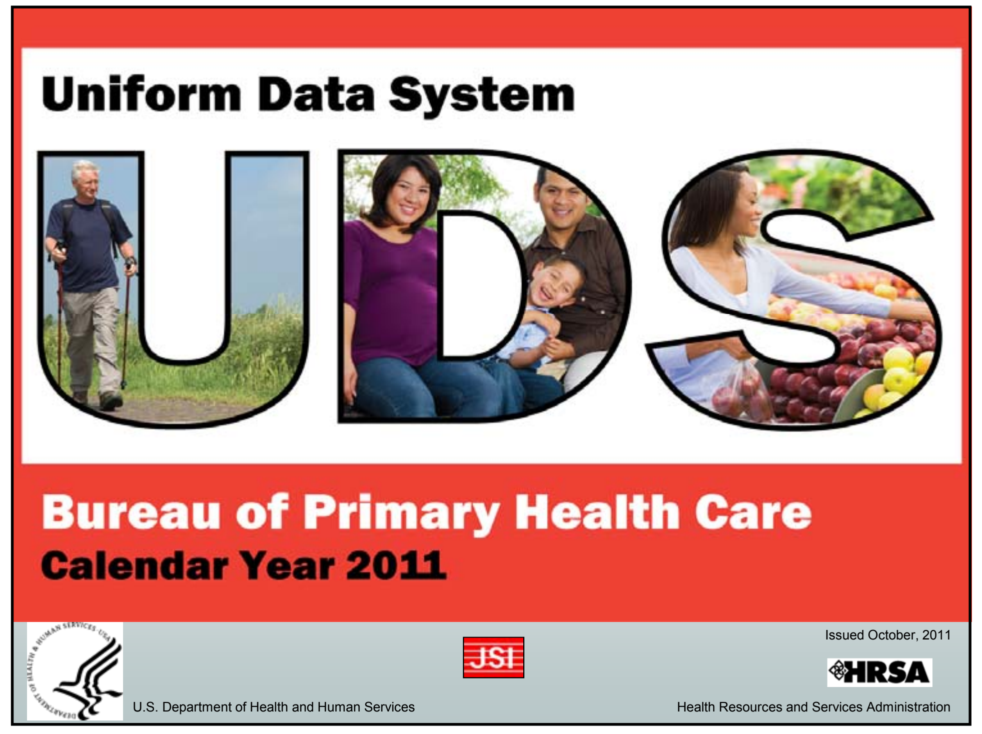


Reference Materials

- Today's Handouts:
  - Copy of the presentation slides
  - 2011 UDS Manual, Tables, Fact Sheets
  - Summary of 2011 and 2012 changes
  - How to get help
- Electronic:
  - This and more on disk and PCA web site

2

Objectives

- New and returning trainees will know:
  - Why the UDS is important and where it is used
  - What has changed since the 2010 UDS
    - New data collected for the first time
    - Data reported in new formats
  - Critical dates in the UDS process
  - How to accurately complete and submit your UDS Report
  - Other ways to get assistance with the UDS

3

Introduction to the UDS

What is the UDS and why is it important?

Importance of the UDS

- Report to Congress and OMB
- Permit BPHC to describe program achievements
- Help shape and monitor grantee Quality Improvement programs

5

What is the UDS?

- The Uniform Data System (UDS) report is a standardized set of data reported by:
  - All grantees receiving support through the Health Center Cluster (Section 330) grant program – CHC, HCH, MHC and PHPC
    - Grantees with multiple funding streams submit additional sub-reports
  - FQHC Look-Alike agencies (effective this year)

6

11 (+1) Tables

- Patient Profile - Number of patients served and their socio-demographic characteristics
  - 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

7

11 (+1) Tables

- Provider and Utilization Profile - Types and quantities of services provided and staff who provide these services
  - Table 5 – Staffing and Utilization
    - FTEs, visits, and patients

8

Tables Continued

- Clinical Profile - Quality of care and Outcome indicators
  - Table 6A – Selected Diagnoses and Services
  - Table 6B – “Quality of Care” Indicators
  - Table 7 – Health Outcomes and Disparities
- *Electronic Health Record (EHR) Addendum*
  - *Series of questions on the adoption of EHRs, certification of systems and how widely adopted the system is throughout the health center’s providers*

9

Tables Continued

- Financial Profile - Cost and efficiency of delivering services and sources and amounts of income
  - 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

10

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 and fact sheets
  - 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
    - (See handout with details)

11

Getting Started:

Who needs to report, how and when?

Reporting Requirements

- **Who**: All grantees with one or more BPHC grants (CHC, MHC, HCH, PH)
  - ***AND*** all FQHC Look-Alike programs
- **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)
  https://grants.hrsa.gov/webexternal/login.asp
- **What**: "Scope of Project" for the period January 1, 2011 - December 31, 2011
  - *Includes* all ARRA NAP, IDS, CIP and FIP support
  - Includes any approved change of scope

13

Tables to Submit

- Everyone submits the 11 basic tables included in the "Universal Report" (plus the EHR form)
  - Filed by agencies supported by only one BPHC funding authority and by FQHC Look-Alike programs
- 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

14

LAL Tables to Submit

- **FQHC Look-Alikes** submit a somewhat modified data set using only the Universal report. Most tables are exactly the same but
  - Table 4: Delete managed care data and details on homeless and/or farmworker patients
  - Table 6A: Deleted from LAL reporting
  - Table 7: Delete race and ethnicity data for clinical measures
  - Table 9D: Delete detail data on managed vs. non-managed care and on retroactive payments
  - Table 9E: Delete data on 330 grant funds as well as ARRA grant funds from BPHC
- These will be reviewed with each table

15

Data Submission and Review

- EHB opens to grantees on January 1, 2012
- Grantees may request assistance from the help line or their Reviewer from 1/1 through their final submission.
- All *initial* submission must be complete and submitted ***by February 15th***.
- Upon receipt, Reviewer will go through the report to identify issues.
  - Corrections will be requested as appropriate.
- All corrections *must* be completed and revisions submitted ***by March 31st***.

16

Table by Table Instructions

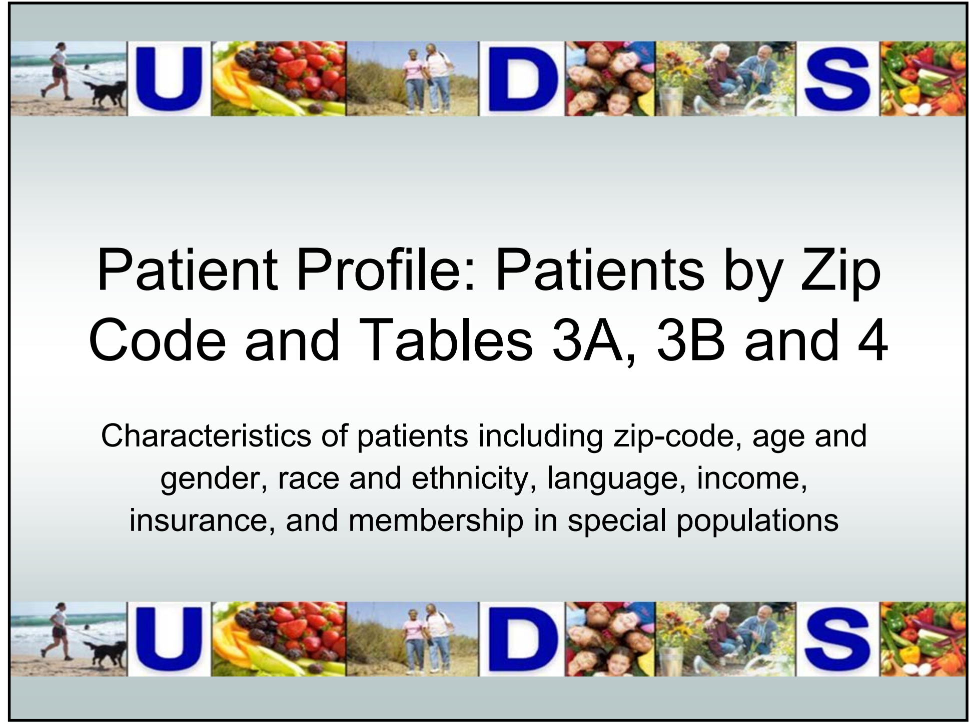
What is reported in each table?

