



Uniform Data System (UDS) Reporting Requirements Training Calendar Year 2019

Bureau of Primary Health Care

Health Resources and Services Administration



Agenda

- **Welcome and Logistics**
- **Overview of the UDS**
- **Reporting the Patient Profile**
- **Reporting Clinical Services and Quality of Care Indicators**
- **Operational and Financial Tables**
- **Other Required UDS Reporting Forms**
- **Tips for Success**



Your Training Binder

- UDS Reporting Instructions
- 2019 UDS Tables
- Beginner and Advanced Training Resource Fact Sheets
- Group Activity Worksheets
- Clinical Measures Handout
- List of Acronyms
- Selected Statistics
- Proposed UDS Changes for Calendar Year 2020 (PAL 2019-05)



Support Available

	UDS Support Center	Health Center Program Support	HRSA Call Center
Purpose	Assistance with content and reporting requirements of the UDS report or about the use of UDS data (e.g., defining patients or visits, questions about clinical measures, questions on how to complete various tables, how to make use of finalized UDS data).	Assistance for health centers when completing the UDS report in the EHBs (e.g., report access/submission, diagnosing system issues, technical assistance materials, triage).	Assistance with getting an EHBs account, password assistance, setting up the roles and privileges associated with your EHBs account, and determining whether a competing application is with Grants.gov or HRSA.
Contact	866-837-4357/866-UDS-HELP udshelp330@bphcdata.net	877-464-4772, Option 1	877-464-4772, Option 3
Website	http://bphcdata.net	http://www.hrsa.gov/about/contact/bphc.aspx	http://www.hrsa.gov/about/contact/ehbhelp.aspx
Hours of Operation	8:30 – 5:00 EST, M–F Extended hours during UDS reporting period	7:00 AM – 8:00 PM EST, M-F Extended hours during UDS reporting period	8:00 AM – 8:00 PM EST, M–F




UDS Training Website (<http://bphcdata.net>)

UDS: UNIFORM DATA SYSTEM

Calendar Year 2019 Training Resources

Trainings

In-person

In-person training sessions for the Calendar Year 2019 UDS reporting have been scheduled throughout the country. Please view the  [training schedule](#) to obtain information about each session.

Webinars

Online webinars on *specific and advanced topics* for the Calendar Year 2019 UDS Report have been scheduled. Please view the [webinar training schedule](#) to obtain information for each session. Content and archives from previously recorded sessions can be viewed here [Online Trainings and Webinars](#).

[Distance Learning Modules](#)

This training is comprised of five on-demand eLearning modules appropriate for staff who are *new* to the UDS and will participate in the data collection and reporting process. Upon completion, learners will be prepared to contribute to the UDS data collection and report submission process.



Recorded Training Modules

1. UDS Overview
2. Patient Characteristics
3. Clinical Services and Performance
4. Operational Costs and Revenues
5. Submission Success



Link to modules: <http://bphcdata.net/html/modules.html>

Training Webinar Series for 2019 UDS Reporting

- Reporting Virtual Visits and the Mental Health and Substance Use Disorder Services Reporting Addendum
- Reporting UDS Clinical Tables to Support Quality Improvement
- Reporting UDS Financial and Operational Tables and Using Comparison Performance Metrics
- Strategies for Successful UDS Reporting
- UDS for Bureau of Health Workforce (BHW) Designees: Review of Reporting Requirements
- New UDS Reporting Requirements for 2020 (Spring 2020)

