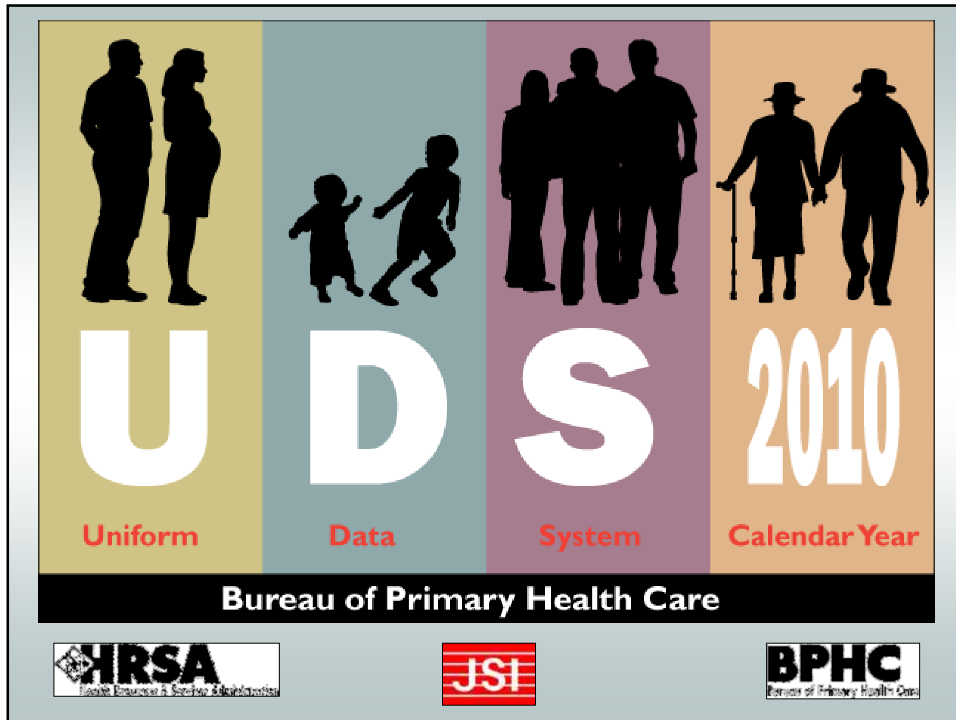
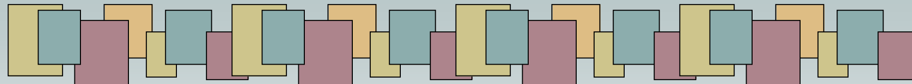


Reference Materials

- Today’s agenda
- Copy of the presentation slides
- 2010 UDS Manual, Tables, Fact Sheets
- PAL and Summary of UDS Changes
- 2009 National Roll-up

Objectives

- The 2010 UDS training is designed to ensure that participants will know:
  - Why the UDS is important
  - What has changed since the 2009 UDS
  - Critical dates in the UDS process
  - How to accurately complete and submit your UDS Report
  - What assistance is available to help you



Introduction to the UDS

What is the UDS and why is it important?

The UDS: What is it?

- The Uniform Data System (UDS) collects standardized information about BPHC funded grantees and programs including:
  - Community Health Centers
  - Migrant/Farmworker Health Centers
  - Health Care for the Homeless Centers
  - Public Housing Primary Care Centers
- Data are consistent from year to year and from grantee to grantee

What is included:

- Number of the patients served and their socio-demographic characteristics
- Types and quantities of services provided
- Types of staff who provide these services
- Quality of care provided to patients
- Cost and efficiency of delivering services
- Sources and amounts of income

11 Tables

- Patient Profile
  - Patients by Zip Code
  - Table 3A – Patients by Age and Gender
  - Table 3B – Patients by Race/Ethnicity/Language
  - Table 4 – Other Patient Characteristics
    - Income, insurance, special populations
- Provider and Utilization Profile
  - Table 5 – Staffing and Utilization
    - FTEs, visits, and patients

Tables – continued

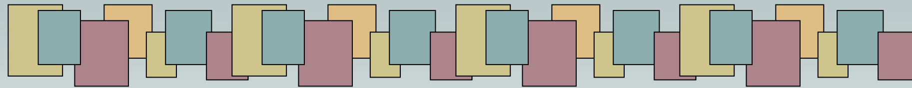
- Clinical Profile
  - Table 6A – Selected Diagnoses and Services
  - Table 6B – “Quality of Care” Indicators
  - Table 7 – Health Outcomes and Disparities
- Financial Profile
  - Table 8A – Costs
    - Accrued costs by cost center
  - Table 9D – Income from patient services
    - Charges, collections, allowances, and discounts by payor type
  - Table 9E – Other revenues
    - Grants, contracts, and other income not generated by patient services

Importance of the UDS

- The BPHC has been collecting health center performance data since 1977
- Data are used to:
  - Document effectiveness of the BPHC programs
  - Guide BPHC support decisions
  - Support program development and improvement at the grantee level
    - Document performance in SAC and BPR
- Besides HRSA and BPHC, data are used by:
  - OMB, Congress, PCAs, Researchers

Getting Help

- Collecting and reviewing UDS data is a year-round process
- Help and information is available through multiple mechanisms including:
  - These training programs
  - Technical support to review submission
  - On line training modules
  - An annually revised UDS Manual
  - A telephone help line (866-UDS-HELP)
  - E-mail help:(udshelp330@bphcdata.net)
  - EHB Support
    - HRSA Call Center 877-464-4772
    - BPHC Help Desk 301-443-7356



Getting Started:

Who needs to report, how and when?

Reporting Requirements

- **Who**: All grantees funded before October 1, 2010 (including New Starts) with one or more BPHC grants (CHC, MHC, HCH, PH)
- **When**: Grantees submit initial UDS no later than February 15th. Final submission is by March 31st
- **How**: UDS data are submitted through the HRSA "Electronic Handbook" (EHB)
- **What**: "Scope of Project" for the period January 1, 2010 - December 31, 2010
  - *Includes* all ARRA NAP,IDS, CIP and FIP support
  - Includes any approved change of scope

Tables to Submit

- Everyone submits the 11 basic tables included in the "Universal Report"
- *Only* the Universal Report is filed by agencies supported by only one BPHC funding authority
- Grant Reports are filed by agencies with multiple BPHC funding streams (CHC, HCH, MFW, PHPC.) These reports:
  - include only Tables 3A, 3B, 4, 5 and 6A
  - cover only those patients served in special populations programs - not their CHC
- Some parts of some tables may be left blank based on individual grantee characteristics

Data Submission and Review

- EHB opens to grantees on January 1, 2011
- Grantees may request assistance from the help line or their Reviewer from 1/1 through the final submission.
- *Initial* submission must be completed ***by February 15th***
- Upon receipt, Reviewer will go through the report to identify any issues and request corrections as appropriate.
- All corrections *must* be completed and revisions submitted ***by March 31***.

?? Questions ??