Table Instructions: Overview

Each table will be reviewed. We will explain:

- Definitions used on each table
- 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

18



LAL Modifications – Table 4

- Most of the table contains exactly the same reporting requirement for FQHC Look-Alikes, except for the following fields which are greyed out:
  - Lines 13a – 13c: Managed care data
  - Lines 14 – 15: details on farmworker patients
  - Lines 17 – 22: details on homeless patients shelter arrangement

20

Patient Definitions

- Patient (***Total***):
  - An individual who had a visit, that was reported on Table 5, during the year.
    - Medical, dental, behavioral health, other professional and selected enabling services.
  - Unduplicated count
    - 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)

21

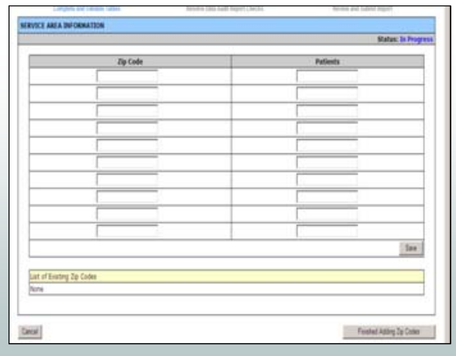
Patient Definition Continued

- Patient (***Grant Program***):
  - An individual who receives one or more documented visits supported by one of the special population grant programs (Homeless, Farm Worker, and/or Public Housing) are reported on Grant Tables.
    - Only reported by centers with multiple 330 funding streams

22

Contact / Patients by Zip Code

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



Additional instructions for Special Populations:

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

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

Report all zip codes with 11 or more patients

Combine the rest as “other zip codes”

23

Table 3A: Patients by Age & Gender

- Report total patients
  - Grant table for multiple funding streams
- 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)		

24

Table 3B: Race

- Patients self select race; if not reported, use line 7
- Use line 6 *only* if patient *chooses* two or more listed races. "More than one" shouldn't be a choice
  - *Do not* use line 6 for Latino + some racial identity

		HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED/ REFUSED TO REPORT (c)	TOTAL (d)
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)				

=

39	Total Patients (Sum Lines 1-38)		

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

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Table 3B: Hispanic/Latino Ethnicity

- Patients self report their Hispanic/Latino ethnicity
- 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.

26

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)
12.	PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH	

27

Table 4: Patients by Income

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

28

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.	CHIP Medicaid		
8.	Total Medicaid (Line 8a + 8b)		
9.	Medicare (Title XVIII)		
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)		

- 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 12 Columns (a) and (b) equals Line 6 Column a

29

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, safety net programs etc. which "*belong" to the clinic* – the patient may not take the benefit elsewhere or use it for other things.
  - These patients are usually uninsured
- Workers Comp is *not* medical insurance

30

Table 4: Insurance Continued

- *Always* report Medicaid patients on line 8, "Medicaid" regardless of the intermediary
  - Medicaid managed care through a private insurance company is still Medicaid.
- Always report Medicare patients on line 9, "Medicare" regardless of the intermediary
  - Including Medicare Advantage patients
- CHIP-RA is handled differently in each state:
  - CHIP-RA provided through Medicaid is reported on Line 8b (Medicaid)
  - CHIP-RA provided through a commercial carrier is reported on Line 10b (Other public – *not* private)

31

Table 4: Managed Care Utilization

	Payor Category	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 (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 1 member (patient) enrolled for 1 month. Report the total member months as the 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."

32

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 Patients (All Grantees Report This Line)	
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 *as of* first visit in 2011 (where they were housed the prior night)
- A veteran is an individual who completed service in the Uniformed Services of the United States

33

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, or in the land, or as an adjunct to or part of a commodity grown on or in 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

34

Table 4: Homeless Defined

- A homeless patient is any person known to be homeless at the time of any service or who was housed but eligible because of having been a homeless patient within 12 months of the service date
- 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

35

Cross Table Issues

- Patients reported by zip code, and on Tables 3A, 3B and 4 describe the *__same patients.__* Totals ***__must__*** be equal.
- If you submit grant tables, numbers on the grant table must be <= the corresponding number on the universal table for each and every cell!
- Table 7 numbers must make sense in light of Table 3B
  - Cannot have more Latino diabetics than the total number of Latinos

36

Analysis: Use of Data

- **WHO:** Profile of patients served including age, gender, race, ethnicity, income, insurance, and special populations status
- **WHERE**: Patients by Zip Code and graphical service areas uploaded to UDS Mapper
- **MEASURES**: Denominators for:
  - Cost, charges, income, etc. per patient
    - Or per Medicare patient, Medicaid patient, etc.
  - Average capitation per member month

37

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

	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 NP, PA, 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			
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	**Total Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologist			
22b	Optometrist			
22c	Other Vision Care Staff			
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	**Grand Total Lines 15+19+20+21+22+22d+23+29+29a+33)**			

39

Col (a): FTEs Defined

- 1.0 FTE is equivalent to 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., 2080 hrs/yr, 1872 hrs/yr)
  - Providers: Based on employment contracts
  - Based on *hours paid* including vacation, sick, continuing education, etc.
- FTEs are adjusted for part-time work or for part-year employment

40

Col (a): FTEs Reported - Continued

- Calculate the FTEs for persons who work on an hourly basis (including volunteers and residents) by dividing hours worked by the comparable hours worked in that position. For example:
  - Resident works 240 hours during the year
  - Full time doctor works 2080 hours less vacation (160) holidays (96) and CME (40) hours = 1784
  - 240 / 1784 = 0.134 FTE

41

Col (a): FTEs Reported

- Report FTEs on lines corresponding to *work performed,* not job title
- Includes all paid, salary and volunteer workers at any approved site
- FTE is actual for the year, **not** *as of* last day
- ***Clinicians are not allocated*** from clinical
  - Medical Director exception for *corporate* only

42

Col (b): Visits Defined

A UDS visit …

- Face to face between patient and provider
  - Except for behavioral health sessions by phone
- Licensed provider for medical, dental, vision
- Acting independently
- Exercising independent judgment
- The service must be charted

43

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 *only*
  - Dental visits: dentists and dental hygienists
  - Vision visits: Ophthalmologists, Optometrists
- Include Visits:
  - Provided by *both* paid *and* volunteer staff
  - Provided by a third party and *paid for in full* by grantee, including managed care referrals or voucher program encounters.
  - When staff see hospitalized patients

44

Col (b): Visits Continued

- Only one visit per patient, per provider type, per day may be counted
  - One medical
  - One mental health
  - One health education
  - One vision
  - One dental
  - One substance abuse
  - One case management
  - 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)

45

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

46

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

47

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
  - – Enabling

(and perinatal which are reported on Table 6B)

48

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!