***All webinars are archived on the [HRSA website](#)**

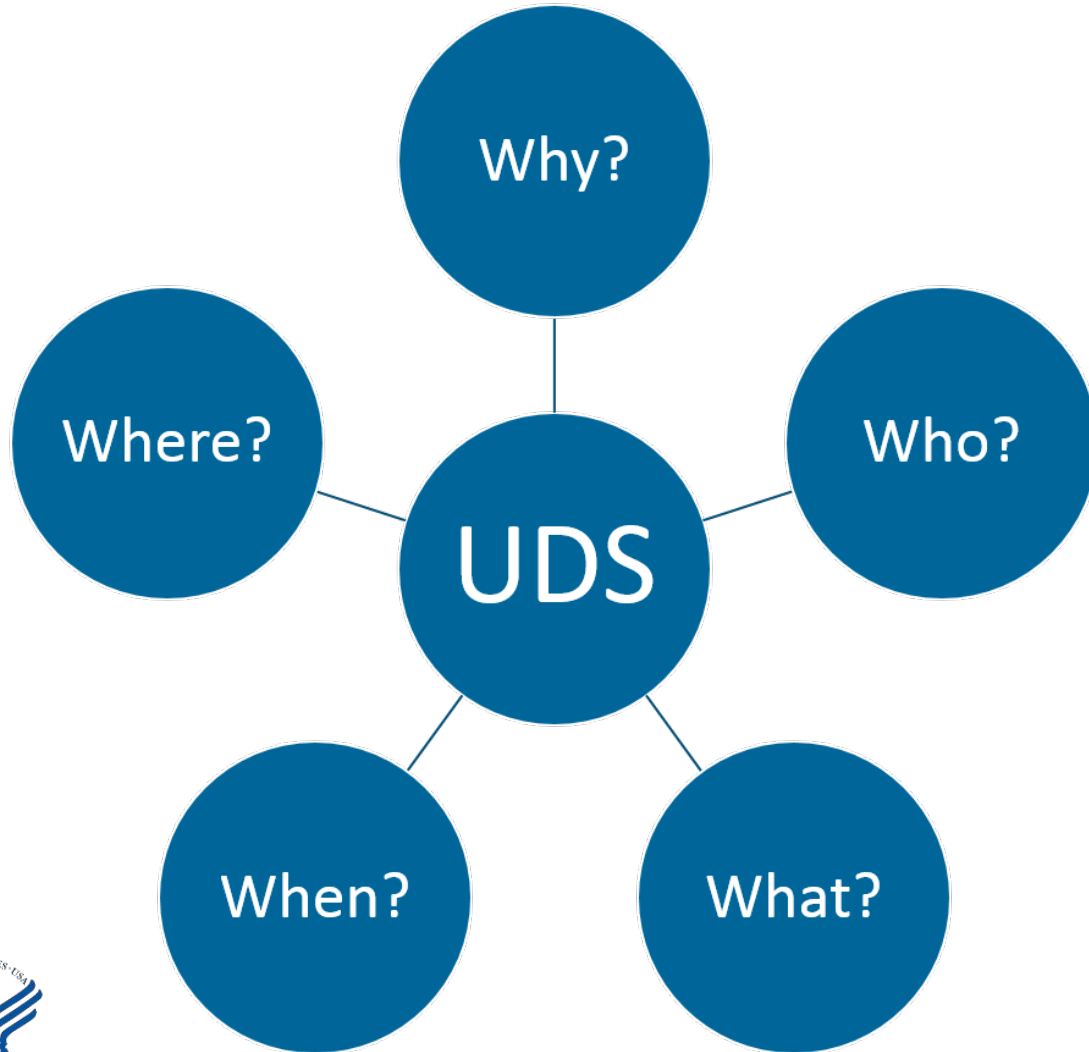




Overview of the UDS

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

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



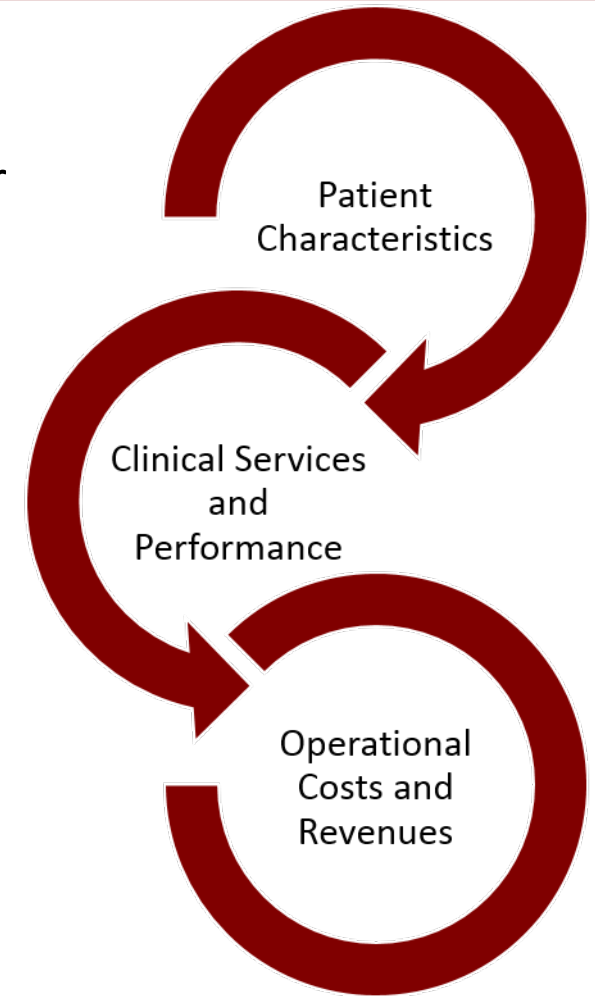
- **Who:** CHCs, HCHs, MHCs, PHPCs, LALs and BHW primary care clinics funded or designated before October 2019
- **What:** 11 tables and 3 forms that provide an annual snapshot of all in-scope activities
 - Universal and grant reports (if applicable)
- **Where:** Report through the EHBs starting January 1, 2020; PRE and offline reporting tools available in fall 2019
- **When:** January 1 - December 31, 2019
- **Why:** Legislatively mandated; used for program monitoring and improvement

Overview of UDS Report

Eleven Tables and Three Forms

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

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



Where to Report: The EHBs

The screenshot shows the HRSA Electronic Handbooks website. The header includes the HRSA logo, the text 'Electronic Handbooks', and links for 'Support' and 'Login'. Below the header is a navigation bar with 'Welcome', 'New User Registration', 'Funding Opportunity', and 'What's New'. The main content area is divided into three columns. The left column has sections for 'Existing Users' (with fields for Username (Email) and Password, a 'Login' button, and a 'Forgot Password?' link) and 'New Users' (with a 'Create an Account' button and a 'Click here to get started' link). The middle column has a 'What's New' section with two announcements: one dated 03/16/2018 about an optimized home page and a new help video, and another dated 01/18/2018 about new features to manage workload and download/print grant documents. The right column has a 'Contact Us' section with contact information: Time (8:00 a.m. to 8:00 p.m. Eastern Time (ET) Monday through Friday), Phone (877-Go4-HRSA/877-464-4772), and a 'Link to contact us' (click here). At the bottom, there are two sections: 'Learn About' with links to 'Grant Program', 'Free Clinic Program', and 'FQHC-LAL Program'; and 'Other Links' with links to 'Browser Requirements', 'Funding Opportunities', 'Track Grant Application', and 'Help'.

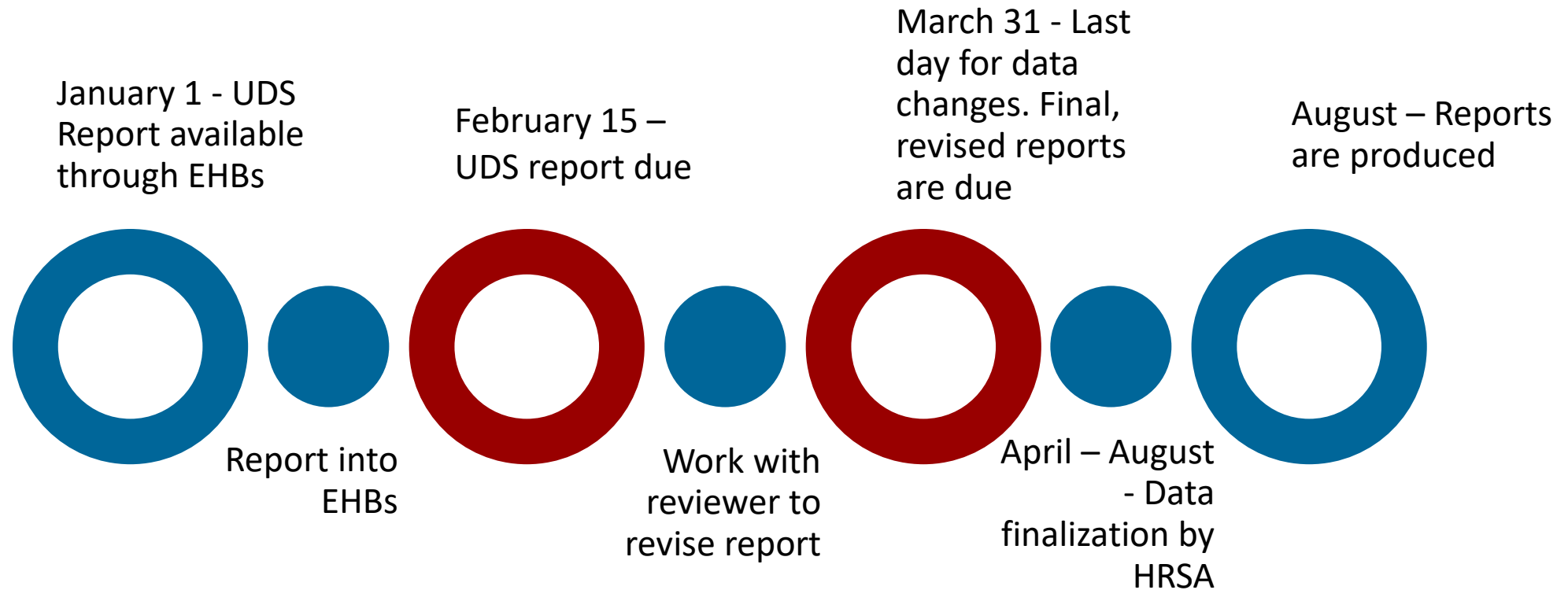
- All people who will be tasked with data entry or review need a login
- Tools ([link to video](#))
 - Excel Template
 - Excel Upload
 - Comparison Tool
 - PRE
 - Edits ([link to video](#))
- Helplines
 - For account or login issues: HRSA Helpdesk (877-464-4772, Option 3)
 - For functionality issues: Health Center Program Support (877-464-4772, Option 1)

Access EHBs at:

<https://grants.hrsa.gov/2010/WebEPSEExternal/Interface/Comment/AccessControl/Login.aspx>



Reporting Timeline



PRE available (Nov.-Dec.)

UDS support available (all-year)



Value of the UDS

More than **28 million** people rely on a HRSA-funded health center for care, including:



1 in 12 PEOPLE



1 in 9 CHILDREN



1 in 5 RURAL RESIDENTS



1 in 3 LIVING IN POVERTY



more than **385K** VETERANS



more than **800K** SERVED AT SCHOOL-BASED HEALTH CENTERS



nearly **1M** AGRICULTURAL WORKERS



about **4.5M** LIVING IN OR NEAR PUBLIC HOUSING



The Patient Profile: Understanding Who You Are Serving

ZIP Code Table, Tables 3A, 3B, and 4



Patients

- **Patient:** A person who has at least one countable visit in one or more service category during the reporting year
- In the tables of the patient profile (ZIP code table and Tables 3A, 3B, and 4), **each person counts once** regardless of the number of visits or services received



ZIP Code Table

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

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

Patients by Age and Sex at Birth

Table 3A

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

- Report total patients by **age and sex** at birth or as reported on birth certificate
 - Use age as of June 30
 - Patients by age must equal Table 4 insurance by age groups (0–17 years old and 18 and older)

Ethnicity, Race, and Language

Table 3B

Line	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (sum Columns a+b+c)
1	Asian		1		1
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (sum Lines 2a + 2b)				
3	Black/African American	3	1		4
4	American Indian/Alaska Native				
5	White	2	4		6
6	More than one race				
7	Unreported/refused to report race	1			1
8	Total Patients (sum of Lines 1 + 2 + 3 to 7)	6	6		12
Line	Patients Best Served in a Language Other than English			Number (a)	
12	Patients Best Served in a Language Other Than English			4	

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

Sexual Orientation and Gender Identity

Table 3B

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

Report total patients by **Sexual Orientation and Gender Identity**

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

The National LGBT Health Education Center can help.