- What is the due date for your UDS data?
  - January 1, 2011
  - February 15, 2011
  - March 31, 2011
  - June 30, 2011

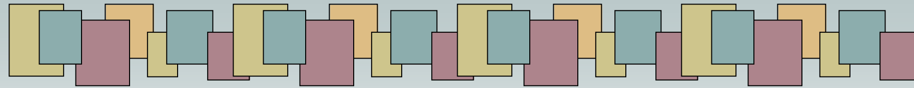


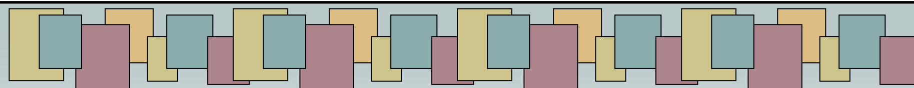
Table by Table Instructions

What is reported in each table:

Overview of Table Instructions

Each table will be reviewed. We will explain:

- Definitions used on that and following tables
- Step-by-step instructions for table completion
  - Reference Manual and Quick Fact Sheets
- Cross Table Issues
  - Tables are interrelated – they cannot be completed *accurately* without cross checking
- How the data are / can be used
  - By grantees for program improvement
  - By BPHC



Patient Profile: Patients by Zip Code and Tables 3A, 3B and 4

Characteristics of patients including zip-code, age and gender, race and ethnicity, language, income, insurance and membership in special populations

Definitions

- ***Total*** Patients: Individuals who receive one or more UDS reported visit (more on visits on Table 5!) *during the reporting year*.
  - They are all called "patients" in the UDS
  - Patient counts are *always* unduplicated whenever they are called for. In each part of the UDS patients are counted *once and only once* regardless of *volume* (the number of times he received services) or *scope* (the number of types of services received)
- ***Grant Program*** Patients: Individual who receive one or more documented visit supported by one of the special population grant programs (Homeless, Farm Worker, and/or Public Housing)

Contact / Patients by Zip Code

- Contact information: Note, incorrect data may prevent you from getting critical information!
- Report number of patients by zip code for all patients

Additional instructions for Special Populations:

Homeless – use zip code of location where patient receives services *if no better data exist*

Migrant – use zip code of the temporary housing they occupy when patient is in the area

Report all zip codes with more than 10 patients

Combine the rest as "other zip codes"

Table 3A: Patients by Age & Gender

- Report all patients who had *any* type of encounter reported on Table 5 during 2010
- Age is calculated as of June 30
- Count each patient once and only once!
- Total on line 39 *must* = total by zip code.

	Age Groups	Male Patients (a)	Female Patients (b)
Number of Patients			
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Age 85 and over		
39	Total Patients (Sum Lines 1-38)		

Table 3B: Race

- Patients self select race; if not reported use line 7
- Use line 6 *only* if patient actually selected two or more races
  - *Do not* use line 6 for Latino + some racial identity

TABLE 3B – PATIENTS BY HISPANIC/LATINO IDENTITY AND RACE

	Patients by Race	Patients by Hispanic or Latino Identity			
		Hispanic/Latino (a)	Not Hispanic/Latino (b)	Unreported/Refused to Report (c)	Total (d)
Number of Patients					
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	Total Hawaiian/Pacific Islander (Sum Lines 2a + 2b)				
3.	Black / African American				
4.	American Indian / Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported / Refused to report				
8.	Total Patients (Sum Lines 1+2 + 3 to 7)				

- If you have *neither* race *nor* Latino identity data report patient on line 7 col c
- Total patients on Line 8 equals patients on Table 3A Line 39 Columns (a) and (b)

39	Total Patients (Sum Lines 1-38)		

Table 3B: Hispanic/Latino Identity

- Patients self report their Hispanic/Latino identity
- Includes all persons who identify with the cultures of the Spanish speaking world
  - *Excludes* Haiti, Portugal, Brazil
- If patient does not indicate "Latino" or "Hispanic" or some other term which is part of the "Hispanic / Latino" population *they are assumed to be non-Hispanic / Latino* and counted in column B.

Table 3B: Patients by Language

- Report all patients who would best be served in a language other than English including:
  - Bilingual persons not fluent in medical English
  - Persons who are served by a bilingual provider
  - Persons who receive interpretation services
  - Persons using sign language
  - Persons in Puerto Rico or the Pacific where a language other than English is used
- This is the only UDS cell that may be estimated!!

PATIENTS BY LANGUAGE		NUMBER (a)
NUMBER OF PATIENTS		
12.	PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH	

?? Questions ??

- Patients who do not indicate that they are Hispanic or Latino are assumed to be Non-Hispanic/Latino for purposes of reporting on the UDS.
  - True
  - False

Table 4: Patients by Income

TABLE 4 – SELECTED PATIENT CHARACTERISTICS

	Characteristic	Number Of Patients (a)
Income As Percent Of Poverty Level		
1.	100% and below	
2.	101 – 150%	
3.	151 – 200%	
4.	Over 200%	
5.	Unknown	
6.	Total (Sum Lines 1 – 5)	

- Use most recent income data
  - Income *may* be self-reported if permitted by your policy
- Income *must* be based on recent data (last year) from patient – otherwise report as unknown
- Total Patients on Line 6 equals Table 3A Line 39 Columns (a) and (b)

Table 4: Patients by Insurance

	Principal Third Party Medical Insurance Source	0-19 Years Old (a)	20 and Older (b)
7.	None/ Uninsured		
8a.	Regular Medicaid (Title XIX)		
8b.	S-CHIP Medicaid		
8.	**Total Medicaid (Line 8a + 8b)**		
9.	**Medicare** (Title XVIII)		
10a.	Other Public Insurance Non-S-CHIP (specify:)		
10b.	Other Public Insurance S-CHIP		
10.	**Total Public Insurance (Line 10a + 10b)**		
11.	**Private Insurance**		
12.	**Total (Sum Lines 7 + 8 + 9 +10 +11)**		

- Report principal 3rd party payor for medical care (*even if patient is not a medical patient*)
- Insurance is reported as of the last visit
  - Even if it did not pay for the visit in whole or in part
- Total Patients on Line 6 equals Table 3A Line 39 Columns (a) and (b)

Table 4: Insurance

- *Count as insured* patients covered by payors such as Medicaid, Medicare, Blue Cross, etc. which *"belong" to the patient*
- *Do not count as insurance* programs such as family planning, breast and cervical cancer, immunization grants, TB control and most state and local safety net programs which "*belong" to the clinic* – the patient may not take the benefit elsewhere.
  - These patients are often uninsured
- Workers Comp is *not* medical insurance
- CHIP-RA is handled differently in each state:
  - CHIP-RA provided through Medicaid is reported on Line 8b
  - CHIP-RA provided through a commercial carrier is reported on Line 10b

?? *Questions* ??

- If a patient receives dental services only, you should report them on the UDS based on their dental insurance coverage.
  - True
  - False

?? *Questions* ??

- In reporting patients by primary medical insurance, which of the following are appropriate types of medical insurance to document insurance coverage?
  - Worker's Compensation
  - Medicaid
  - Medicare
  - Aetna
  - SCHIP
  - Delta Dental
  - Breast and Cervical Cancer Control

Table 4: Managed Care Utilization

Managed Care Utilization		Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid S-CHIP (c)	Private (d)	Total (e)
Payor Category						
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**Total Member months (13a + 13b)**					

- These lines are completed ONLY by health centers with capitated and/or FFS ***managed care (HMO) contracts.*** *Do not* count PCCM patients
- A member month is defined as 1 member (patient) enrolled for 1 month. Total member months = sum of the monthly enrollments for 12 months
- Member month information should be obtained from monthly enrollment lists supplied by managed care companies to their providers
- In some cases, members might not be patients

Table 4: Target Populations

Characteristics – Special Populations			Number Of Patients -- (a)
14.	Migrant	(330g grantees only)	
15.	Seasonal	(330g grantees only)	
16.	Total Migrant/Seasonal Agricultural Worker or Dependent (All Grantees Report This Line)		
17.	Homeless Shelter	(330h grantees only)	
18.	Transitional	(330h grantees only)	
19.	Doubling Up	(330h grantees only)	
20.	Street	(330h grantees only)	
21.	Other	(330h grantees only)	
22.	Unknown	(330h grantees only)	
23.	Total Homeless (All Grantees Report This Line)		
24.	Total School Based Health Center (All Grantees Report)		
25.	Total Veterans (All Grantees Report This Line)		

All grantees must report total number of targeted patients (if any) on Lines 16, 23, 24 and 25.