49

Table 5 – Line 29a

- Other Program Services
  - Activities that are in the scope of the project, but are not direct health care delivery services
  - Includes notably:
    - — WIC programs
    - — Head Start
    - — Shelters
    - — Child care
    - — Fitness
    - – Job training programs
    - – Early Head Start
    - – Housing programs
    - – Frail elderly support programs
    - – Adult Day HealthCare

29a	Other Programs / Services (specify___)			

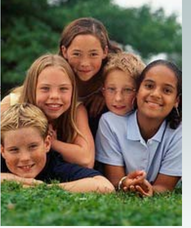
50

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

51

Cross Table Issues



- Tables 5 and 8A: Staff 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
- Total patients on Table 3A can't be less than any single category of patients reported on Table 5
- Visits and patients reported in any cell of a grant table cannot exceed the number reported on the universal table

52

Analysis: Use of Data

- Staffing Ratios: Calculate ratio of support staff to providers
- Provider Productivity by provider type
- Panel size: Patients per provider
- 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

53

Change *Scheduled* for 2012

- This change is proposed but not yet approved.
  - Data will be reported in 2013
  - Based on data that will be collected in 2012
- Added: Table 5A
  - Total number of current occupants of selected clinical and administrative positions
    - Warm bodies – not FTEs
  - Total number of months employed by those employees while in that position
    - E.g. – 2 ½ years would add 30 months to the total

54

U
D
S
Financial Tables
Tables 8A, 9D and 9E
U
D
S

U
D
S
Table 8A Financial Cost
Costs by cost center
U
D
S

		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 ___________)			
9a	Vision			
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)			
	Financial Costs of Enabling and Other Program Related 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)			
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)			

Table 8A – Financial Costs

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

57

Table 8A – New for 2011

- Line 9a – Vision – has been added
  - Was previously included in line 9 – other professional services
  - Is directly tied to Table 5, Line 22d, *added last year*

		Accrued Cost (a)	Allocation of Facility and Administration (b)	Total Cost After Allocation of Facility and Administration (c)
9.	Other Professional (Specify ___________)			
9a	Vision			
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)			

58

Table 8A – Column (a)

- Include direct costs for each cost center consistent with FTEs reported on Table 5

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical providers and clinical support staff	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16 – 18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a – 20c: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g. nutritionists, podiatrists, etc.)	9: Other Professional
22a-22c: Vision (Ophthalmologist, Optometrist, Optometric Assistant, Other Vision Care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs / services (non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

59

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, 9 and 9a include all personnel (hired or contracted) and all “other” direct expenses
    - Psychiatry on line 6 – mental health
    - Vision care *now* on line 9a

60

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 in column b, on line 8a, pharmacy

		Accrued Cost (a)	Allocation of Facility and Administration (b)	Total Cost After Allocation of Facility and Administration (c)
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: ______________________)			

61

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.
- Other Program Related costs:
  - Line 12 includes staff and contract personnel reported on Table 5, Line 29a as well as other related direct expenses for non-health-care services such as:
    - WIC
    - Job training
    - Child care
    - Shelters
    - Housing Corporations
    - Head Start /Early Head Start
    - Adult Day Health Care
    - Fitness programs
  - Include here any “pass through” funds

	Financial Costs of Enabling and Other Program Related 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)
12.	Other Related Services (specify:______________)
13.	TOTAL ENABLING AND OTHER SERVICES (Sum Lines 11 and 12)

62

Table 8A - Lines 14 –16 Overhead

	OVERHEAD AND TOTALS			
14.	Facility			
15.	Administration			

- Line 14: Facility costs include rent or depreciation, mortgage 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.

63

Allocation of Overhead - Facility

- Recommended Allocation Method:
  - Allocate each building separately
    - Captures differences in costs per building such as improvements, donated space, etc.
  - Allocate based on proportion of square footage utilized by each cost center
  - Add administrative space expenses to administrative costs to be allocated

64

Allocation of Overhead - Admin

- Recommended Allocation Method:
  - Administrative costs, including admin share of facility costs, are allocated based to cost centers based on actual use
    - Billing, medical records, front desk, etc.
- Alternative:
  - Admin expenses allocated on a straight line method, using the proportion of total costs excluding overhead attributable to the service category

65

Cross Table Issues

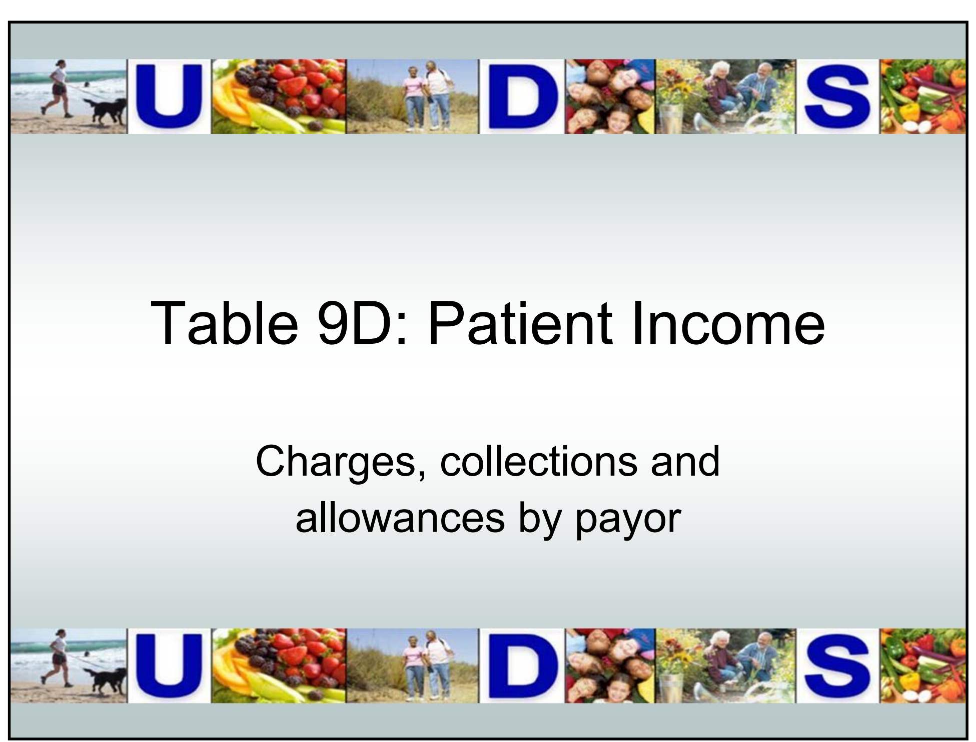
- Table 5 and 8A:
  - Staff FTEs reported by service on Table 5 must be consistent with costs reported on Table 8A by cost center
    - For example, calculated cost per Case Manager, based on FTE reported on Table 5, and Case Management Costs on Table 8A, should make sense.
  - Costs by visit and by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

66

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.
- Average cost per FTE
- % overhead costs (admin and facility)
  - National: Facility = 7%; Admin = 25%

67



LAL Modifications – Table 9D

- Most of the table contains exactly the same reporting requirement for FQHC Look-Alikes, except for the following fields which are greyed out:
  - Lines 2a & b, 5a & b, 8a & b, 11a & b: Managed care detail. *Only complete the total lines 3, 6, 9, 12, 13, and 14.*
  - Columns c1-c4: Retroactive Payments

69

Table 9D – 2011 *Changes*

PAYOR CATEGORY		FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING 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 RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY / PAYBACK (c4)			
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									

- Retroactive payment cells open - In prior years, column c3 was available only for managed care lines and totals
  - The non-managed care lines are now opened up for
    - "Pay for Performance" and other bonus systems
    - Successful litigation that recovers funds from third party payors
- Do *NOT* use this for IT/EHR bonus payments from CMS
  - This will be reported on table 9E

70

Table 9D – ***Charges*** Col (a)

	Payor Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding 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 retroactive payments including risk pool/ incentive/ withhold (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)									

- 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

71

Table 9D – ***Collections*** Col (b)

Amount Collected This Period (b)

- Amount collected as payment for *or related to* health care services:
  - Cash collections from patients
    - Including nominal fees
    - *Not* including cash "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, *regardless of who check comes from*
    - 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.