Special Populations

Table 4

- All health centers report lines 16, 23, 24, 25, and 26
- MHC Awardees
 - Report migratory (**line 14**—temporary home) and seasonal (**line 15**)
- HCH Awardees
 - Report (**lines 17–22**) where individuals who experience homelessness are housed as of first visit during reporting year

*Special Populations Resources: HRSA-funded
National TA/T Centers*

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



Considerations When Reporting Patient-Related Data



Table	Description
ZIP code	Don't type the word "Other" as a ZIP code. Report the count in the already available "Other" field.
ZIP code Table 4	Report Medicaid, CHIP, and Other Public together on the ZIP code table, but on separate lines on Table 4.
Table 3B	Understand what counts to include in SOGI "other", "don't know", and "something else" fields. Also, consider how minors are reported in the SOGI section.
Table 4	Public Housing is a location-based reporting.

Group Discussion Activity – Worksheet 1, Section A

In your small groups, discuss the following three questions. You will have 15 minutes.

1. Who needs to be involved to report these patient demographic data?
2. What data do you need from them to report successfully?
3. What do the data look like when you get them from your EHR?



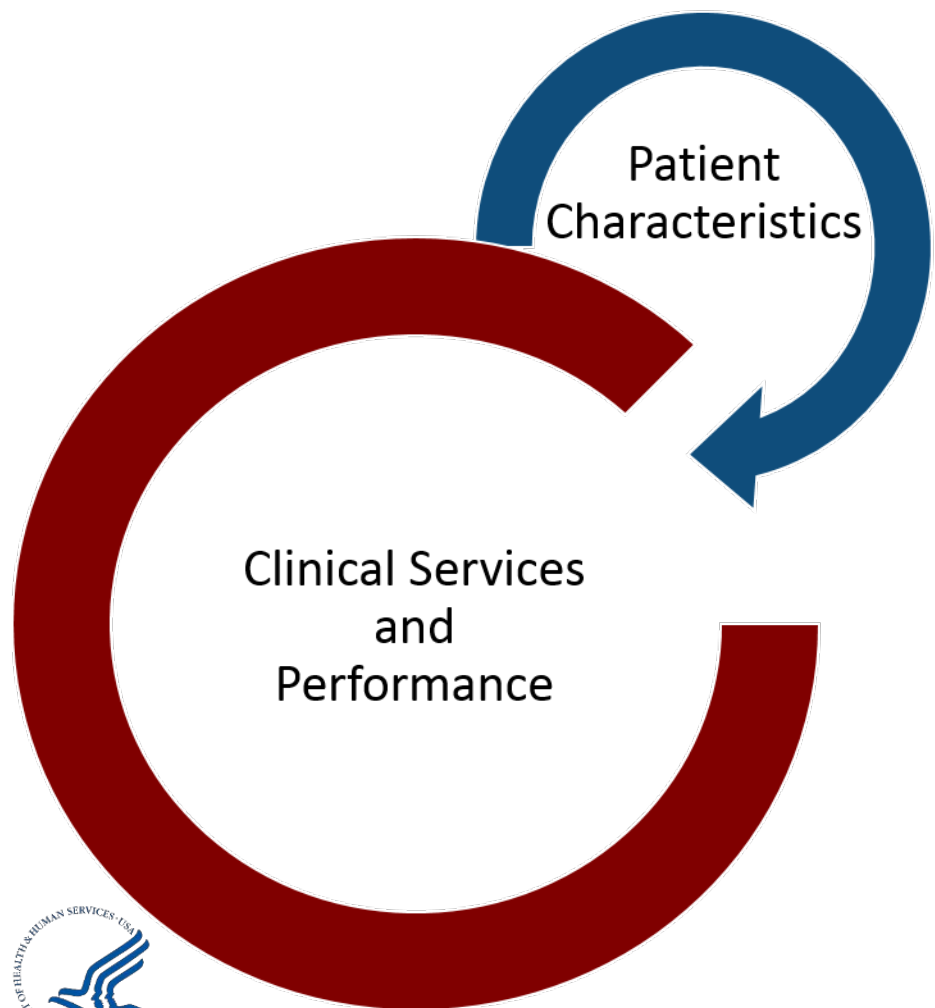
The Rest of Table 4 Will Be Discussed with Table 9D

Income and Insurance

Patient Revenues

Break

Stretch, drink water, relax.
We will meet back here in 15 minutes.



Reporting Clinical Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7



Defining a Visit

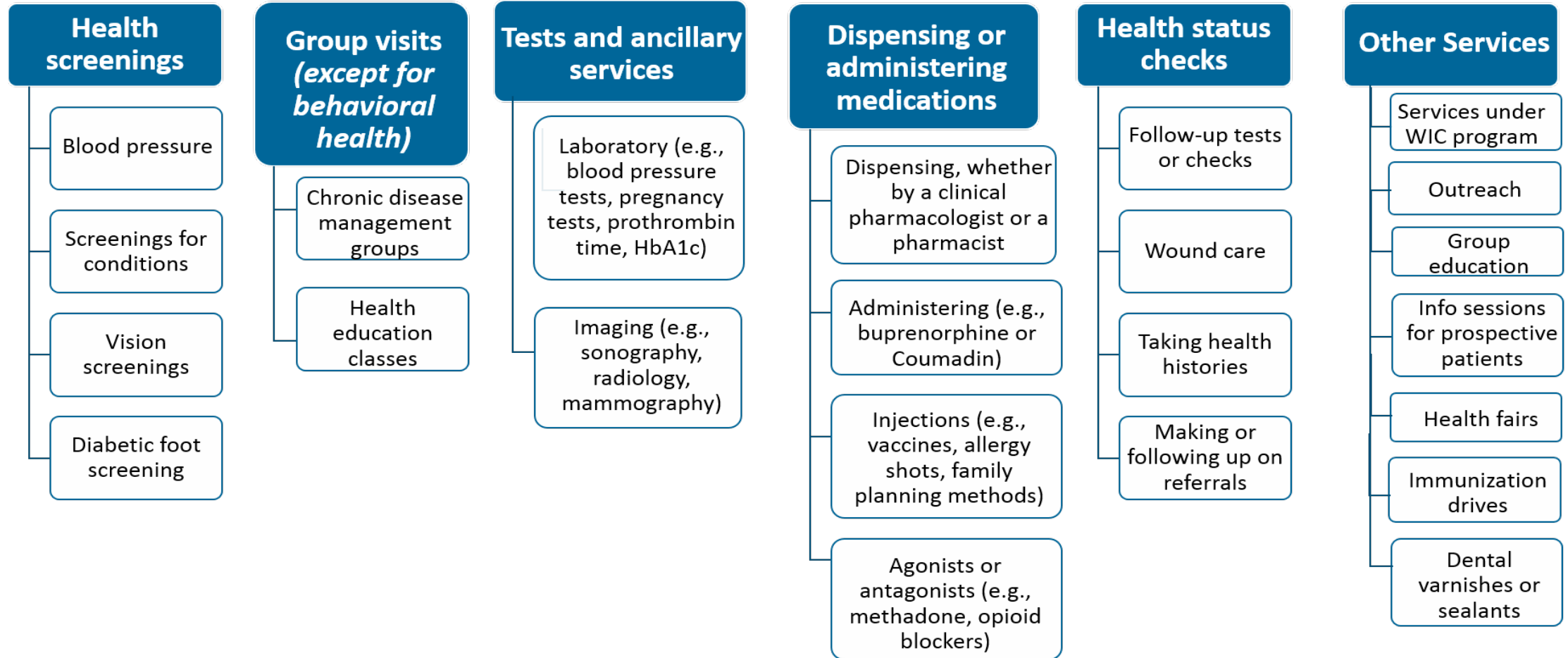
- Documented
- One-on-one
- Licensed/credentialed provider
- With a provider who exercises independent and professional judgement
 - Group visits are only countable for behavioral health
 - Clinic and virtual visits are allowable for each of the service categories