- Grantees who receive Special Populations funding must report additional information:
  - 330(g) MHC Grantees report migrant and seasonal farmworkers separately
  - 330(h) HCH Grantees - report patient’s shelter arrangement at the time of first visit in 2010 (where they were housed the prior night)
- A veteran is an individual who completed service in the Uniformed Services of the United States

Table 4: Farmworker Defined

- A farmworker is an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and/or their dependents.
  - “Migrants” establish temporary housing
  - “Seasonals” do not
- Agriculture means farming, including
  - Cultivation and tillage of the soil
  - The production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in, or on, the land; and
  - Any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with the above

Table 4: Homeless Defined

- A homeless patient is any person known to be homeless at the time of any service provided during the reporting year or who is housed but eligible because of being a homeless patient within 12 months
- Shelter arrangements (at first visit):
  - “Street” includes living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed “ fit for human occupancy”
  - Persons who spent the prior night incarcerated, in an institutional treatment program (mental health, substance abuse, etc.) in a hospital or in jail should be reported based on where they intend to spend the night after their encounter/release. If they do not know, code as “street”.
  - “Doubled up” must be temporary and unstable

Cross Table Issues

- Patients by zip code, and those reported on Tables 3A, 3B and 4 describe the *same patients.* The totals on each of these tables ***must*** be equal.
- If you submit grant tables, the total number of patients reported on the grant table must be less than or equal to the corresponding number on the universal table for each and every cell!

Analysis: Use of Data

- Patients by Zip Code: UDS Mapper shows patients by service area and identifies potential overlaps
- Patient Profile: Documents health center service to the target populations including low income, uninsured, minorities, and others with barriers to access
- Denominators for other measures:
  - Cost, charges, income, etc. per patient
    - Or per Medicare patient, Medicaid patient, etc.
    - Or per medical patient, dental patient, etc.
  - Average capitation per member month

?? Question ??

- 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 patients differently

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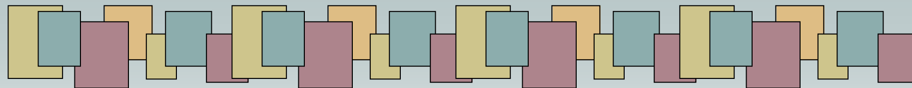


Table 5
Staffing and Utilization

Staff FTEs, patient visits
and patients by service

Changes for 2010

- Vision services
  - FTEs are broken down between:
    - Ophthalmologists (MD – they – are physicians)
    - Optometrists (OD – they are *not* physicians)
    - Optometric assistants (they do not provide visits)

22	**Other Professional Services (specify___)**			
22a	Ophthalmologist			
22b	Optometrist			
22c	Optometric Assistant			
22d	**Total Vision Services (Lines 22a-c)**			

  - Ophthalmology was previously included on line 7

7	Other Specialty Physicians			

  - Optometry was previously included on line 22

Table 5: Staffing & Utilization

- Col (a) – Staff full-time equivalents (FTEs) reported by position
- Col (b) – Clinic visits reported by provider type
- Col (c) – Patients reported by service type including a *new service type.*

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 – 7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total "Mid-Levels" (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			
18	Dental Assistants, Aides, Techs			
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	**Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologist			
22b	Optometrist			
22c	Optometric Assistant			
22d	**Total Vision Services (Lines 22a-c)**			
23	**Pharmacy Personnel**			
24	Case Managers			
25	Patient / Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify___)			
29	**Total Enabling Services (Lines 24-28)**			
29a	**Other Programs / Services (specify___)**			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
30	**Total Administrative Staff (Lines 30a-30c)**			
31	Facility Staff			
32	Patient Support Staff			
33	**Total Admin & Facility (Lines 30 – 32)**			
34	**Total Lines 15+19+20+21+22+23+29+29a+33)**			

Col (a): FTEs Defined

- 1.0 FTE is equal to the equivalent of one person working full-time for one year
- Each agency defines the number of paid hours it considers to be “full-time” work
  - (e.g., if a physician is hired full-time and works 36 hours per week, she is 1.0 FTE)
- FTEs are based on employment contracts for clinicians and exempt employees; FTE is calculated based on paid hours for non-exempt employees (e.g., 2080 hrs/yr, 1872 hrs/yr, etc.)
- FTEs are adjusted for part-time work or for part-year employment

Col (a): FTEs Reported

- Report FTEs on lines corresponding with *work performed,* not job title
- Include as FTEs:
  - Employees
  - Contract personnel (not paid by unit of service)
  - *Volunteers* based on hours worked
  - *Residents* based on hours worked
- Do not reduce clinical FTEs for vacation, CME, meetings, holidays, etc.
- Do not allocate a portion of MDs’ and midlevel practitioners’ time to non-clinical functions

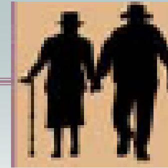
?? Questions ??

- A full-time equivalent (FTE) is calculated by dividing worked hours by total full-time hours as defined by the health center
  - True
  - False
- FTEs for which type of physician are not included on the Total Physician line?

?? Questions ??

- Which of the following should 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

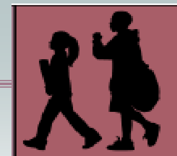
Col (b): Visits Defined



A UDS visit …

- **<u>Must</u>** be face to face between the patient and the provider
  - (The ***<u>only</u>*** exception is for behavioral health telemedicine sessions)
- Medical / dental providers ***<u>must</u>*** be licensed
  - Mental health may be licensed or unlicensed
  - All others are credentialed by the center
- The provider **must** be acting independently
- The provider **must** be exercising *<u>professional</u>* judgment
  - Not all *interactions* require professional judgment
- The service must be charted

Col (b): Visits Reported



- Report visits on the line for the staff providing the service
  - Medical visits are provided by physicians, mid-level practitioners and licensed nurses *<u>only</u>*
  - Dental visits are provided by dentists and dental hygienists *<u>only</u>*
- Include Visits:
  - Provided by *both* paid *and* volunteer staff
  - Provided by a third party and *<u>paid for in full</u>* by grantee, including managed care referrals or voucher program encounters.
  - When staff see hospitalized patients

Col (b): Visits Reported

- Only one visit per patient (user), per <u>provider type,</u> per day may be counted
  - One medical
  - One dental
  - One mental health
  - One substance abuse
  - One of each type of enabling services (health education, case management)
  - One vision
  - One of each type of "other professional" service
- Exception: Two visits of the same type with two *different* providers at two *different* locations *may* both be counted
- (NOTE: This UDS rule is not consistent with the rules of *each and every* third party payor)

Col (b):Visits per Provider

- A provider counts only one visit with a patient during the day regardless of the number of services provided to that patient
  - A pediatrician providing fluoride drops during a medical visit cannot count a dental visit
  - Case managers frequently provide case management and health education – but there is just one visit
  - Dentists may count only one visit, regardless of the number of teeth worked on

Col (b) Visits: Interactions that are not visits

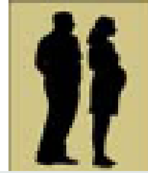
- "Group visits"
  - Only mental health group counseling visits may be counted – if and only if it is charted in each patient's chart and each patient is charged
  - No medical group visits may be counted even if billed
  - Group health education interactions are not counted
- Other uncounted interactions:
  - Health education classes
  - Community meetings
  - Health fairs or mass screenings
  - "Immunization clinics" or "immunization only" services
  - Lab tests or "lab only" visits, x-rays or x-ray only visits
  - Pharmacy visits, refills, "Clinical Pharmacist" services
  - Outreach which provides only information on services

Col (c) "Patients" Defined

- **Service** Patient: An individual who receives one or more documented "visit" of any specific service type:
  - – Medical – Dental
  - – Mental Health – Substance Abuse
  - – Other Professional – Vision

(and perinatal which are reported on Table 6B)

Col (c): Patients Reported



- A patient should be counted *once and only once* in *each* category in which they receive services
  - Thus, the same individual *must!* be counted as both a medical patient and a dental patient if they used both services
  - But they would be counted only once in any given category regardless of the number of visits they had
- The total of any combination of patient categories *should not* equal total patients on Tables 3A and 4 unless only one type of service is offered!