72

Table 9D – Adjustments Col (c1-c4)

- These amounts are *also* included in col (b)
- Columns (c1) and (c2): payments for FQHC or CHIP-RA 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

73

Table 9D – Adjustments Col (c1-c4) Continued

- Column c4 shows paybacks if any
  - Amounts which are returned to a third party
  - Generally because of an overpayment – most often an FQHC overpayment identified after reconciliation
  - The amount paid back is expressed as a positive number!

74

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

ALLOWANCES
(d)

75

Table 9D – Allowances

- 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
- 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)

76

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

77

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

78

Table 9D – Payors (lines 1-6)

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

79

Table 9D – Payors (lines 7-12)

- Lines 7 - 9: Other Public includes
  - State or other public insurance programs
  - *Non-Medicaid* S-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, Workers Comp. etc.
  - Contracts with schools, jails, head start, etc.

80

Table 9D – Payors (Self Pay)

- 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

81

Table 9D – Reclassify Charges

- It is <u>*essential*</u> 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

82

Cross Table Issues

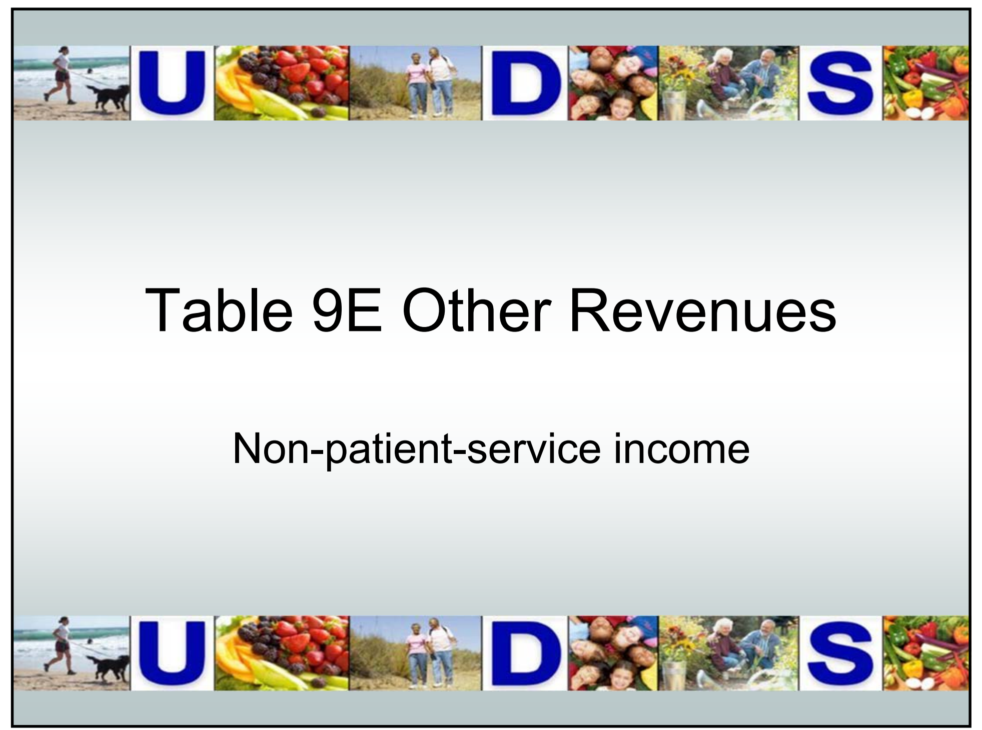
- Table 4 Lines 7-12 and 9D: Charges and collections by payor on Table 9D should tie to insurance enrollment on Table 4
- Table 4 Lines 13a-b and 9D: Managed care revenues on 9D must make sense in light of member months on Table 4
- Presumed billable visits reported on Table 5 are compared with charges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

83

Data Analysis

- Average charge per encounter
- Payor mix
- Charge to cost ratio (indication that fees cover costs)

84



LAL Modifications – Table 9E

- Most of the table contains exactly the same reporting requirement for FQHC Look-Alikes, except for the following fields which are greyed out:
  - Lines 1a – 1k: BPHC 330 Grants
  - Lines 4 – 4a: ARRA Grants

86

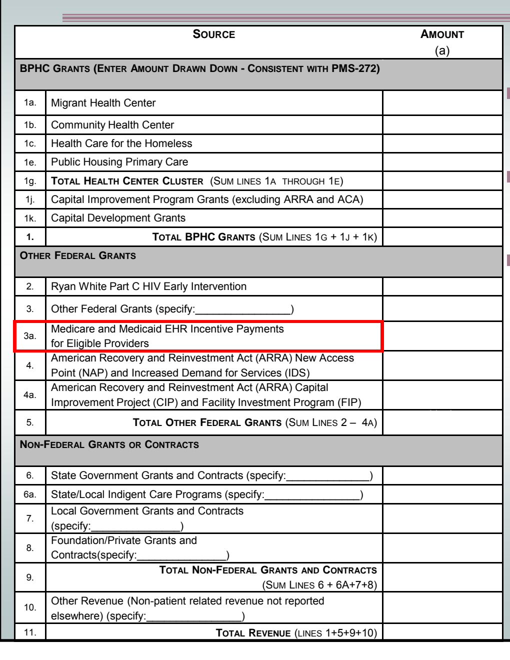
Table 9E – 2011 *Changes*

	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	

- Line 3a has been added:
  - Report "Medicare and Medicaid EHR Incentive Payments for Eligible Providers"
  - Substantial amounts given for "meaningful use" of EHR systems by eligible providers
  - Eligibility (from Medicare or Medicaid) determined by proportion of practice in Medicare or Medicaid
  - Payments which are made out directly to providers and turned over to the health center are also recorded here! *(the only exception to last party rule)*

87

Table 9E – Other Revenues



	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 CLUSTER (SUM LINES 1A THROUGH 1E)	
1j.	Capital Improvement Program Grants (excluding ARRA and ACA)	
1k.	Capital Development Grants	
1.	TOTAL BPHC GRANTS (SUM LINES 1G + 1J + 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	
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)	

- Report 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"

88

Table 9E – BPHC Grants

- Line 1: BPHC Grant *drawdowns*
  - Report all funds received *directly* from BPHC regardless of their end use
    - Include funds which are technically ACA grants
  - Include funds received from BPHC and passed through to another agency:
    - If you count the patients on Tables 3A, 3B, 4 and 5 and the staff and visits 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

89

Table 9E – Other Revenues (lines 3–6)

- 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 2011
- 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

90

Table 9E – Other Revenues (line 6a)

- 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 discount
- Do not include state *insurance* plans

91

Table 9E – Other Revenues (lines 8 & 10)

- 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.

92

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.)