Counting Multiple Visits

- On any given day, a patient may have only one visit per service category per provider
 - Service categories include medical, dental, mental health, substance use disorder, other professional, vision, and enabling
- If multiple providers in a single service category deliver multiple services at the **same location** on a single day, count only one visit
- If medical services are provided by **two different medical providers** located at **two different sites** on the same day, count two visits
 - A virtual visit and a clinic visit are considered to be two different sites and may both be counted as visits even when they occur on same day

Contacts That Do Not Count as Visits



Locations of Visits

Table 5

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

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	blank	blank	blank	
2	General Practitioners	blank	blank	blank	
3	Internists	blank	blank	blank	
4	Obstetrician/Gynecologists	blank	blank	blank	
5	Pediatricians	blank	blank	blank	
7	Other Specialty Physicians	blank	blank	blank	
8	Total Physicians (Lines 1–7)	blank	blank	blank	
9a	Nurse Practitioners	blank	blank	blank	
9b	Physician Assistants	blank	blank	blank	
10	Certified Nurse Midwives	blank	blank	blank	
10a	Total NPs, PAs, and CNMs (Lines 9a–10)	blank	blank	blank	
11	Nurses	blank	blank	blank	
12	Other Medical Personnel	blank			
13	Laboratory Personnel	blank			
14	X-ray Personnel	blank			
15	Total Medical (Lines 8 + 10a through 14)	blank	blank	blank	blank
16	Dentists	blank	blank	blank	
17	Dental Hygienists	blank	blank	blank	
17a	Dental Therapists	blank	blank	blank	
18	Other Dental Personnel	blank			
19	Total Dental Services (Lines 16–18)	blank	blank	blank	blank
20a	Psychiatrists			blank	
20a1	Licensed Clinical Psychologists			blank	
20a2	Licensed Clinical Social Workers			blank	
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Lines 20a–20c)				
* Excerpt from Table 5					

Location of Visits: Clinic

Table 5

- **Clinic Visits (column b):**
Report documented *face-to-face contact* between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	Total Physicians (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Lines 20a–20c)				
*	Excerpt from Table 5				



Location of Visits: Virtual

Table 5

- **Virtual visits (column b2):**
Report documented *virtual (telemedicine) contact* between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient.
 - Must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	Total Physicians (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Lines 20a–20c)				
* Excerpt from Table 5					

Patients and Visits by Service

Table 5

Visits (b and b2)	Patients (c)	Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
<p>Count clinic and virtual visits that meet definition</p> <ul style="list-style-type: none">Not all staff generate visitsNot all contacts = visitsA single visit may consist of multiple services, but counts as only one <p>Report in column (b) or (b2) by service provider</p>	<p>Unduplicated count of patients by service category</p> <ul style="list-style-type: none">Same person can receive multiple servicesSum of patients by service ≠ total patients <p>Report in column (c) by service category</p>	1	Family Physicians				
		2	General Practitioners				
		3	Internists				
		4	Obstetrician/Gynecologists				
		5	Pediatricians				
		7	Other Specialty Physicians				
		8	Total Physicians (Lines 1–7)				
		9a	Nurse Practitioners				
		9b	Physician Assistants				
		10	Certified Nurse Midwives				
		10a	Total NPs, PAs, and CNMs (Lines 9a–10)				
		11	Nurses				
		12	Other Medical Personnel				
		13	Laboratory Personnel				
		14	X-ray Personnel				
		15	Total Medical (Lines 8 + 10a through 14)				
		16	Dentists				
		17	Dental Hygienists				
		17a	Dental Therapists				
		18	Other Dental Personnel				
		19	Total Dental Services (Lines 16–18)				
		20a	Psychiatrists				
		20a1	Licensed Clinical Psychologists				
		20a2	Licensed Clinical Social Workers				
		20b	Other Licensed Mental Health Providers				
		20c	Other Mental Health Staff				
		20	Total Mental Health (Lines 20a–20c)				
		*	Excerpt from Table 5				



Selected Services Detail Addendum

Table 5

- Report data on mental health treatment services provided by medical providers.
- Report data on substance use disorder treatment services provided by medical providers and mental health providers.
- The MH/SUD visits reported in the main part of Table 5 and the MH/SUD services reported in the Addendum, together, provide an unduplicated count of MH and SUD services across all provider types.

Reporting Visits in the Table 5 Addendum

- Report the number of clinic and virtual visits and patients by provider type, where the service included treatment for
 - Mental health (lines 20a01–20a04)
 - Substance use disorder (lines 21a–21h)

Selected Service Detail Addendum					
Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Clinical Nurse Midwives				
	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				



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

Staffing Levels
Operating Costs



Considerations When Reporting Virtual Visit–Related and MH/SUD Addendum Data



Table	Description
Table 5	Check for accuracy when virtual visits are greater than clinic visits (check in each service category).
Table 5	Be sure virtual visits reported are coded as such and using interactive, synchronous audio and/or video telecommunication systems that permit real time communication between the provider and a patient, and the interaction otherwise meets the definition of a visit (not all interactions are visits).
Table 5	Check for accuracy when reporting more patients in the addendum than the main part of table 5. For example, more patients reported in SUD addendum for psychiatrists (line 21e) than there are total mental health patients on the main part of Table 5 (line 20).
Table 5	Be sure the addendum only reflects activity already reported as part of a visit on the main portion of Table 5. The addendum only includes MH/SUD treatment provided by medical or MH providers not already reported as part of an existing MH or SUD visit on the main part of Table 5.

Group Discussion Activity – Worksheet 2, Section A

In your small groups, discuss the following three questions. You will have 10 minutes.

1. Who needs to be involved to report these data elements on patients and visits?
2. What data do you need from them to report successfully?
3. What do the data look like when you get them from your EHR?

Table 5 Resources

- **UDS Training Website**
 - [Virtual Visit Reporting Handout](#)
 - [Mental Health/Substance Use Disorder Services Detail Handout](#)
 - [Nurse Visit Guidance Handout](#)
- **Reporting Virtual Visits and the Mental Health and Substance Use Disorder Services Reporting Addendum Resources for Telehealth webinar recording**
- **Telehealth Resource Centers**: 12 HRSA-supported regional and 2 national centers (including the Center for Connected Health Policy) provide expert and customizable technical assistance, advice on telehealth technology and state-specific regulations and policies such as Medicaid or private payers as well as Medicare
- **Centers for Medicare and Medicaid Services: Telehealth**: Provides Medicare telehealth services definitions



Selected Diagnoses and Services

Table 6A

	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2	Symptomatic/ Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-		
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21		
Selected Diseases of the Respiratory System				
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40- through J44-, J47-		
Selected Other Medical Conditions				
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-		

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



Excerpted from Table 6A

Clinical Process and Outcome Measures

Tables 6B and 7

Disease Management

Use of Appropriate Medications for Asthma

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Ischemic Vascular Disease (IVD):
Use of Aspirin or Another Antiplatelet

HIV Linkage to Care

Controlling High Blood Pressure

Diabetes: Hemoglobin A1c (HbA1c)
Poor Control (>9%)

Preventive Care

Childhood Immunization Status

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Colorectal Cancer Screening

Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Dental Sealants for Children between 6-9 Years

Women's Health

Early Entry into Prenatal Care

Cervical Cancer Screening

Low Birth Weight



To learn more about how these measures align with other national reporting, please visit pages 186-187 in the **2019 UDS Reporting Instructions**.

