is calculated by dividing paid hours by total full-time hours as defined by the health center.

True
False

[The correct response to Question 1 is “True”.]

2. A full time employee who begins work on July 1, 2009 is counted as:

    1.0 FTE
    0.75 FTE
    0.50 FTE
    Not counted in 2009
    None of the above

[The correct response to Question 2 is “0.50 FTE”. If a person works full time hours for half of the year, they are considered to be a 0.5 FTE.]

3. The most accurate way to report FTEs is based on:

Job title
Licensure or certification
Work performed and credentials/licensure
Work performed

[The correct response to Question 3 is “Work performed and credentials/licensure”.]

4. Which of the following should NOT be included in the staffing reported for the UDS?

Employee staff
Volunteers
Contracted staff
Residents
Locum tenens
NHSC providers
Employees on temporary unpaid leave
Employees on paid maternity leave

[The correct response to Question 4 is “Employees on temporary unpaid leave”. If an employee is taking unpaid leave, the time spent on leave should not be counted on the UDS. However, if their leave is paid, for example maternity leave, you will want to be sure to include that time in their FTE calculation.]

5. Which of the following are required for a contact to count as a UDS encounter?

a. Face-to-face with provider
b. Provider (appropriately credentialed/licensed if applicable) must be acting independently and exercising professional judgment
c. Encounter must be provided by employee
d. Visit must be documented in the medical record
e. Encounter must be billable
f. Encounter must be provided on-site at health center

a,b,c
a,d,e
a,b,d
All of the above

[The correct response to Question 5 is “a,b,d”. In order for an encounter to be counted on the UDS, that encounter must be face-to-face between a provider and the patient, the provider (who must be credentialed/licensed if applicable) must be acting independently and exercising professional judgment, and the encounter must be documented in the patient’s record.]

6. Which of the following does not count as a UDS encounter?

Visit with a volunteer physician
Paid referral visit
A behavioral health group visit
A visit with an RN to get a blood pressure check
A case management visit

[The correct response to Question 6 is “A visit with an RN to get a blood pressure check”. Blood pressure checks are not counted as encounters on the UDS report.]

7. What is the primary difference between the number of patients reported on Table 5 compared with Tables 3A, 3B and 4?

Tables 3A, 3B and 4 report an unduplicated total patient count whereas Table 5 reports unduplicated patients by service category (e.g. medical, dental, etc.), often resulting in a duplicated patient count.
Patients who receive different kinds of services are counted more than once on Tables 3A, 3B and 4, but they are counted only once for each type on Table 5.
There is no difference between the patients reported on Tables 3A, 3B, 4 and 5.

[The correct response to Question 6 is “Tables 3A, 3B and 4 report an unduplicated total patient count whereas Table 5 reports unduplicated patients by service category (e.g. medical, dental, etc.), often resulting in a duplicated patient count”.]

8. Special population Grant Table(s) are subsets of the Universal Table. This means:

You cannot report more patients on a grant table than on the universal table.
The grant table and the universal table must be equal.
The grant table can report more patients than the universal table.
The patients reported on a grant table are not counted on the universal table.

[The correct response to Question 8 is :You cannot report more patients on a grant table than on the universal table".]

Module 4:

1. Which of the following should NOT be included in the total count of prenatal patients on the UDS?

A patient who had a positive pregnancy test and counseling only
A pregnant patient who received one or more prenatal visit with your provider
A pregnant patient who was transferred to another provider after receiving one or more prenatal visits at the health center
A patient who received prenatal care but then miscarries
A patient who has an abortion after one or more prenatal visits with your provider
A pregnant patient who delivers during the reporting year
A pregnant patient who saw your prenatal provider in 2009 but will not deliver until 2010.

[The correct response to Question 1 is “A patient who had a positive pregnancy test and counseling only”. If someone comes in only for these services, they are not considered to be a prenatal patient.]

2. A patient who has her first prenatal visit with the health center in her third trimester but who transferred from another provider where she began care in the first trimester, is considered to have begun prenatal care:

In the first trimester with another provider
In the second trimester with another provider
In the third trimester with your health center
In the third trimester with another provider

[The correct response to Question 2 is “In the first trimester with another provider”.]

3. It is not possible to report significantly more women aged 24-64 in the universe for the pap test than total women reported on Table 3A aged 24-64.

True
False

[The correct response to Question 3 is “True”. It is not possible to provide more pap tests to more women between the ages of 24 to 64 than you have total female patients within this age group.]