93

Cross Table Issues

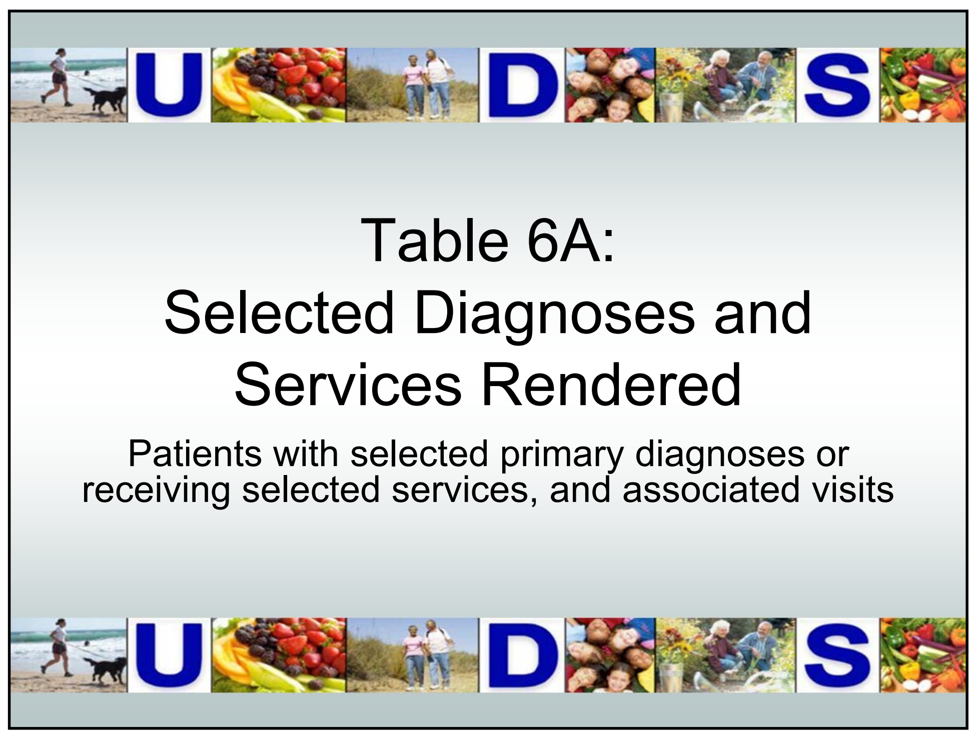
- Table 5 and 9E: Reporting of other related services including WIC
- Table 9D and 9E: Reporting of patient and non-patient related revenues
  - Sliding fee discount versus indigent care program funds

94

Data Analysis

- Table 9D, 9E, and 5: 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

95



LAL Modifications – Table 6A

- FQHC Look-Alikes do not complete this table.

98

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

	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				
1-2.	Symptomatic HIV , Asymptomatic HIV	042 , 079.53, V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32		
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71		
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;		

99

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 - 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

100

Table 6A - Continued

- 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.

101

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

102

Analysis: Use of Data

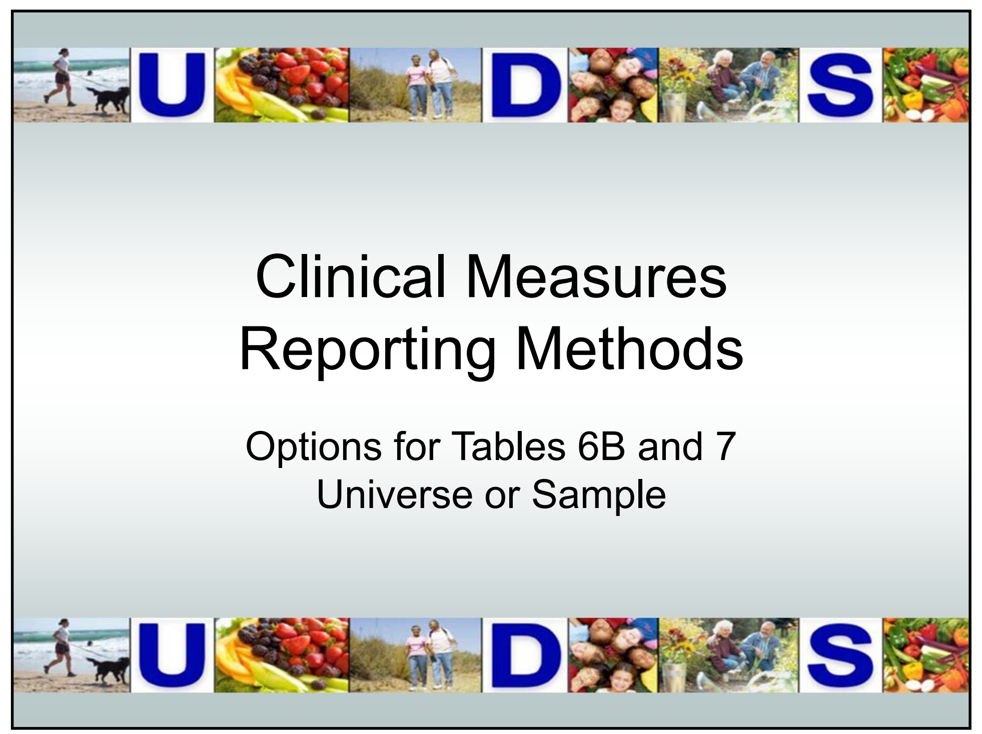
- Average visits per year for selected chronic conditions (HTN, DM)
- Frequency of acute care services by service (well child immunizations)
- Penetration rate for routine preventive services (well child, family planning, Pap tests)

103

Changes *Under Discussion* for 2012

- This has been proposed but not yet approved
  - If approved, numbers will be reported in 2013
  - Based on data that will be collected in 2012
- Change – All diagnosis, not only primary:
  - ***All*** visits with a diagnoses meeting the criteria listed on lines 1 through 20d will be reported in column a
  - ***All*** patients with a diagnoses meeting the criteria listed on lines 1 through 20d will be reported in column b
- Consequence:
  - Data will more closely reflect population prevalence
  - Because diagnoses that are not normally primary (especially mental health, substance abuse, obesity) will now be reported, these numbers will reflect dramatic increases

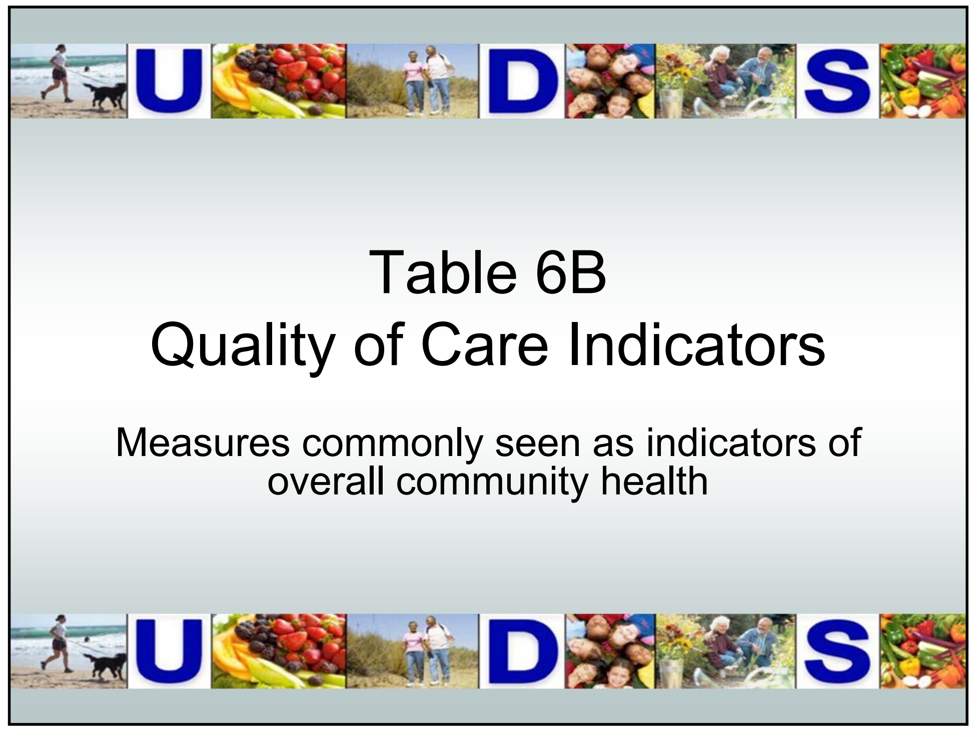
104



Options for Reporting

- ***Report Universe*** **– All patients who meet the reporting criteria.**
  - **Must report universe when:**
    - **Universe has fewer than 70 patients who meet the criteria**
    - **Reporting Prenatal Care and Delivery Outcome variables**
- ***Report Sample*** **– A sample of 70 charts from the Universe.**
  - **Must report sample when:**
    - **Unable to verify all aspects of compliance on entire universe**
- **There is no BPHC preference for reporting universe or sample**
  - **you may choose differently for each measure**