Table 5 - Grant Tables

- Table 5 *Grant Reports* will include *only* visits by type (column b) and patients by service (column c)
  - FTEs are not reported on the grant report
  - All activities for grant report patients (those patients reported on Grant Tables 3A, 3B, and 4) are included on the Table 5 grant report, regardless of funding sources
    - e.g., a dental visit for a Public Housing patient is included on the public housing Grant Table, even if another source, such as Medicaid, paid for the visit

Cross Table Issues

- Tables 5 and 8A: Staff (FTEs) reported on Table 5 must be included in the same cost center on Tables 8A.
- Tables 5 and 9D: Billable visits reported on 5 should relate to patient charges reported on 9D
- Visits and patients reported in any cell of the grant tables cannot exceed the number reported on the universal table

Analysis: Use of Data

- Staffing Ratios: FTEs are used to calculate ratio of staff to FTE provider
- Provider Productivity by provider type:
  - Visits per provider FTE
- Continuity of Care: Visits per patient
- Performance cost / charge measures:
  - Service cost per service patient
  - Service cost per service visit
  - Charges per visit
  - Collections per visit
  - Average costs per FTE by type

?? Question ??

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

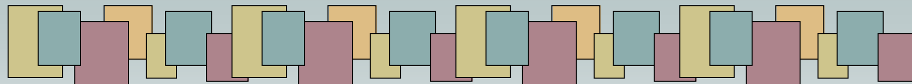


Table 8A Financial Costs

Costs by cost center

Table 8A – Financial Costs

TABLE 8A – FINANCIAL COSTS

		Accrued Cost (a)	Allocation of Facility and Administration (b)	Total Cost After Allocation of Facility and Administration (c)
Financial Costs for Medical Care				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 through 3)			
Financial Costs for Other Clinical Services				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify ____________)			
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9)			
Financial Costs of Enabling and Other Program Related Services				
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11f.	Interpretation Services			
11g.	Other Enabling Services (specify: ____________)			
11.	Total Enabling Services Cost (Sum lines 11a through 11g)			
12.	Other Related Services (specify: ________________)			
13.	**TOTAL ENABLING AND OTHER SERVICES** (Sum Lines 11 and 12)			
Overhead and Totals				
14.	Facility			
15.	Administration			
16.	**TOTAL OVERHEAD** (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)			

- Col (a) Accrued Costs:
  - Direct costs (*only!)*
  - Report donated ("in-kind") costs on line 18 <u>*only*</u>
  - *Exclude* bad debt
  - Include depreciation
- Col (b) Allocation of Facility and Admin:
  - Allocate indirect costs from Line 16 to cost centers
- Col (c) Total Cost:
  - Sum of direct and indirect expenses

Table 8A - Lines 1 - 10

- Medical Care Costs:
  - Line 1 Medical staff salaries and benefits including staff on contract and contracted visits
    - Excludes ophthalmologists and psychiatrists
  - Line 2: All *medical (not* dental!) lab and x-ray costs including supplies, etc.
  - Line 3: All other direct medical costs: dues, supplies, depreciation, travel, CME, EHR, etc.
- Other Clinical Services Costs:
  - Lines 5, 6, 7 and 9 Include all personnel (hired or contracted) and "other" direct expenses
    - Psychiatry on line 6
    - Vision care on line 9

Table 8A - Lines 8a/8b Pharmacy

- Pharmacy costs are divided:
  - Line 8b = cost of pharmaceuticals *only*.
  - Line 8a = all other costs including MIS, staff, equipment, non-pharmaceutical supplies, etc.
  - If you cannot separate non-drug cost from total cost (contract or pre-pack arrangements), report all costs on line 8b – "pharmaceuticals"
  - All overhead is reported on line 8a

8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			

  - Note: *do not include donated pharmaceuticals on either line!* This is shown on line 18

18.	Value of Donated Facilities, Services and Supplies (specify: ____________________)

Table 8A - Lines 11a -13

- Line 11: Enabling (total):
  - Detail on Lines 11a-11g include all staff and contract personnel as well as all other related direct expenses for enabling services.

11a.	Case Management
11b.	Transportation
11c.	Outreach
11d.	Patient and Community Education
11e.	Eligibility Assistance
11 f.	Interpretation Services
11g.	Other Enabling Services (specify: __
11.	Total Enabling Services Cost (Sum lines 11a through 11g)

- Other Program Related:
  - Line 12 includes all staff and contract personnel as well as other related direct expenses for non-health-care services such as:
    - WIC
    - Job training
    - Housing Corporations
    - Home-maker chore
  - Include here any "pass through" funds

Table 8A - Lines 14 –16 Overhead

Overhead and Totals		
14.	Facility	
15.	Administration	

- Line 14: Facility costs include rent or depreciation, interest payments, utilities, security, janitorial services, maintenance, etc.
  - No CIP or FIP costs, but include appropriate depreciation
- Line 15: Administrative costs include costs for *corporate* admin staff, billing and collections staff, medical records and intake staff as well as all associated costs including supplies, equipment, depreciation, travel, etc.

Table 8A – Financial Costs

The cost of staff reported On Table 5:	Are reported on Table 8A:
Lines 1-12 Medical (MD, ML, nurses, etc)	Line 1
Lines 13-14 Lab and X-ray	Line 2
Lines 16-19 Dental	Line 5
Lines 20a-20 Mental Health	Line 6
Line 21 Substance Abuse	Line 7
Line 22 Other Professional (podiatry, nutrition, PT, etc.)	Line 9
Line 22a – Vision Services	Line 9
Line 23 Pharmacy	Line 8a
Line 24-29 Enabling	Line 11a-11g
Line 29a Other Programs/ Services (WIC and other non-health care programs)	Line 12
Line 30a-c, 30, 32 Admin, Patient Support	Line 15
Line 31 Facility	Line 14

- Include direct costs for each cost center consistent with FTEs reported on Table 5 (except vision)

Allocation of Overhead

- Overhead costs on Line 16 (facility and administration) are allocated to cost centers in Col (b)
- Traditional methods are described in manual but are not necessarily the best or most accurate way of doing the allocation
- *More accurate* alternative methods – especially for administrative costs – should be used whenever possible

Allocation of Overhead - Facility

- Traditional method:
  - Facilities costs are allocated based on proportion of square footage utilized by each cost center
- Common modifications:
  - Allocate each building separately.
  - Dedicated buildings (admin, dental clinic, etc.) have full costs allocated directly
  - Improvements of a specific cost center (e.g., converting storage to exam rooms) are allocated to that specific cost center

Allocation of Overhead - Admin

- Traditional method:
  - Administrative costs, including admin share of facility costs, are allocated based on a straight line method, using the proportion of total costs excluding overhead attributable to the service category
- Common modifications:
  - Medical records allocated only to medical or to medical + dental + behavioral health as appropriate (based on chart pulls??)

Allocation of Overhead - Admin

- Common modifications – continued:
  - Billing functions allocated to Medical + Dental + Behavioral as appropriate. (Based on charges? Codes entered?)
  - Minimal allocation to cost of pharmaceuticals
  - Minimal allocation to cost of “extra-mural contract services (e.g., contract dental visits)
  - Minimal or no allocation to depreciation elements (e.g., depreciation of expensive facility)

Cross Table Issues

- Table 5 and 8A:
  - Staff FTEs reported by service on Table 5 must be consistent with costs reported on Table 8A by cost center
    - For example, calculated cost per Case Management FTE reported on Table 5, using Case Management Costs on Table 8A, should make sense.
  - Cost by visit and by patients for service types reported on Table 5 compared to 8A
    - For example, medical cost per medical visit or dental cost per dental patient.

Data Analysis

- Total cost per total patient
- Average cost per service patient
  - Medical cost per medical patient, etc.
- Average cost per service visit
  - Medical cost per medical visit, etc.
- % overhead costs (admin and facility)
  - National: Facility = 7%; Admin = 25%

?? Questions ??