4. You can use a log of women who received a pap test to identify the universe of women for the pap test clinical performance measure.

True
False

[The correct response to Question 4 is “False”. Using a log of women who have received a pap test in order to determine your universe for the pap test measure will artificially inflate your compliance rate.]

5. Which of the following clinical performance measures does NOT have an exclusion?

Childhood immunization
Pap test
Controlled diabetes

[The correct response to Question 4 is “Childhood immunizations”. There are no exclusions for this measure.]

6. Self reported clinical information received from the patient (e.g. on vaccines received or date for a Pap test) is sufficient to document compliance for the clinical measures?

True
False

[The correct response to Question 6 is “False”. Self reported information is not sufficient for documenting compliance.]

7. A patient is considered to be out of compliance with the clinical performance measure (e.g., immunization, pap test) if documentation in the record clearly demonstrates that the clinician explained the importance of the service and the patient refused.

True
False

[The correct response to Question 7 is “True”. While providing an explanation of the importance of the service is important and shows an effort on the part of the health center, if the patient refuses care they are considered to be out of compliance.]

8. The number of patients who deliver during the reporting year should equal the number of women who receive prenatal care.

True
False

[The correct response to Question 8 is “False”. The number of women who deliver during the reporting year will not be equal to the total number of prenatal patients reported as it is expected that some patients who begin prenatal care during 2009 will deliver in 2010.]

9. The number of women who deliver may be different from the number of birth outcomes reported for which of the following reasons?

a. A woman miscarried or had an abortion sometime during her prenatal care
b. A woman had multiple births
c. A woman had a stillbirth
d. A woman was high risk and was transferred to another provider

a,b
b,d
b,c
all of the above

[The correct response to Question 9 is “b,c”. If a woman delivers multiples, only one delivery will be counted, but there will be multiple birth outcomes for that one delivery. If a delivery results in a stillbirth, the delivery will be counted, but there will be no birth outcome to report.]

10. A patient for whom all criteria is met for inclusion in the universe, but for whom there is no documented HbA1c or blood pressure reading available for the reporting year should be considered out of compliance on the diabetes or hypertension measures

True
False

[The correct response to Question 10 is “True”. If a patient meets the criteria for inclusion in the universe, but there is no documented HbA1c or blood pressure reading available, they should still be included in the universe and are considered to be out of compliance.]

11. It is possible to report significantly more African American patients with hypertension than total African American patients reported on table 3B.

True
False

[The correct response to Question 11 is “False”. You can not report more African American patients with hypertension than you have total African American Patients.]

Module 5:

1. Which of the following are examples of acceptable random samples?

10 random charts selected from each of 7 service sites
70 random charts selected from the PECs database which includes patients from the two collaborative sites but not the smaller site not in the collaborative
90 charts pulled from a universe of 1350 patients – 10 for each provider
First 70 patients seen for a condition in the reporting year
All qualifying patients from one of two service sites
None of the above

[The correct response to Question 1 is “None of the above”.]

2. To accurately report on all patients who meet the criteria for a clinical measure, the data source must meet all but which of the following criteria?

It must include patients from all service sites
It must include patients from all funded programs
It must include searchable fields with required clinical measure(s)
It must support reporting of all clinical measures
It must include data for the required time frame (e.g., 3 years)
It must permit identification of patients to be excluded from the universe

[The correct response to Question 2 is “It must support reporting of all clinical measures”. You are not required to use the same data source for all clinical measures. If you are able to report on the entire universe for some measures, but only on a sample for others, then that is acceptable.]

Module 6:

1. Administrative costs include all of the following except for:

Corporate administrative staff
Billing and collections staff
Medical records and intake staff
Patient registration IT system
Accounting and legal expenses
Provider benefits

[The correct response to Question 1 is “Provider Benefits”. Provider Benefits are not included on the corresponding staff cost line (ex/ Medical staff for medical providers, Dental for dental providers, etc…).]

2. Medical direct costs include the costs of front desk staff and medical records staff.

True
False

[The correct response to Question 2 is “False”. Front desk staff and medical records staff should be reported on the administrative costs line.]

3. Which of the following is an example of an other professional cost?

Family practice
Legal services
Podiatry
Cardiologist
Contracted Provider
Grant Writer

[The correct response to Question 3 is “Podiatry”.]

4. Which of the following should NOT be reported as Other Program Related costs?

Direct personnel and supplies expenses for “pass through” funds
Non-health-care services
WIC
Nutritionists/Dieticians
Job training
Home-maker chore programs

[The correct response to Question 4 is “Nutritionists/Dietitians”. Costs associated with Nutritionists or Dietitians are not considered to be Other Program Related Costs and should instead be reported on the Other Professional line.]