106



Changes for 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**:
  - Age 2 – 17, weight assessment (BMI percentile recorded) and diet and physical activity counseling documented
  - Age 18+, BMI recorded and if underweight or overweight, a followup plan documented
  - Age 18+, queried about tobacco use in last 24 months
  - Age 18+ tobacco users, received “cessation intervention”
  - Age 5 – 40, with persistent asthma, prescribed or using specific pharmaceuticals

108

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.

109

Quality of Care Indicators

- **Weight Assessment, nutrition counseling and counseling on activities for children:** *If* children have their weight routinely assessed and they and their parents receive anticipatory guidance on good nutrition and daily activities, *then* they are less likely to become obese and suffer the sequela of overweight such as diabetes.
- **Adult Weight Assessment:** *If* adults have their weight routinely assessed, and if those whose weight is outsight normal expectations are counseled and a follow-up plan documented, *then* they will be less likely to suffer the consequences of low or high weight
- **Tobacco Use Assessment:** *If* adults are routinely assessed on their tobacco use *then* timely intervention is more likely to occur and they will be less likely to suffer adverse sequela of such use.

110

Quality of Care Indicators

- **Tobacco Cessation Intervention:** *If* persons who use tobacco are provided with counseling and guidance on quitting tobacco use, *then* they are more likely to quit and less likely to suffer the sequela of smoking including asthma, bronchitis, lung cancer, etc.
- **Asthma Intervention:** *If* patients with *persistent* asthma receive pharmacologic intervention, *then* they are less likely to suffer chronic disabling breathing problems, and less likely to require hospital intervention.

111

Early Entry into Prenatal Care

(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 2011* 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

112

Early 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 considered to be 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.)

113

Childhood Immunizations

	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	Children who have received age appropriate vaccines who had their 2nd birthday during measurement year (on or prior to 31 December)			

- Col (a) Universe: All children who turned 2 in 2011 (born 1/1 – 12/31/09); who had at least one medical visit in 2011; 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 who 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

114

Required Vaccines

- Fully complaint means compliant for each of 14 diseases normally vaccinated against with:
  - 4 DTP/DTaP,
  - 3 IPV,
  - 1 MMR,
  - 2 HIb,
  - 3 HepB,
  - 1 VZV (Varicella)
  - 4 Pneumococcal conjugate
  - 2 HepA
  - **2 or 3 Rotavirus (RV)**
  - **2 Influenza (flu)**

115

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

116

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	Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

- Col (a) Universe: All women aged 24 – 64 (born 1/1/47 – 12/31/87); 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

117

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 of 70 to complete Col (b) and Col (c)
- If a woman 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

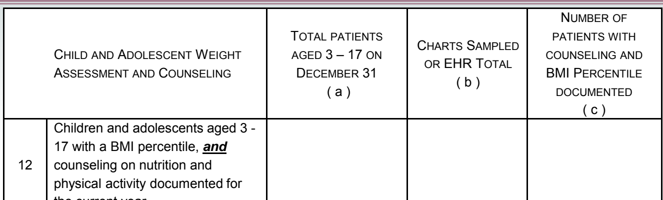
118

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
  - She claims to have had one but cannot document it

119

Child Weight Assessment and Counseling



Child and Adolescent Weight Assessment and Counseling		Total Patients Aged 3 – 17 on December 31 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Percentile Documented (c)
12	Children and adolescents aged 3 - 17 with a BMI percentile, ***and*** counseling on nutrition and physical activity documented for the current year			

- Col (a) Universe: All children aged 3 – 17 on December 31st (born 1/1/94 – 12/31/08); with at least one medical visit in a health center *clinic* during the reporting year; who was first seen before age 17
- Col (b) Sample: Universe ***or*** 70 patient sample
- Col (c): Number of patients in Col (b) who
  - Had a recorded BMI percentile during 2011 **AND**
  - Had documented counseling on nutrition (not just diet) **AND**
  - Had documented counseling on activity (not just exercise)

120

Weight Assessment and Counseling - Continued

- Just recording that a well child visit was done does not meet the requirement
- Exclusions:
  - Pregnant adolescents

121

Adult Weight Assessment and Follow-up

	Adult Weight Screening and Followup	Total patients 18 and over (a)	Charts sampled or EHR total (b)	Number of patients with BMI charted and follow-up plan documented as appropriate (c)
13	Patients aged 18 and over with (1) BMI charted ***and*** (2) follow-up plan documented ***if*** patients are overweight or underweight			

- Col (a) Universe: All adults aged 18 and over on December 31st (born on or before 12/31/1993); with at least one medical visit in a health center *clinic* during the reporting year
- Col (b) Sample: Universe ***or*** 70 patient sample

122

Adult Weight Assessment and Follow-up (Column C)

- Col (c): Number of patients in Col (b) who:
  - Had their BMI recorded at their last visit or within six months of that visit
  - Had a followup plan documented if they were
    - under age 65: BMI was ≥ 25 OR < 18.5

    OR
    - age 65 and over: BMI was ≥ 30 OR < 22

123

Adult Weight

- Just recording height and weight is not adequate – BMI must be visible in chart or on template
- Exclusions:
  - Pregnant women
  - Terminally ill patients

124

Tobacco Assessment

	Tobacco Assessment	Total patients 18 and over (a)	Charts sampled or EHR total (b)	Number of patients assessed for tobacco use (c)
14	Patients queried about tobacco use one or more times in the measurement year or prior year			

- Col (a) Universe: All adults
  - aged 18 and over on December 31st (born on or before 12/31/1993 ***AND***
  - last seen after they turned 18 ***AND***
  - who have been seen at least twice (ever) in the practice ***AND***
  - with at least one medical visit in a health center *clinic* during the reporting year

125

Tobacco Assessment - Continued

- Col (b): Sample: Universe ***or*** 70 patient sample
- Col (c): Patients in the sample who were queried about their tobacco use one or more times by any provider (e.g. dental, vision) during their last visit or within 24 months of their last visit.
- Exclusions: None

Charts sampled or EHR total (b)	Number of patients assessed for tobacco use (c)

126

Tobacco Cessation Intervention

	Tobacco Cessation Intervention	Total Patients with Diagnosed Tobacco Dependence (a)	Charts Sampled or EHR Total (b)	Number of Patients Advised to Quit (c)
15	Tobacco users aged 18 or older who have received cessation advice or medication			

- Col (a) Universe: All adults
  - Who used any form of tobacco ***AND***
  - Were aged 18 and over on December 31st (born on or before 12/31/1993) ***AND***
  - Were last seen after they turned 18 ***AND***
  - Who have been seen at least twice (ever) in the practice ***AND***
  - Had at least one medical visit in a health center *clinic* during the reporting year