- Administrative costs include which of the following?
  - Corporate administrative staff
  - Billing and collections staff
  - Medical records and intake staff
  - Patient registration staff
  - IT staff
  - Accounting and legal expenses
  - Provider continuing education
  - Provider benefits
  - Electronic Health Record expenses

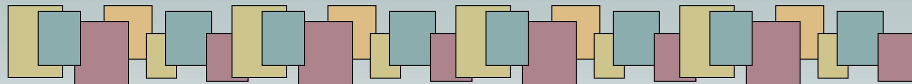


Table 9D: Patient Income

Charges, collections and allowances by payor

Table 9D – ***Charges*** Col (a)

TABLE 9D (Part I of II) –PATIENT RELATED REVENUE (Scope of Project Only)

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

- Undiscounted, unadjusted charges for services based on fee schedule; charges should cover costs
- Include all charges (i.e., medical, dental, pharmacy, mental health, etc.)
- Do not include "charges" where no collection is attempted or expected such as charges for enabling services, donated pharmaceuticals, or free vaccines

Table 9D – ***Collections*** Col (b)

- Amount collected as payment for *or related to* health care services:
  - Cash collections from patients
    - Including nominal fees
    - *Not* including "donations" (which are shown on Table 9E)
  - Payments from third party payors
    - Including all private insurance companies
    - Including public payors such as Medicaid, S-CHIP and Medicare
    - Including contract payments such as school nurse, vocational health, jails, etc.
  - All capitation payments
    - If capitations are not recorded in the receivables system, be sure to recover this number from the GL and enter it in Col (b) of Table 9D.
  - Wrap-arounds, reconciliations, risk pools etc.

Amount Collected This Period
(b)

Table 9D – Adjustments Col (c1-c4)

- These amounts are *also* included in col (b)
- Columns (c1) and (c2): payments for FQHC or CHIPRA settlements (difference between established per-visit rate and initial payments) and reconciliations (additional amounts based on a cost report)
- Col (c3) – "Other Retroactive Payments" including
  - risk pools / incentives / PFP: bonuses paid for successfully controlling utilization and/or for providing high quality care
  - withholds: amounts deducted from capitation for specific services and paid back if not spent
  - Court ordered payments

Table 9D – Allowances (Col d)

- Reductions in payment by a third party based on a contract
- Allowances *do not* include:
  - non-payment for services that are not covered by the third party
  - non-payment of bills which were submitted late, not properly signed, or otherwise not properly submitted (according to the 3rd party)
  - deductibles or co-payments that are due from the patient and not paid by a third party

Table 9D – Allowances

- Allowances in capitated programs
  - For capitated plans ***only***, the allowance is calculated as the difference between total charges and total collections unless there are early or late capitation payments. Thus: col d = (col a – col b)
- If FQHC payments are later made for some or all of these visits, reduce the allowance in Column d by the amount of FQHC adjustments

Sliding discounts Col (e)

- A reduction in the amount *charged* (paid or owed) for services rendered which
  - Is based solely on the patient's *documented* income and family size *at the time of service* as it relates to the federal poverty level
  - May be applied to insured patients' co-payments, deductibles and non-covered services when the charge has been moved to self pay if consistent with how uninsured patients are treated
  - May *not* be applied to past due amounts

Table 9D – Bad debt Col (f)

- Amounts considered to be uncollectable and *formally* written off during the current calendar year, regardless of when the service was provided
- Only self-pay bad debt is reported, not third party bad debt
- Bad debt is *never* reported as a “cost” on Table 8A.
- Bad debt can *never* be changed to a sliding discount

Table 9D – Payors -1

Payor Category	
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)
5b.	Medicare Managed Care (fee-for-service)
6.	Total Medicare (Lines 4 + 5a+ 5b)
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)

- Lines 1 - 3: <u>Medicaid</u> includes
  - All routine Medicaid under any name
  - EPSDT – under any name
  - Medicaid part of Medi-Medi or crossovers
  - CHIP, <u>*if paid through Medicaid*</u>
  - *In some states,* may also include fees for other state programs which are paid by the Medicaid intermediary
- Lines 4-6: <u>Medicare</u> includes
  - All routine Medicare
  - Medicare Advantage
  - Medicare portion of Medi-Medi or crossovers

Table 9D – Payors -2

- Lines 7-9: Other Public includes
  - State or other public insurance programs
  - *Non-Medicaid* CHIP programs
  - State-based programs which cover a specific service or disease such as BCCCP, Title X, Title V, TB, etc.
  - Does not include indigent care programs
  - NOTE: Patients who benefit from services paid for by "other public payers" are not necessarily counted under "other public insurance" on Table 4!
- Lines 10-12: Private includes
  - Private and commercial insurance
  - Medi-gap programs, Tricare, Trigon, Workers Comp.
  - Contracts with schools, jails, head start, etc.

Table 9D – Payors -3

- Line 13: Self Pay includes
  - Charges for which patients are responsible and all associated collections including those for:
    - Full fee patients
    - Patients receiving sliding discounts
    - "nominal fee" or "zero-pay" patients
    - Co payments and/or deductibles
    - Services not otherwise covered by a patient's insurance
    - Services which form or will form the basis for state or local safety net (uncompensated care) funds
    - Dental patients who only have medical insurance

Table 9D – Reclassify Charges

- It is *essential* to reclassify rejected charges:
  - This includes co-payments and deductibles *as well as* charges for non-covered services which are rejected by third parties:
    - Deduct unpaid charges or portion of charge from original payor (Medicaid, Medicare, Private etc.)
    - Add to charges on line for the secondary (tertiary, etc) payor:
      - Line 1 for Medicaid cross-over, or line 10 (for MediGap or multiple policies) or Line 13 (for patient responsibility)
    - Show collections of these amounts on the appropriate line

Cross Table Issues

- Table 4 Lines 7-12 and 9D: Charges and collections by payor on Table 9D should tie to insurance enrollment on Table 4
- Table 4 Lines 13a-b and 9D: Managed care revenues on 9D must make sense in light of member months on Table 4
- Presumed billable visits reported on Table 5 are compared with charges on 9D (charge per visit national average = $183.)
- Table 8A and 9D: Ratio of charges to reimbursable costs (national = 119%)

Data Analysis

- Average charge per encounter
- Payor mix
- Charge to cost ratio

?? Questions ??

- Sliding discounts equal the difference between patient charges and the amount collected from patients.
  - True
  - False
- 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 part collections are overstated and self pay charges are understated

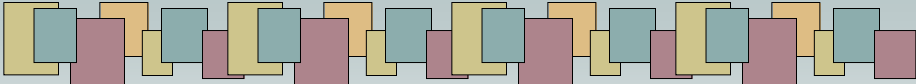


Table 9E Other Revenues

Non-patient-service income

Table 9E – Other Revenues

	Source	Amount (a)
	[illegible]	
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	Total Health Center Cluster (Sum Lines 1a through 1e)	
1j.	Capital Improvement Program Grants	
1.	Total BPHC Grants (Sum Lines 1g + 1j)	
	Other Federal Grants	
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify:________________)	
4.	American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS)	
4a.	American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investment Program (FIP)	
5.	Total Other Federal Grants (Sum Lines 2 – 4a)	
	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)	

- Reports on non patient-service income
- Cash basis – amount received during year
- Report "last party" to handle funds before you receive them
  - Federal dollars received through the state are reported as "state"
  - Grant passed through another health center is "private"

Table 9E – BPHC Grants

- Line 1: BPHC Grants
  - Report all funds received *directly* from BPHC regardless of their end use
  - Include funds received from BPHC and passed through to another agency:
    - If you count the users on Tables 3A, 3B, 4 and 5 and the staff and production on Table 5:
      - Show costs by type of Table 8A
    - If you report nothing else about the grant:
      - Show costs (usually, the same amount) as "other" on Table 8A Line 12