5. What is the goal in allocating overhead to direct cost centers?
Maximize costs for medical services which are billable
Minimize time and effort in allocating overhead
Assign costs to accurately reflect the cost to deliver services

[The correct response to Question 5 is “Assign costs to accurately reflect the cost of delivering services”.]

Module 7:

1. Total patient service charges should include which of the following?

Estimated value of non-billable services such as pharmacy samples and enabling services.
Net charges after allowable discount based on a sliding scale.
Charges from the fee schedule for all billable services including medical, dental, ancillary, behavioral health, etc., including charges for pharmaceuticals
Adjusted (+ or -) charges based on amount payor will reimburse.

[The correct response to Question 1 is "Charges from the fee schedule for all billable services including medical, dental, ancillary, behavioral health, etc., including charges for pharmaceuticals".]

2. Total collections include which of the following?

Cash payments received for charges incurred in 2009
Patient payments from 2008 received in 2009
PPS or FQHC reconciliation payments received in 2009
Capitation payments received in 2009
All of the above

[The correct response to Question 2 is All of the above.]

3. Allowances equal charges minus collections for:

All payors.
Capitated managed care plans, only.
Self-pay, only.
Fee-for-service and capitated plans.

[The correct response to Question 3 is Capitated managed care plans, only.]

4. Sliding discounts equal the difference between patient charges and the amount collected from patients.

True
False

[The correct response to Question 4 is "False". Sliding fee discounts must be calculated using the health center's fee schedule and the sliding fee scale.]

5. Failure to reclassify the patient portion of third party charges to self pay results in which of the following

Third party and self pay collection rates are correctly stated.
Third party collections are understated and self pay collections are overstated.
Third party collections are overstated and self pay charges are understated.

[The correct response to Question 5 is Third party collections are understated and self pay collections are overstated.]

6. Grants and contracts should be reported using the last party rule. Select the example below that satisfies the rule.

Federal dollars received through the state are reported as "state."
Federal dollars passed through another health center are reported as "federal."

[The correct response to Question 6 is Federal dollars received through the state are reported as "state".]

Module 8:

1. This year, the due date for final submission of the UDS is March 31, 2010. It's strongly encouraged that you make your UDS report ready for review by which date?

February 1, 2010
February 15, 2010
March 1, 2010
March 31, 2010

[The correct response to Question 1 is "February 15, 2010". Making your report ready for review by this date will ensure that your UDS reviewer will have time to work with you on your report prior to the final submission due date.]

2. On tables 3B and 7, if a patient has identified their race, but not their Hispanic/Latino identity, you should:

Assume that they are Hispanic or Latino
Assume that they are not Hispanic or Latino
Report them as Unreported/Refused to report.

[The correct response to Question 2 is Assume that they are not Hispanic or Latino.]

3. There have been new lines for ARRA funding added to table 9E. On these lines, you should only include ARRA funding received from the Bureau of Primary Health Care.

True
False

[The correct response to Question 3 is "True". Only ARRA funding received from the Bureau should be reported on the newly added ARRA lines, all ARRA money received from non-BPHC sources should be reported as Other Federal Grants.]

Module 9:

1. Patient Profile information reported on the zip code table and tables 3A, 3B, and 4 is useful for which of the following reasons?

It can be used to map service areas.
It can be used to document health center services that are being provided to target populations.
The data can be used as denominators for other measures.
All of the above.

[The correct response to Question 1 is "All of the above".]

2. To calculate productivity for a family physician, you would divide family physician visits by family physician patients.

True
False

[The correct response to Question 2 is "False". Dividing visits by patients allows you to see the average number of visits per patient. To calculate productivity, you must divide visits by FTEs.]

3. Table 7 information can be aggregated at the national or state level and analyzed to draw conclusions about health disparities by race and ethnicity.

True
False

[The correct response to Question 3 is "True". Aggregated data can be used to draw conclusions about health disparities by race and ethnicity; however, grantees are cautioned against drawing conclusions at the individual grantee level as the numbers at this level would be too small.]

4. Which of the following measures can be calculated using table 5 data (Staffing and Utilization) and table 9D data (Patient Related Revenue)?
Average cost per medical patient
Average cost per medical encounter
Average charge per billable encounter
None of the above

[The correct response to Question 4 is "Average charge per billable encounter".]