127

Tobacco Cessation Intervention - Continued

- Col (b): Sample: Universe ***or*** 70 patient sample
- Col (c): Patients in the sample who
  - Received tobacco use cessation services ***OR***
  - Received an order for cessation medication (Rx or OTC) ***OR***
  - Was on medication
- Exclusions: None

Charts Sampled or EHR Total (b)	Number of Patients Advised to Quit (c)

128

Asthma Pharmacologic Therapy

	Asthma Treatment Plan	Total Patients aged 5 - 40 with persistent asthma (a)	Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

- Col (a) Universe: Patients aged 5 through 40:
  - Were diagnosed with *persistent* asthma ***AND***
  - Were born between 1/1/71 and 12/31/06 ***AND***
  - Were last seen while between ages 5 and 40 ***AND***
  - Were last seen after they turned 5 ***AND***
  - Who have been seen at least twice (ever) in the practice ***AND***
  - Had at least one medical visit in a health center *clinic* during the reporting year

129

Asthma Pharmacologic Therapy - Continued

- Col (b): Sample: Universe ***or*** 70 patient sample
- Col (c): Patients in the sample who
  - Received or had a prescription for inhaled corticosteroids ***OR***
  - Received or had a prescription for an approved alternative medication ***OR***
  - Was on medication
- Exclusions:
  - Allergic reaction to asthma meds
  - Intermittent asthma

Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)

130

Cross Table Issues

- Table 3A and 5 and 6B: Reporting of each universe must be consistent with total patients by age on 3A as adjusted for the proportion 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

131

Analysis: Use of Data

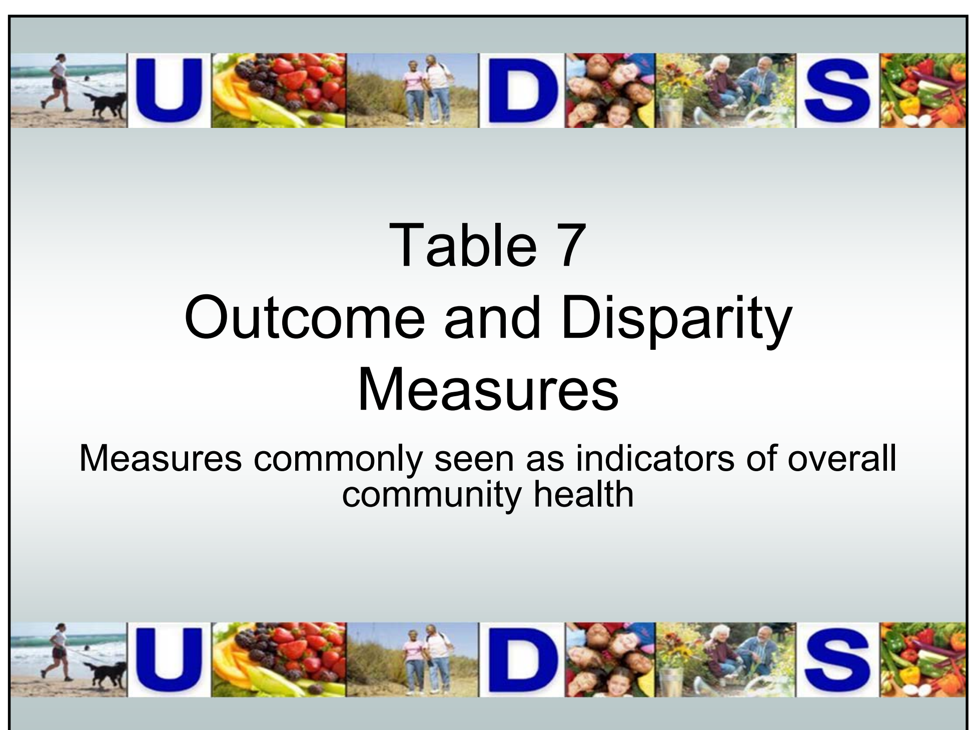
- Compliance rates for clinical measures
  - SAC/BPR reporting
  - Your three year trend – improving?
  - Comparison with national averages for BPHC funded programs
  - Comparison with Healthy People goals

132

Changes *Scheduled* for 2012

- These are proposed but not yet approved.
  - They will be reported in 2013
  - Based on data that will be collected in 2012
- Added (for specific age ranges):
  - Coronary Artery Disease (CAD): Lipid Therapy
    - CAD patients 18 and over prescribed lipid-lowering therapy
  - Ischemic Vascular Disease (IVD): Aspirin Therapy
    - IVD patients 18 and over with documentation of use of aspirin or other antithrombotic
  - Colorectal Cancer Screening
    - Patients 50 – 75 with appropriate screening

133



LAL Modifications – Table 7

- Most of the table contains exactly the same reporting requirement for FQHC Look-Alikes, except for the following fields which are greyed out:
  - Lines 1a – 1g, 2a – 2g, and line h: Disparities (race/ethnicity) data. *Complete only the total line i.*

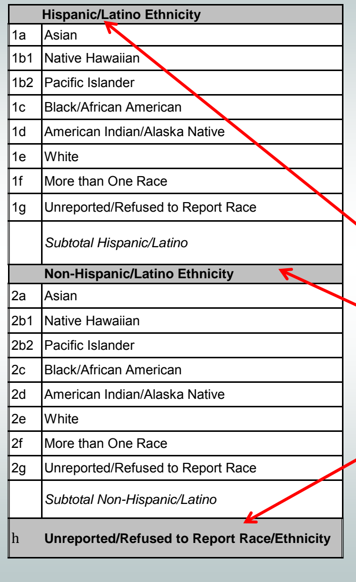
135

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

136

Disparities Format Update



	Hispanic/Latino Ethnicity
1a	Asian
1b1	Native Hawaiian
1b2	Pacific Islander
1c	Black/African American
1d	American Indian/Alaska Native
1e	White
1f	More than One Race
1g	Unreported/Refused to Report Race
	Subtotal Hispanic/Latino
	Non-Hispanic/Latino Ethnicity
2a	Asian
2b1	Native Hawaiian
2b2	Pacific Islander
2c	Black/African American
2d	American Indian/Alaska Native
2e	White
2f	More than One Race
2g	Unreported/Refused to Report Race
	Subtotal Non-Hispanic/Latino
h	**Unreported/Refused to Report Race/Ethnicity**

- All outcome data are reported in a matrix to show ethnicity *and* race
  - Format has changed to make it more readable
  - Race and ethnicity are now *rows*
- Latino patients are reported in section 1
- Patients who report race but not ethnicity are assumed non-Hispanic and reported in section two.
- Patients with *neither* race *nor* ethnicity are reported as Unknown section 3

137

Change for 2011

- Changed:
  - For diabetes: categories will be <7, 7 – 7.9, 8 – 9 and >9.
    - This adds a category
    - Controlled is considered ≤ 9, not < 8

138

Birthweight

- Line “0” Universe: Report all pregnant HIV patients seen in the clinic, regardless of whether or not they received prenatal care.
  - All grantees report, including those with no prenatal care program
- Line 2: Report the total number of deliveries *performed by center clinicians* including deliveries to non-health center patients.
  - Only agencies which provide prenatal care complete line 2 – line is blanked out for others

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

139

Birthweight - Continued

- Column 1a: Report – by race and ethnicity – all prenatal patients from Table 6B who were *known to have delivered* during the year, even if the delivery was done by another provider.
- Columns 1b – 1d: Report all live births born to CHC patients in the program year by weight, including multiples, regardless of who performed the delivery.