Table 9E – Other Revenues

- Line 3: Other Federal Grants
  - Grants received directly from Federal Government except BPHC
    - *Absolutely no BPHC funds* Except Black Lung and Radiation grants)
  - Do not report Ryan White Part A or Part B unless you are a governmental entity that receives them directly.
  - Do not report Ryan White Part C funds from another grantee.
  - Do not include IHS funds for compacted and contracted services
    - These are considered "safety net" (line 6A)
- Line 4 – 4a: ARRA – NAP, IDS, CIP and FIP
  - Report only your actual drawdowns for 2009
- Line 6: State Grants ~~ and ~~ Line 7: Local Grants
  - Non health service delivery grants (WIC, prevention, outreach, etc.)
  - Grants for health services which are not tied to service delivery
    - Includes grants that pay for line items rather than products
    - Are not "product sensitive" -- won't be reduced if you under-produce or be increased if you over-produce

Table 9E – Other Revenues

- Line 6a: Indigent Care Programs
  - State and local programs that pay for health care in general and are based on a current or prior level of service, though not on a specific fee for service
    - *May* be based on a pre-set "*per-visit*" fee
  - Full charges for these programs are reported on Table 9D as self-pay charges and everything not due from the patient is written off as a sliding discounts.
- Do not include state *insurance* plans

Table 9E – Other Revenues

- Line 8: Foundation / Private Grants
  - Funds received from foundations or private organizations (including funds received from another health center)
- Line 10: Other Revenues
  - Contributions, fund raising income, rents and sales, patient record fees, etc.

Revenues Not Reported on 9E

- Do not include value of donated services supplies or facilities
- Do not include capital received as a loan
- Do not include patient-related revenues (e.g., pharmacy, BCCCP, etc.)

Cross Table Issues

- Table 5 and 9E: Reporting of other related services including WIC
- Table 9D and 9E: Reporting of patient and non-patient related revenues
  - Sliding fee discount versus indigent care program funds

Data Analysis

- Table 9D and 9E: Total revenues and revenues per patient, provider FTE, etc.
- Table 9D and 9E versus 8A: Cash collections compared with costs as indicator of cash flow
- Table 9D and 9E: diversification of funding

?? Question ??

- Grants and contracts should be reported using the "last party rule" Select the example below that satisfies that rule.
  - Federal dollars received through the state are reported as "state"
  - Federal dollars passed through another health center are reported as "federal"

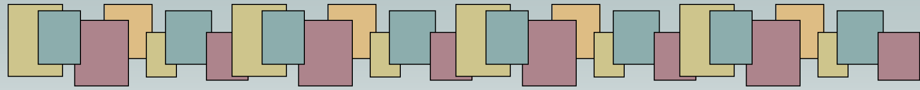


Table 6A
Selected Diagnoses and Services Rendered

Patients with or receiving, and encounters for, selected primary diagnoses and services

Changes for 2010

- **Services Rendered:** Add 3 new services
  - Line 21a: Hepatitis B test
  - Line 21b: Hepatitis C test
  - Line 26d: Comprehensive and intermediate eye exams
  - (Note – Line 24b: H1N1 flu vaccine is still listed to capture early 2010 service – will be removed next year)
- **Diagnoses:** Add 2, Change 2
  - Add line 4a: Hepatitis B
  - Add line 4b: Hepatitis C
  - Change line 1: HIV – Symptomatic *or Asymptomatic*
  - Delete line 2: Asymptomatic HIV

Table 6A: Diagnoses and Services

- Lines 1-20d *Selected* primary diagnoses
  - *Most* visits do not involve one of these diagnoses
  - Diagnoses which are usually not "primary" may appear under reported (e.g., SA and MH)
- Lines 21-34 Selected services
  - Use ICD-9 or CPT codes
- Col (a) – Visits
- Col (b) – Unduplicated number of patients with this primary diagnosis or having received this service

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Infectious and Parasitic Diseases				
1.	Symptomatic HIV, Asymptomatic HIV	042 , 079.53, V08		
2[u8].	~~Asymptomatic HIV~~	~~V08~~		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
4a.	Hepatitis B	ICD -9-CM Codes Needed		
4b.	Hepatitis C	ICD -9-CM Codes Needed		
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx – 492.xx		
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11.	Hypertension	401.xx – 405.xx;		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx – 992.xx		
14a.	Overweight and obesity	ICD-9 : 278.0 – 278.02 or V85.xx excluding V85.0, V85.1, V85.51 V85.52		
Selected Childhood Conditions				
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		

Table 6A

- When reporting *diagnoses*, (lines 1 – 20d) a visit may be counted on only one line, but multiple visits for this diagnosis may be reported each year.
- When reporting *services* Lines 21 through 26c, a visit is counted once for *each* countable service
  - For example, a visit might be reported on the pap test, mammogram and family planning service lines

Table 6A

- In the visit column, a visit is counted only once for any given service code even if multiple services are given (e.g. five vaccines or two fillings in one visit is counted only once)
- When reporting *patients*, each patient may be counted once and only once on each appropriate line on any given diagnoses or services line

Cross Table Issues

- Visits and patients reported in any cell of the grant tables cannot exceed the number reported on the universal table
- Tables 6A and 7: Comparison of universe of patients with hypertension and diabetes on T7 with number of patients with HTN or DM diagnosis on Table 6A

Analysis: Use of Data

- Average visits per year for selected chronic conditions (HTN, DM)
- Frequency of acute care services by service (well child immunizations)
- Penetration rate for routine preventive services (well child, family planning, Pap tests)

?? Question ??

- A patient who receives a pap test and a mammogram in a single visit can be counted on each of these services lines.
  - True
  - False
- Patients who are diabetic *and* hypertensive will be reported on both lines for a single visit.
  - True
  - False

Should you Report on Universe or a Sample?

Options for 6B and 7 Clinical Measures

Options for Reporting

- Options exist only for:
  - Childhood immunizations
  - Pap tests
  - Controlled hypertension
  - Controlled diabetes
- (Perinatal care measures must be universe)
- Report universe (may be less than 70 if there are fewer than 70 in the universe)
- or sample of 70
- There is no BPHC preference for reporting universe or sample

Reporting on the Universe

- Universe defined: All patients who meet the reporting criteria
- To report on the entire universe, the data source must:
  - Include all patients from all sites and programs (e.g., HCH, CHC, PH, MHC)
  - Include searchable fields with required clinical measures over the required time frame (e.g., 3 years)
  - Identify patients with “exclusions” to remove from universe
- (We will discuss sampling later)

?? Question ??

- If you are reporting on a sample for any measure, what is the accepted sample size?
  - 75
  - ½ of the total universe
  - 70
  - At least 10 per provider

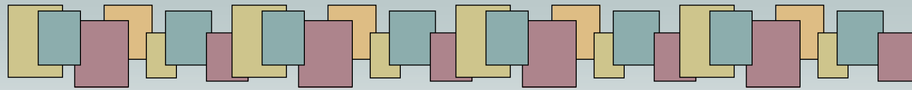


Table 6B
Quality of Care Indicators

Measures commonly seen as indicators of overall community health

Quality of Care Indicators

- **These are all "process measures":** *If* patients receive timely routine and preventive care, *then* we can expect improved health
  - **Early entry into prenatal care:** *If* women enter care in their first trimester *then* the probability of adverse birth outcome will be reduced
  - **Childhood immunizations:** *If* children receive their vaccinations in a timely fashion *then* they will be less likely to contract vaccine preventable diseases or to suffer from the sequela of these diseases
  - **Pap tests:** *If* women receive Pap tests as recommended *then* they can be treated earlier and will be less likely to suffer adverse outcomes from HPV and cervical cancer

Early Entry into Prenatal Care

TABLE 6B – QUALITY OF CARE INDICATORS

(No prenatal care provided? Check here: ☐)		
Section A: Age Categories for Prenatal Patients (Grantees who provide prenatal care only)		
Demographic Characteristics of Prenatal Care Patients		
	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	
5	Ages 45 and over	
6	Total Patients (Sum lines 1 – 5)	

Section A is *ONLY* completed by grantees with Prenatal Programs.