Clinical Process and Outcome Measures

Table 6B Format

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

Example: Section C - Childhood Immunization Status				
Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age- appropriate vaccines by their 2nd birthday	100	93	75

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



Clinical Process cont'd.

Table 7 Format

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

Example	Section B: Controlling High Blood Pressure			
Line #	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	<i>Subtotal Hispanic/Latino</i>			
Non-Hispanic/Latino				
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	<i>Subtotal Non-Hispanic/Latino</i>			
Unreported/Refused to Report Race and Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity			
i	<i>Total</i>			

Alignment with Electronic Clinical Quality Measures (eCQMs)

- An eCQM is a clinical quality measure that is specified in a standard electronic format and is designed to use structured, encoded data present in the electronic health record
- Most UDS measures align with eCQMs
- To accurately report, you need to
 - Understand how to access and read specifications
 - Know where your EHR is looking for required data elements to calculate eCQMs
 - Make sure your providers are recording required data in correct fields
 - Note: Some health centers with certain EHR vendor packages may see change/possibly a decline in clinical performance as data is corrected in the vendor packages



Accessing Codes from USHIK Database



Link: [Accessing and Using the USHIK](#)

Resources to Support Clinical Process and Outcomes Reporting

Table	Line	UDS Measure Name	eCQM #	Major Differences from UDS to eCQM
6B	7–9	Early Entry into Prenatal Care	<u>no eCQM</u>	None
6B	10	Childhood Immunization Status	<u>CMS117v7</u>	None
6B	11	Cervical Cancer Screening	<u>CMS124v7</u>	None
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	<u>CMS155v7</u>	<ul style="list-style-type: none"> • eCQM denominator is limited to outpatient visits with a primary care physician or obstetrician/gynecologist. UDS includes children seen by nurse practitioners and physician assistants • Numerator BMI, nutrition, and activity are reported separately in the eCQM, but combined in the UDS
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	<u>CMS69v7</u>	None
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	<u>CMS138v7</u>	<ul style="list-style-type: none"> • Denominator patient population and numerator are reported separately in the eCQM, but evaluated as one group in the UDS
6B	16	Use of Appropriate Medications for Asthma	<u>CMS126v5</u>	Note: eCQM specifications for this measure have not been updated.



View the [Clinical Measures Handout](#) for national averages, 2019 differences, and useful tips.

Resources to Support Clinical Process and Outcomes Reporting

Table	Line	UDS Measure Name	eCQM #	Major Differences from UDS to eCQM
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v2	None
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v7	None
6B	19	Colorectal Cancer Screening	CMS130v7	None
6B	20	HIV Linkage to Care	no eCQM	None
6B	21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v8	None
6B	22	Dental Sealants for Children between 6-9 Years	CMS277v0	Note: Although measure title is age 6 through 9 years, draft eCQM reflects ages 5 through 9 years — health centers should continue to use ages 6 through 9 years, as measure steward intended
7	1a-1d	Low Birth Weight	no eCQM	None
7	2a-2c	Controlling High Blood Pressure	CMS165v7	None
7	3a-3f	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v7	None

View the [Clinical Measures Handout](#) for national averages, 2019 differences, and useful tips.



Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v2)

- New for 2019 reporting
- Removed Coronary Artery Disease (CAD) measure

Component	Description
Denominator (a)	<ul style="list-style-type: none"> • Patients age 21 or older who have an active diagnosis of atherosclerotic cardiovascular disease (ASCVD); or • Patients age 21 or older who ever had a fasting or direct laboratory result of LDL-C \geq 190 mg/dL, or who 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 • And, had a medical visit during the measurement period
Numerator (c)	<ul style="list-style-type: none"> • Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period
Exclusions	<ul style="list-style-type: none"> • Patients who have a diagnosis of pregnancy, are breastfeeding; have a diagnosis of rhabdomyolysis, have an adverse effect, allergy, or intolerance to statin medication, are receiving palliative care; with active liver disease or hepatic disease or insufficiency, or have end-stage renal disease (ESRD). • Patients 40 through 75 years of age with diabetes who have the most recent fasting or direct LDL-C laboratory test result <70 mg/dL and are not taking statin therapy



HIV Linkage to Care

Table 6B, Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis			

Component	Description
Denominator (a)	Patients first diagnosed with HIV by the health center between October 1, 2018, through September 30, 2019, who had at least one medical visit during the 2-year period
Numerator (c)	Newly diagnosed patients who received medical treatment within 90 days of diagnosis <ul style="list-style-type: none"> Treatment may be initiated with your health center provider or by referral
Exclusions	None



View the [Helpful Codes for HIV](#) document that may be helpful for 2019 reporting.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (CMS69v7)

Component	Description
Denominator (a)	<ul style="list-style-type: none">Patients 18 years of age or older on the date of the visit with at least one medical visit
Numerator (c)	<ul style="list-style-type: none">Patients with<ul style="list-style-type: none">A documented BMI during their most recent visit in the measurement period or during the previous 12 months of that visit, andWhen the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit
Exclusions	<ul style="list-style-type: none">Patients who are pregnant during the measurement periodPatients who are receiving palliative carePatients who refuse measurement of height and/or weight or refuse follow-up during the visitPatients with a documented medical reason during the visit or within 12 months of the visit

Tables 6A, 6B, and 7 Resources

- **UDS Training Website**
 - [Clinical Quality Measures Handout](#)
 - [Helpful Codes for HIV Linkage to Care Measure](#)
 - [Table 6A Code Changes Handout](#)
- **Clinical Measures Webinar Recording**
- **Health Information Technology, Evaluation, and Quality Center (HITEQ): A HRSA-funded National Cooperative Agreement**



Considerations When Reporting Clinical Measure Related Data



Table	Description
Table 6A Table 6B Table 7	<p>Patients with certain diagnosis (ex. hypertension) are reported on both Tables 6A and 6B or 7; however, the definitions for inclusion are different and it is unlikely they would be exactly equal.</p>
Table 6B Table 7	<p>Check for:</p> <ul style="list-style-type: none"> • Large shifts in compliance from the prior year. • Large changes in prevalence or universe. • No universe reported. • Not reporting race/ethnicity on Table 7 in the same manner as Table 3B. • Denominators that are equal to Table 3A population counts.

Group Discussion Activity – Worksheet 2, Section B

In your small groups, discuss the following three questions. You will have 15 minutes.

1. Who needs to be involved to report these data elements?
2. What data do you need from them to report successfully?
3. What do the data look like when you get them from your EHR?
4. How do you overcome challenges with your reporting software?