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)

- Column 1a need not / will not / should not equal the sum of columns 1b + 1c + 1d except by coincidence

140

Controlled Hypertension

- Column 2a: Universe. Report the total number of patients
  - ***aged 18 to 85***
  - with a diagnosis of hypertension prior to 6/30/***11***;
  - with at least 2 medical visits during the reporting year
- Column 2b: Charts reviewed: Either everyone reported in column 2a or a sample of 70 patients
- Column 2c: Compliance: Number of charts reported in column 2b which report the most recent blood pressure as less than 140/90
- Exclusions: Pregnant women & End Stage Renal Disease

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

Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)

141

Controlled Diabetes

- Column 3a: Universe: All patients
  - ***aged 18 to 75***
  - with a diagnosis of diabetes
  - with at least 2 medical visits during the reporting year
- Column 3b: Charts reviewed: Either everyone reported in column 3a or a sample of 70 patients
- Column 3c – 3f: Test result: Number of charts in Column 3b whose last HBA1c in the reporting year is in the given range

Note that new categories are being used. The new categories do not change the definition of compliance and can be added up to the old ones.

Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%<= Hba1c <8% (3d)	Patients with 8%<= Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)

142

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 column 3a patients:
- If your system *cannot* identify *all* such exclusions report the universe unadjusted:
  - Column 3a will equal the universe (including patients with these excludable diagnoses)
- If a patient with one of these diagnoses is identified in the sample, do not reduce Column 3a, but exclude the patient and add a substitute patient from the universe

143

Cross Table Issues

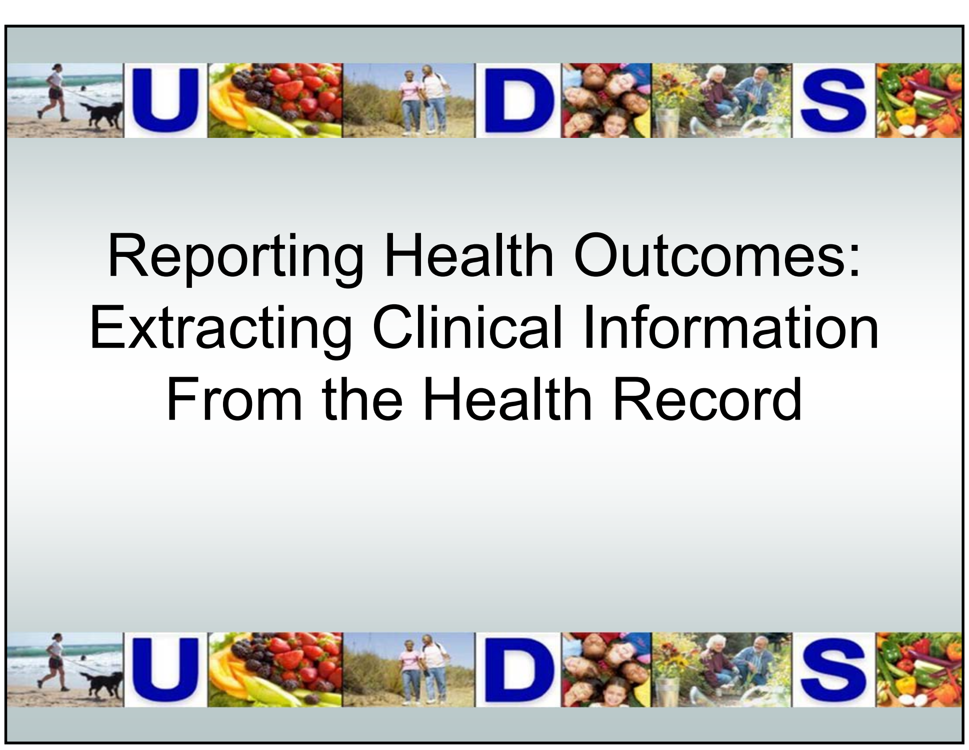
- Table 3A / 3B and 7: Diabetic and/or hypertensive patients on Table 7 may not exceed:
  - Total estimated number of medical patients for that race or ethnicity reported on Table 3B
  - Total medical patients on Table 5
  - Total estimated medical patients by age on Table 3A adjusted by % medical on 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

144

Analysis: Use of Data

- Compliance rates for clinical measures
  - SAC/BPR reporting
  - Your three year trend – improving?
  - Comparison with national averages for BPHC funded programs
  - Comparison with Healthy People goals
  - Disparities in health outcomes by race and ethnicity (only at national level)

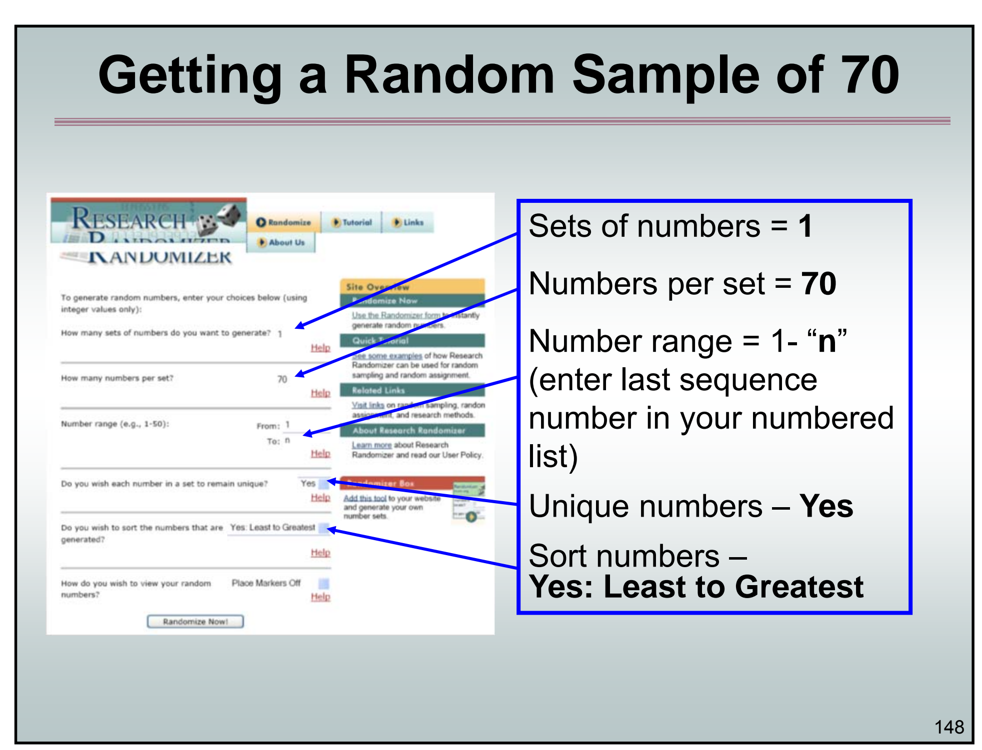
145



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…***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***.**
  - 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

147



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.

149

Data sources

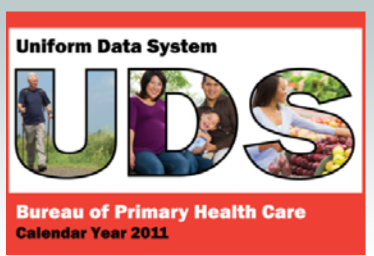
- Before charts are actually pulled and reviewed, other sources may be queried for the "answer" on compliance:
  - EHRs, EMRs, PMSs
    - May not cover all patients or be in place for a long enough time, but may still be used to review patients and periods which *are* recorded
  - Immunization registries 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

150

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

151



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

HRSA

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