- Section A: Prenatal patients by age
  - Report all patients who received prenatal care during the year, regardless of whether they delivered, including women whose only service *in 2010* was their delivery
  - Include women who transferred or were "risked out", as well as women who were delivered by another provider
  - Do not include patients who may have had tests, vitamins, assessments or education but did not have their initial clinical visit with the obstetrical provider

Early Entry into Prenatal Care

Section B – Trimester of Entry Into Prenatal Care			
Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year		Women Having First Visit with Grantee (a)	Women Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Section B is *ONLY* completed by grantees with Prenatal Programs.

- Section B: Trimester of entry into prenatal care
  - For ***all*** prenatal patients reported in Section A, indicate what trimester they began care and whether it was with the health center or another provider
  - "Entry into prenatal care" is recorded as when the patient has had a visit with a physician or midlevel provider who initiates prenatal care with a complete physical exam (i.e., not a pregnancy test, nurse assessment, etc)

?? Questions ??

- 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 care:
  - In the first trimester with another provider
  - In the third trimester with your health center
  - In the third trimester with another provider

- Which of the following should 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 visits 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 pregnant patient who saw your provider in 2010 but will not deliver until 2011

Childhood Immunizations

SECTION C – CHILDHOOD IMMUNIZATION				
CHILDHOOD IMMUNIZATION		TOTAL NUMBER PATIENTS WITH 2ND BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10	Number of children who have received required vaccines who had their 2nd birthday during measurement year (on or prior to December 31)			

- Col (a) Universe: All children who turned 2 in 2010 (born 1/1 – 12/31/08); who had at least one medical visit in 2010; and were first ever seen prior to their 2nd birthday.
- Col (b) Sample: Universe ***or*** sample of 70 patients
- Col (c): Number of children in Col (b) who, by their 2nd birthday are fully compliant, i.e., for each disease they (1) received vaccine, or (2) had evidence of the disease or (3) have a contraindication for vaccine
- Exclusions: None

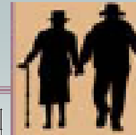
Required Vaccines

- Fully complaint means compliant for each of 11 diseases normally vaccinated against with:
  - 4 DTP/DTaP,
  - 3 IPV,
  - 1 MMR,
  - 3 Hib,
  - 3 HepB,
  - 1VZV (Varicella)
  - 4 Pneumococcal conjugate
- *These will be changing next year – more later*

Additional Vaccine Guidance

- BPHC follows NQF and "meaningful use" criteria
  - see manual for details
- Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted as evidence of compliance
- A note that "patient is up-to-date" with immunizations *that does not list the date of each immunization and the name of immunization provider* does not constitute sufficient evidence of immunization for this measure.
- Good faith efforts to get a child immunized which nonetheless fail remain "non-compliant" including
  - Parental failure to bring in the patient
  - Parents who refuse for religious reasons
  - Parents who refuse because of beliefs about vaccines

PAP Tests



SECTION D – PAP TESTS				
PAP TESTS		TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11	Number of female patients aged 24-64 who had at least one Pap test performed during the measurement year or during one of the two previous calendar years			

- Col (a) Universe: All women aged 24 – 64 (born 1/1/86 – 12/31/45); with at least one medical visit in a health center *clinic* during the reporting year; who was first seen before age 65
- Col (b) Sample: Universe ***or*** 70 patient sample
- Col (c): Number of women in Col (b) who received one or more *documented* Pap tests (regardless of where performed) during the measurement year or during the two years prior to the measurement year.

Pap Test Exclusions

- Exclude women with documented hysterectomy
- If your system can identify *all* women in the universe with a hysterectomy (most can't!), exclude these women in column (a)
- If your system *cannot* identify all women in the universe with a hysterectomy, report the universe unadjusted:
  - Col (a) will equal the universe (including an unknown number of women who have had a hysterectomy)
  - Use a sample to complete Col (b) and Col (c)
- If a women with a hysterectomy is included in your initial sample, do not reduce Col (a) but substitute another randomly selected patient for the excluded woman so sample remains 70 eligible women.

Additional Pap Test Guidance

- Count as "in compliance" a medical record with
  - A copy of the test result (your lab or another lab)
  - An evidence based notation in the patient's chart including provider, test date and result, entered by your provider or clinic staff
- A note that "patient was referred" or "patient reported receiving pap test" that does not have provider confirmation of date and test result does not constitute sufficient evidence of pap test for this measure.
- Even if a good faith effort was made to get the patient tested, she is "non-compliant" even if:
  - She refused to have test
  - She failed to return for a scheduled test

?? Question ??

- Patients can self report vaccines received or date of pap test to document compliance.
  - True
  - False

Cross Table Issues

- Table 3A and 5 and 6B: Reporting of the universe of patients for childhood immunizations and pap tests must be consistent with total patients by age on 3A and / or the percentage of patients who are medical patients
  - We estimate the target if other patient types, especially dental patients, are served
- Table 6B and 7: Number of prenatal patients should exceed number of women delivering

Analysis: Use of Data

- Compliance rates for clinical measures
  - SAC/BPR reporting
- Prenatal risk factors
  - % Early entry into prenatal care

Changes *scheduled* for 2011

- These are proposed but not yet approved.
  - They will be reported in 2012
  - Based on data that will be collected in 2011
- Changed:
  - For two year old vaccinations **add** two Hepatitis A shots, two or three Rotavirus shots, and two influenza shots and **Change** HIb from three to two shots
- Added (for specific age ranges):
  - Age 2 – 17, weight assessment (BMI recorded) and diet and physical activity counseling
  - Age 18+, BMI recorded and if underweight or overweight, a followup plan documented
  - Age 18+, Queried about tobacco use in previous 24 months
  - Age 18+ tobacco users, received “cessation intervention”
  - Age 5 – 40, with persistent asthma, prescribed pharmaceuticals

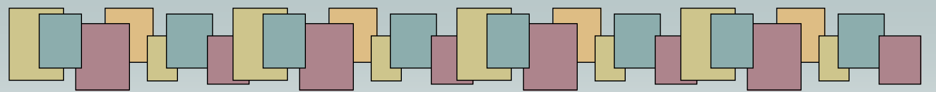


Table 7
Outcome and Disparity Measures

Measures commonly seen as indicators of overall community health

Health Outcomes

- These are all "intermediate outcome measures": *If* this measurable intermediate outcome is improved, *then* later negative health outcomes will be less likely.
  - Normal Birthweight: *If* there are fewer low birthweight children born, *then* there will be fewer children who suffer mental or physical delays or organ damage
  - Controlled Hypertension: *If* there is less uncontrolled hypertension, *then* there will be less cardiovascular damage, fewer heart attacks, fewer strokes, less organ damage later in life
  - Controlled Diabetes: *If* there is less uncontrolled diabetes *then* there will be fewer amputations, less blindness, less organ damage later in life

Disparities

- All outcome data are reported using a matrix to indicate Hispanic / Latino identify *and* Race:

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

Hispanic/Latino (1)								Non - Hispanic/Latino (2)								Unreported / Refused to Report Race and Identity (h)	Total (i)
Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to Report (g)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to report (g)		

- Latino patients are reported in section 1
- Patients who report their race but do not indicate that they are Latino / Hispanic ***are assumed to be non-Hispanic and reported in section two***.
- Patients for whom *neither* Hispanic identify *nor* race are known are reported as Unknown in the third section (column h)

Birthweight

SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND LATINO IDENTITY

		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)
	HIV Positive Pregnant Women			
(No PRENATAL CARE PROVIDED? CHECK HE				
SECTION A:				
1	Prenatal care patients who delivered during the year			
2	Deliveries performed by Grantee Provider			
3	Live Births < 1500 grams			
4	Live Births 1500 – 2499 grams			

Section A is *ONLY* completed by grantees with Prenatal Programs.