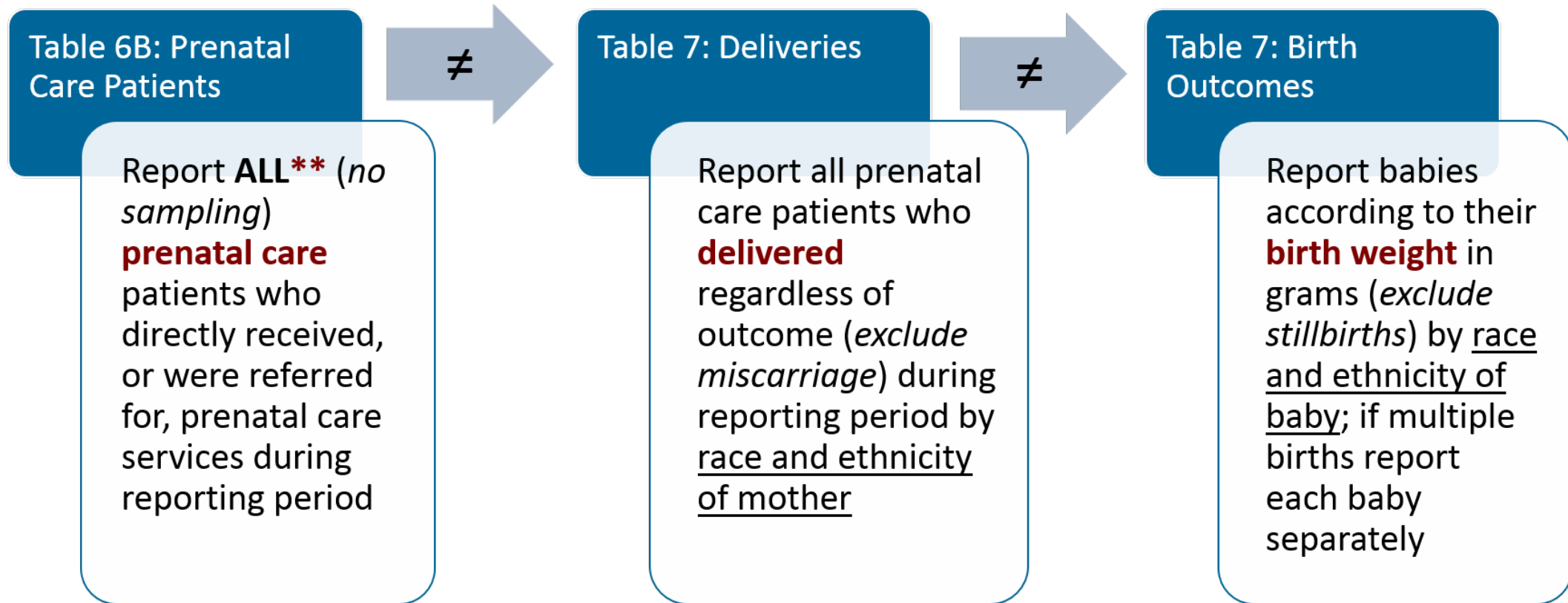
Break for Lunch

Enjoy!

We will meet back here in 1 hour.



Women's Health: Prenatal and Birth Outcome Measures



***Include women who a) began prenatal care in previous year (2018), b) began and delivered in reporting period (2018 & 2019), and c) will not deliver until next year (2020).**

Prenatal Patients by Age and Entry into Prenatal Care

Table 6B

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

0	Prenatal Care Provided by Referral Only (Check if Yes)		
Section A—Age Categories for Prenatal Patients: Demographic Characteristics of Prenatal Care Patients			
Line	Age	Number of Patients (a)	
1	Less than 15 Years		
2	Ages 15-19		
3	Ages 20-24		
4	Ages 25-44	1	
5	Ages 45 and over		
6	Total Patients (Sum of lines 1-5)	1	

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	1	
8	Second Trimester		
9	Third Trimester		



Deliveries & Birth Outcomes

Table 7

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



Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
Hispanic/Latino					
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American	1	1	1	
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	<i>Subtotal Hispanic/Latino</i>	1	1	1	
Non-Hispanic/Latino					
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	<i>Subtotal Non-Hispanic/ Latino</i>				
Unreported/Refused to Report Race and Ethnicity					
h	Unreported/Refused to Report Race and Ethnicity				
i	Total	1	1	1	

Deliveries and Birth Outcomes

Table 7

Section A

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

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



View the [Prenatal and Birth Outcomes Fact Sheet](#) for more information.

Considerations When Reporting Prenatal and Birth Outcome Related Data



Table	Description
Table 6B	Do not report referral only in column (b) for trimester of entry into prenatal care (this is an error). Report in column (a).
Table 6B	Remember to include women still pregnant at the end of the prior year in the current year prenatal and delivery sections.
Table 7	Do not report women as having delivered during the reporting period when there is no evidence of delivery.
Table 7	Count multiple births separately with their weights.



Financial and Operational Tables

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

FTE(s) by Provider Type

Table 5

- **Report all staff who support in-scope operations**
 - Include employees, interns, volunteers, residents, and contracted staff
 - Do not include paid referral provider FTEs when paid by service (not by hours)
- **Report staff by function and credentials**
 - Staff time can be allocated across multiple lines
 - Clinicians should be reported on their line of credentialing
 - [Appendix A](#) in the UDS Reporting Instructions is a helpful tool that can be used to classify personnel in the UDS
- **Report FTE: 1 FTE = 1 person full-time for entire year**
 - Full-time defined by health center
 - Employment contract for clinicians
 - Non-exempt, volunteers, based on worked hours (can exceed 1.0 FTE if paid overtime)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b)	Patients (c)
1	Family Physicians	.25	10	2	
...		
5	Pediatricians	1.0	12	1	
7	Other Specialty Physicians				
8	Total Physicians (Sum lines 1-7)	1.25	22	3	
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NP, PA, and CNMs (Sum lines 9a - 10)	.6	3		
11	Nurses	3.0			
12	Other Medical Personnel				
13	Laboratory Personnel	1.0			
14	X-Ray Personnel				
15	Total Medical (Sum lines 8+10a through 14)	5.85	25	3	10
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Sum lines 16-18)		9		5
...
24	Case Managers	2.4	6		
25	Patient/Community Education Specialists				
26	Outreach Workers				
27	Transportation Staff				
27a	Eligibility Assistance Workers	0.3			
27b	Interpretation Staff	0.3			
27c	Community Health Workers				
28	Other Enabling Services (specify__)				
29	Total Enabling Services (Sum lines 24-28)	3.0	6		1
29a	Other Programs/Services (specify__)				
29b	Quality Improvement Staff				
30a	Management and Support Staff	2.5			
30b	Fiscal and Billing Staff	1.5			
30c	IT Staff	0.5			
31	Facility Staff				
32	Patient Support Staff	3.0			
33	Total Facility and Non-Clinical Support Staff (Sum lines 30a - 32)	7.5			
34	Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)	16.35	40	3	



Example: Calculate FTE



Employees with full benefits*

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

1. Calculate base hours for full-time:

Total hours per year:

40 hours/week x 52 weeks = 2,080 hours

2. Calculate this staff person's paid hours:

Total hours for 6 months:

40 hours/week x 26 weeks = 1,040 hours

3. Calculate FTE for this person:

1,040 hours/2,080 hours = **0.50 FTE**

Employees with no or reduced benefits*

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

1. Calculate base hours for full-time:

Total hours per year:

40 hours/week x 52 weeks = 2,080 hours

2. Deduct unpaid benefits: (10 holidays, 12 sick days, 5 continuing medical education [CME] days, and 3 weeks vacation)

10+12+5+15 = 42 days * 8 hours = 336

2,080-336 = 1,744

3. Calculate combined person hours:

Total hours: 1,040 hours

4. Calculate FTE:

1,040 hours/1,744 hours = **0.60 FTE**

***Benefits defined as vacation/holidays/sick benefits**



Reporting Personnel in the Table 5 Addendum

- In Column (a1), report the **number** of providers listed who provided MH and/or SUD treatment services
 - Providers may be counted in multiple service categories, as appropriate
 - Providers contracted on a fee-for-service basis should be counted
- FTEs are not reported in Column (a1)

Selected Service Detail Addendum					
Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Clinical Nurse Midwives				
	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Resources to Support Table 5 Reporting

- [UDS Training Website](#)
 - [UDS Reporting Instructions](#) Appendix A: Listing of Personnel (pages 132-136)
 - [Mental Health/Substance Use Disorder Services Detail](#)