- Line 1 Universe: Report all prenatal patients from Table 6B who were *known to have delivered* during the year, even if the delivery was done by another provider.
- Line 2: Report the total number of deliveries *performed by center clinicians* including non-health center patients.
- Lines 3-5: Report all live births born to CHC patients in the program year by weight,including multiples, regardless of who performed the delivery.

?? Question ??

- The number of prenatal care patients who deliver should equal the number of women who receive prenatal care.
  - True
  - False

Controlled Hypertension

SECTION B: HYPERTENSION BY RACE AND LATINO IDENTITY
Patients 18 to 85 diagnosed with hypertension whose last blood pressure was less than 140 / 90

6	Total patients with hyper-tension
7	Charts sampled or EHR total
8	Patients with controlled blood pressure

- Line 6 Universe: All patients ***aged 18 to 85***; with a diagnosis of hypertension prior to 6/30/***10***; with at least 2 medical visits during the reporting year
- Line 7 Charts reviewed: Universe or sample of 70 patients
- Line 8 Compliance: Number charts reported on Line 7 which report the most recent blood pressure less than 140/90
- Exclusions: None

Note: No documented blood pressure during the reporting year is counted as out of compliance.

Controlled Diabetes

SECTION C: DIABETES BY RACE AND LATINO IDENTITY

Patients 18 to 75 diagnosed with Type I or Type II diabetes: Most recent test results

9	Total patients with Type I or Type II diabetes
10	Charts sampled or EHR total
11	Patients with HBA1c < 7%
12	Patients with 7% ≤ HBA1c ≤ 9%
13	Patients with HBA1c > 9% **OR** No test during year

- Line 9 Universe: All patients ***aged 18 to 75***; with a diagnosis of diabetes; with at least 2 medical visits during the reporting year
- Line 10 Charts reviewed: Universe or sample of 70 patients
- Line 11-13 Test result: Number of charts on Line 10 whose last HBA1c in the reporting year is in the given range

Note: If there is no documented HBA1c test during the reporting year, report on Line 13.

Exclusions: Diabetes

- Exclude: Patients with *only* a diagnosis of gestational diabetes or steroid-induced diabetes
- If your system can identify *all* these patients exclude them from line 9 patients:
- If your system *cannot* identify *all* patients in the universe with these diagnoses, report the universe unadjusted:
  - Line 9 will equal the universe (including patients with these excludable diagnoses)
  - Use a sample to complete Lines 10-13 (NOTE: If a patient with one of these diagnoses is identified in the sample, do not reduce Line 9 but substitute the excluded patient with another patient from the sample)

?? Question ??

- A patient for whom no HbA1c or blood pressure is documented in the chart in the reporting year should be excluded from the universe (sample).
  - True
  - False

Cross Table Issues

- Table 3A / 3B and 7:
  - Diabetic and/or hypertensive patients on Table 7 may not exceed the total estimated number of medical patients for that race or for Latino identity reported on Table 3B
  - Reported patients on Table 7 cannot exceed total projected medical patients by age on Table 3A
  - Total on Table 7 cannot exceed medical patients on Table 5
- Table 6A and 7: Comparison of patients in the universe on Table 7 is made with patients with a primary diagnosis of hypertension or diabetes on Table 6A

Analysis: Use of Data

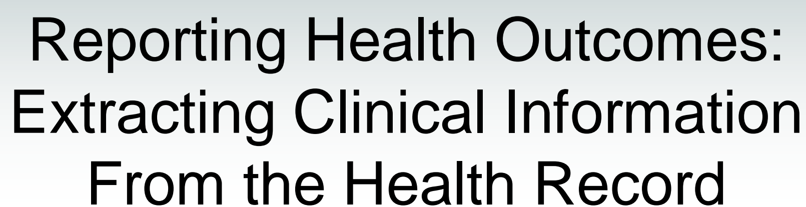
- Outcomes from interventions:
  - *Data from the first year* are less than perfect because of mistakes made
  - Hypertension shows 63% compliance
    - Up from 58% in the first year
  - Diabetes showed 40% compliance
    - Down from 70% in the first year
  - Normal birth weight reported for 92.7%
    - Same as prior year (2008 =92.4%)
- Disparities in health outcomes by race and ethnicity (only at national level)

?? *Question* ??

- It is possible to report more African American patients with hypertension on Table 7 than total African American patients on Table 3B.
  - True
  - False

Changes *scheduled* for 2011

- These are proposed but not yet approved.
  - They will be reported in 2012
  - Based on data that will be collected in 2011
- Changed:
  - For diabetes: categories will be <7, 7 – 7.9, 8 – 9 and >9.
    - This adds a category
    - Controlled will be considered < 8, not <9



Reporting Health Outcomes: Extracting Clinical Information From the Health Record

Sample or Universe?

- BPHC does not have a “preference” as to which you choose to use
- If done correctly, the numbers should be the same for all significant populations
- If you do not have an EHR or disease registry system, you almost certainly will have to use a sample.
- If you have some EHR component which permits using the universe you *may* use it, but you do not have to.

EHR?

- Last year it appeared that the largest errors and number of errors came from clinics which relied on automated systems
- Problems which were noted:
  - Implementation for less than 100% of patients
  - System too new – less than 3 years of data
  - Provider coding errors
  - Outside data not being transferred in all cases
  - Measuring wrong group (e.g., 2 years of users)
  - Defaulting to wrong data (examples)

Reporting on a Sample

- If you choose to report on a sample, or if you *must* use a sample, it must be a **random sample…**<u>*a part of the universe where each member of the universe has the exact same chance of being selected as every other member of the universe*</u>**.**
  - Prepare numbered list of all patients in universe
  - Use web site to generate random numbers
    http://www.randomizer.org/form.htm
  - Random numbers correspond with the charts identified in the numbered list of patients
  - Review identified charts

Getting a random sample of 70

Sets of numbers = **1**

Numbers per set = **70**

Number range = 1- “**n**” (enter last sequence number in your numbered list)

Unique numbers – **Yes**

Sort numbers – **Yes: Least to Greatest**

Getting replacement charts

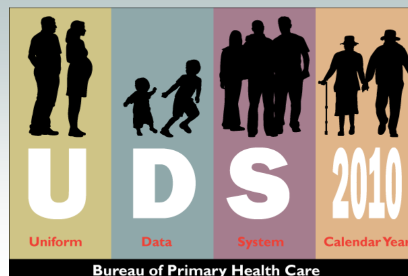
- Create a second "set" of random numbers using same method with 5 records in the set
- Do NOT sort the sample!
- If a record in the sample of 70 patients needs to be excluded, replace that record with a record from the second set (sample of 5).
- Examples of exclusions:
  - a woman in the pap test sample who is a dental only patient
  - A child who turns out to have *only* been in for vaccines
  - A hypertensive whose second visit was a case management visit.

Data sources

- Before charts are actually pulled and reviewed, other sources may be queried for the "answer" on compliance:
  - EHRs, EMRs, PMSs
    - May not cover all patients or be in place for a long enough time, but may still be used to review patients and periods which *are* recorded
  - Immunization registries maintained by the state.
  - Collaborative registries which include some, but not all of the patients who meet the criteria (or which include patients who do not meet the criteria)
  - Logs or other "off line" lists

Reviewing the Charts

- Eventually, some or all charts in the sample for one or more of the measures will need to be reviewed.
- With multiple locations:
  - All charts may be brought to a central point
  - Single reviewer may travel to each site
  - Multiple reviewers may review at each site
- Tools are available from the Helpline



Thank you for attending
and for working to provide clean
and accurate data to BPHC!

Ongoing questions can be addressed to
UDSHelp330@BPHCDATA.NET
866-UDS-HELP