Financial Costs

Table 8A

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)
<ul style="list-style-type: none"> Medical Dental Mental Health Substance Use Disorder Pharmacy & Pharmaceuticals Other Professional Vision Enabling Other Related Services Admin Facility 	<ul style="list-style-type: none"> Report accrued direct costs Include costs of: <ul style="list-style-type: none"> Staff Fringe benefits Supplies Equipment Depreciation Related travel Exclude bad debt 	<ul style="list-style-type: none"> Allocate to all other cost centers (lines) Must equal Line 16, Column a 	<ul style="list-style-type: none"> Sum of Columns a + b (done automatically in EHBs) Represents cost to operate service Used to calculate cost per visit and cost per patient

Tables 5 and 8A Crosswalk

Table 5

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	.25	12		
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians	1.0	13		
7	Other Specialty Physicians				
8	Total Physicians (Sum lines 1-7)	1.25	25		
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NP, PA, and CNMs (Sum lines 9a - 10)	.6	3		
11	Nurses	3.0			
12	Other Medical Personnel				
13	Laboratory Personnel	1.0			
14	X-Ray Personnel				
15	Total Medical (Sum lines 8+10a through 14)	5.85	28		10
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Sum lines 16-18)		9		5
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Sum lines 20a-c)				

Table 8A

	Cost Center
	Financial Costs of Medical Care
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	Total Medical Care Services (Sum Lines 1- 3)
	Financial Costs of Other Clinical Services
5	Dental
6	Mental Health
7	Substance Use Disorder
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: _____)
9a	Vision
10	Total Other Clinical Services (Sum Lines 5 through 9a)

Financial Costs

Table 8A

Report costs by cost center

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

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



Column a, Lines 14-19

Table 8A

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

Line Facility and Non-Clinical Support Services and Totals	
14	Facility
15	Non-Clinical Support Services
16	Total Facility and Non-Clinical Support Services (Sum Lines 14 and 15)
17	Total Accrued Costs (Sum Lines 4 + 10 + 13 + 16)
18	Value of Donated Facilities, Services, and Supplies (specify: _____)
19	Total with Donations (Sum Lines 17 and 18)

- **Line 16:** Total indirect costs to be allocated in Column b

Allocating Overhead Expenses to Column b

Table 8A

Facility (Line 14)

- Identify **square footage** utilized by each cost center and cost per square foot
- Distribute square footage costs to each cost center

Non-Clinical Support (Line 15)

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



Reporting Donations

- **Table 8A, Line 18: “In-kind” services; donated facilities, supplies, and pharmaceuticals; and volunteer hours**
 - Value pharmaceuticals at 340B pricing
 - “In-kind” at imputed value
- **Cash donations are reported on Table 9E**

For more information, view [Reporting Donations](#) handout



Considerations When Reporting Cost-Related Data



Tables	Description
Table 5 Table 8A	Review large changes in productivity from the prior year.
Table 5 Table 8A	Check if there are mismatches between Tables 5 and 8A of costs that do not appear to be representative of staff FTE and visits.
Table 8A	Include in-kind donation values.

Group Discussion Activity – Worksheet 3, Section A

In your small groups, discuss the following three questions. You will have 10 minutes.

1. Who needs to be involved to report these data elements?
2. What data do you need from them to report successfully?
3. What do the data look like when you get them from your EHR?

Break

**Stretch, drink water, relax.
We will meet back here in 15 minutes.**

Income and Insurance

Table 4

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

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

Insurance Categories

Table 4

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

Line	Principal Third Party Medical Insurance
7	None/Uninsured
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	Total Medicaid (Line 8a + 8b)
9a	Dually Eligible (Medicare and Medicaid)
9	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)
10a	Other Public Insurance (Non-CHIP) (specify)
10b	Other Public Insurance CHIP
10	Total Public Insurance (Line 10a + 10b)
11	Private Insurance
12	TOTAL (Sum Lines 7 + 8 + 9 + 10 + 11)

Managed Care

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

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	Total Member Months (Sum Lines 13a + 13b)					

Managed Care Utilization

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

A member month = one member enrolled for 1 month

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

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

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

There is generally a relationship between:

Member months on Table 4

Example: 36,788 Medicaid member months $\div 12 = 3,066$

Insurance categories on Table 4

Example: 4,174 Medicaid patients

Managed care lines on Table 9D

Example: Medicaid net capitation $\$1,044,850 \div \text{member months } 36,788 = \28

Considerations When Reporting Income-Related Data



Table	Description
Table 4 Table 9D	Review the reporting if the percentage of patients with unknown income on Table 4 is high when compared to sliding fee discounts reported on Table 9D.
Table 4 Table 9D	Follow up with managed care contracts for enrollment data if missing for managed care contracts. Collect monthly enrollment for the full year.
Table 4	Understand the level of coverage for adults under CHIP when a large percentage of adults are reported on the CHIP line.

Patient-Related Revenue

Table 9D

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Receipts, Settlements, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation/ Wrap-Around Current Year (c1)	Collection of Reconciliation/Wrap- Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)			
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for- service)									
3	Total Medicaid (Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									

Report (columns)

- > (a) Charges (2019)
- > (b) Collections (**cash** basis)
- > (c1-c4) Supplemental payments
- > (d) Contractual allowances
- > (e) Self-pay sliding discounts
- > (f) Self-pay bad debt write-off

By Payer (rows)

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

By Form of Payment

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



Column (a): Full Charges

Table 9D

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

- **Full Charges:** Total billed charges across all services, reported by payer source
 - Undiscounted, unadjusted, gross charges for services
 - Based on fee schedule
 - Do not include:
 - “Charges” where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, or free vaccines)
 - Capitation or negotiated rate as charges
 - Charges for Medicare G-codes
- ✓ To learn more about [CMS payment codes](#) visit the CMS website

Column (b): Collections

Table 9D

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

- Include **all payments** received in 2019 for services to patients
 - Capitation payments
 - Contracted payments
 - Payments from patients
 - Third-party insurance
 - Retroactive settlements, receipts, and payments
 - ✓ Include pay for performance, quality bonuses, and other incentive payments
- Do not include “Promoting Interoperability” payments from Medicaid and Medicare here (report on Table 9E)

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

Table 9D

Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)			
	Collection of Reconciliation /Wrap-Around Current Year (c1)	Collection of Reconciliation /Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
<ul style="list-style-type: none"> Payments reported in c1–c4 are part of column (b) total, but do not equal column (b) 	<ul style="list-style-type: none"> Federally qualified health center (FQHC) prospective payment system (PPS) reconciliations (based on filing of cost report) 	<ul style="list-style-type: none"> Wrap-around payments (additional amount per visit to bring payment up to FQHC level) 	<ul style="list-style-type: none"> Managed care pool distributions Pay for performance (P4P) Other incentive payments Quality bonuses 	<ul style="list-style-type: none"> Paybacks or payer deductions by payers because of over payments (report as a positive number)



Column (d): Allowances

Table 9D

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

- **Allowances: Agreed-upon reductions/write-offs in payment by a third-party payer**
 - Reduce by amount of retroactive payments in (c1), (c2), and (c3)
 - + Add paybacks reported in c4
- **May result in a negative number**
- **For managed care capitated lines (2a, 5a, 8a, and 11a) *only*, allowances equal the difference between charges and collections (Column d = a – b)**

Column (e): Sliding Fee Discounts

Table 9D

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

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

Column (f): Bad Debt Write Off

Table 9D

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

- **Bad debt: owed by patients considered to be uncollectable and formally written off during 2019, regardless of when service was provided**
- **Only report **patient bad debt** (not third-party payer bad debt)**
 - Report on Line 13
 - Third-party payer bad debt is not reported in the UDS
- **Do not change bad debt to a sliding discount**
- **Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount)**

Table 9D Example

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

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

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

Table 9D Example

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

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

- Post service charge for private payer = \$200 at time of service
- Post payment of \$120 with a \$50 allowance on the private line when payment is received
- Reduce the initial charge of \$200 to private insurance by \$30—this is the co-pay owed by the patient
- Reclassify the \$30 co-pay to self-pay charges
- The patient was eligible for a \$10 sliding discount
- Of the amount patient was responsible for (\$20), patient paid \$10
- At end of year, \$10 remained uncollected, was considered bad debt, and was formally written off

Considerations When Reporting Patient Revenue Related Data



Table	Description
Table 9D	Investigate dollars reported if there are more in collections and write-offs than charges for self pay.
Table 9D	Verify that retroactive payments (c columns) are included in collections (column b) and subtracted from allowances (column d).
Table 9D	Verify large year-end balances owed by payer.
Table 9D	Adjust allowances to be contractual amount discounted between what is charged and what payer agrees to pay for services.

Group Discussion Activity – Worksheet 3, Section B

In your small groups, discuss the following three questions. You will have 10 minutes.

1. Who needs to be involved to report these data elements?
2. What data do you need from them to report successfully?
3. What do the data look like when you get them from your EHR?

Other Revenue

Table 9E

- Report **non-patient receipts** received or drawn down in 2019
 - **Cash basis** – amount drawn down (not award)
 - Include income that supported activities described in your scope of services
 - Report funds from the entity from which you received them
 - Complete “specify” fields
- Revenue reported on Tables 9E and 9D represent total income supporting scope of services

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS - 272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	Total Health Center (Sum Lines 1a through 1e)	
1k	Capital Development Grants, including School Based Health Center Capital Grants	
1	Total BHPC Grants (Sum Lines 1g + 1k)	
Other Federal Grants		
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify:____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5	Total Other Federal Grants (Sum Lines 2-3a)	
Non- Federal Grants Or Contracts		
6	State Government Grants and Contracts (specify:____)	
6a	State/Local Indigent Care Programs (specify:____)	
7	Local Government Grants and Contracts (specify:____)	
8	Foundation/Private Grants and Contracts (specify:____)	
9	Total Non-Federal Grants and Contracts (Sum Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:____)	
11	Total Revenue (Lines 1+5+9+10)	



Revenue Categories

- **BPHC Grants:** Funds you received directly from BPHC, including funds passed through to another agency
- **Other Federal Grants:** Grants you received directly from the federal government other than BPHC
 - Ryan White Part C
 - Other Federal grants (e.g., HUD, SAMHSA, CDC)
 - EHR Incentive Payments: Include Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule)

Line	Source
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)	
1a	Migrant Health Center
1b	Community Health Center
1c	Health Care for the Homeless
1e	Public Housing Primary Care
1g	Total Health Center (Sum Lines 1a through 1e)
1k	Capital Development Grants, including School Based Health Center Capital Grants
1	Total BPHC Grants (Sum Lines 1g + 1k)
Other Federal Grants	
2	Ryan White Part C HIV Early Intervention
3	Other Federal Grants (specify:____)
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers
5	Total Other Federal Grants (Sum Lines 2-3a)

Revenue Categories

- **State and Local Government:** Funds received from a state or local government, taxing district, or sovereign tribal entity (e.g., WIC)
- **State/Local Indigent Care Programs:** Funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue:** Miscellaneous non-patient-related revenues
 - Do not report bad debt recovery or 340B payments here – these revenues are reported on Table 9D

Line	Source
Non-Federal Grants Or Contracts	
6	State Government Grants and Contracts (specify:_____)
6a	State/Local Indigent Care Programs (specify:_____)
7	Local Government Grants and Contracts (specify:_____)
8	Foundation/Private Grants and Contracts (specify:_____)
9	Total Non-Federal Grants and Contracts (Sum Lines 6 + 6a + 7 + 8)
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:_____)
11	Total Revenue (Lines 1+5+9+10)



Resources to Support Financial and Operational Reporting

- [UDS Training Website](#)
 - Operational Costs and Revenue training module
 - [Reporting Donations guide](#)
 - [Financial Tables Guidance handout](#) (common error checks)
 - [Table 8A Fact Sheet](#)
 - [Table 9D Fact Sheet](#)
 - [Table 9E Fact Sheet](#)
- [Reporting UDS Financial and Operational Tables and Using Comparison Performance Metrics webinar](#)



Other Forms to Complete

Health Center Health Information Technology (HIT) Capabilities

Appendix D

- **Revised for 2019 reporting**
 - Questions specific to providing summaries of office visits, MU, and the use of HIT for enabling services were removed
 - Three questions were also added—one about utilization of HIT beyond patient care, data collection on social risk factors, and standardized screeners for social risk factors
- **Questions about health center's implementation of EHR, certification of systems, and how widely adopted the system is**
- **Advancing Health Information Technology (HIT) for Quality Awards recognized health centers that utilized five HIT services and/or telehealth services to increase access to care and advance quality of care between 2017 and 2018**
- **For clinical measure reporting, the use of a certified EHR fully installed at all sites and used by all providers is critical for accuracy**
- **The use of EHRs to report on all CQMs provides opportunity to be recognized as part of a Quality Improvement Award**



Other Data Elements

Appendix E

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

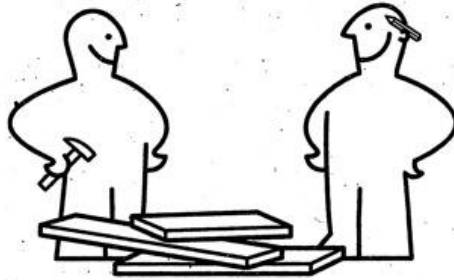
Workforce Form

Appendix F

- New for 2019 reporting
- Helps clarify current state of health center workforce training and staffing models
- Topics include:
 - Professional education/training
 - Satisfaction surveys

Tips for Success

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



- **Adhere to definitions and instructions**
- **Check your data before submitting**
 - Refer to last year's reviewer's letter emailed to the UDS Contact
 - Compare with benchmarks/trends
 - Review the Comparison Tool
- **Address edits in EHBs by correcting or providing explanations that demonstrate your understanding**
- **Work with your reviewer**
- **View the [Strategies for Successful Reporting Webinar](#)**

Administering Program Conditions

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

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

Source: [*Chapter 18: Program Monitoring and Data Reporting Systems of the Health Center Compliance Manual*](#)

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

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



Proposed Changes for 2020 UDS Reporting

The Program Assistance Letter (PAL) 2019-05

Join us for a webinar on the 2020 changes in Spring 2020

PAL 2020 Highlights:

1. Update quality of care measures to align with the eCQMs: Tables 6B and 7
2. Retiring the Asthma Measure: Use of Appropriate Medications for Asthma
3. Replacing the Dental Sealants for Children between 6-9 years measure (CMS277) with Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists Measure (CMS74V9)
4. Adding the Depression Remission at Twelve Months Measure (CMS159V8)
5. Revising the HIV Linkage to Care Measure (No ECQM)
6. Adding the HIV Screening Measure (CMS349V2)
7. Adding Data on Prescriptions for Pre-Exposure Prophylaxis (PREP)
8. Adding International Classification of Diseases (ICD)-10 Codes to Capture Human Trafficking and Intimate Partner Violence (IPV)
9. Adding Diabetes: Eye Exam (CMS131V8), Diabetes: Foot Exam (CMS123V7), and Diabetes: Medical Attention to Nephropathy (CMS134V8)
10. Adding the Breast Cancer Screening Measure (CMS125V8)
11. Adding a Question to Appendix D: Health Center Health Information Technology (HIT) Capabilities
12. Revising Questions in Appendix D: Health Center Health Information Technology (HIT) Capabilities





Please Complete an Evaluation!

Your input is important to us



Contact Information

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

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net





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