

2021 UDS Training Q & A

DISCLAIMER: This FAQ document is our best attempt to capture all the Questions and Answers that were discussed during the first 4 Massachusetts 2021 UDS sessions. Please view the 2021 UDS Manual and other complementary HRSA materials as the ultimate source of truth.

11/29/2021 QUESTIONS:

Q: ARE HEALTH CENTERS USING THE PRELIMINARY REPORTING ENVIRONMENT (PRE) FOR EARLY ACCESS?

A: The PRE allows health centers to login to your UDS performance report prior to January 1. It's a benefit for new staff who haven't used the system, to get familiar with the EHB. The EHB is open now. 25% of health centers did access the PRE in 2020, and that was an increase from the prior year. To access the PRE, login like you normally would after January 1. See the banner on top of the EHB that will say "you are in the Preliminary Reporting Environment". Remember, your data is not complete until December 31.

Poll UDS reporting experience

Poll ended | 1 question | 80 of 99 (80%) participated

1. How much UDS experience do you have? (Single Choice) *

80/80 (100%) answered



Q: WILL 2023 DEIDENTIFIED PATIENT LEVEL DATA BE COVERED?

A: For UDS 2022, there is a proposed PAL, not yet finalized. It should be available in the next week or two and will include final changes for 2022. The UDS Patient-Level Submission (UDS+) is a redesigned section of the UDS report that will replace the existing patient-oriented tables,

aggregated at the health center level, with patient-level data in the 2023 UDS report. **[UPDATE SINCE TRAINING: HRSA HAS FINALIZED THE 2022 UDS CHANGES:** <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2022-uds-pal-2021-05.pdf>; **in this PAL, The methodology for using patient chart sampling to report clinical quality measures on Tables 6B and 7 will no longer be an option beginning with 2022 UDS.]** The UDS+ Initiative aims to increase the utility of UDS report data and to reduce annual reporting burden by aligning with interoperability standards and reporting requirements used across the U.S. Department of Health and Human Services and within the healthcare industry. Resource: <https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html>

Q: WILL WE BE GOING OVER THE COVID-SPECIFIC GUIDANCE IN THIS SEMINAR?

A: In our next session we will cover COVID specific guidance as it relates to COVID encounters which may determine who does, or doesn't count as a patient, and what does/does not count as a visit.

Q: WHAT DEFINES A COUNTABLE VISIT? GIVEN THE PANDEMIC, DO PATIENTS NEED TO COME ONSITE TO REGISTER?

A: There is not a requirement that patients have to come onsite to register. A patient visit does not need to be in-person, however, a virtual encounter must meet the criteria / threshold of a countable visit. All countable visit criteria remains the same.

Q: IN THE ZIP CODE TABLE, DO WE REPORT ALL INDIVIDUALS, INCLUDING THOSE WHOSE VISITS ARE NOT PART OF THE COUNTABLE VISITS (COVID-19)? IN THE INSURANCE TABLE IT LISTS TO REPORT ALL.

A: On the zip code table 3A and 4, only report patients who are patients of your health center. They must have a countable visit on Table 5. Patients with only a COVID-19 test / vaccine would not be considered a patient of the health center and would not be included in 3A, 3B (Ethnicity, Race & Language), 4, etc. The only exception would be that the provider time which is considered in scope would be counted in Table 5 FTE.

Q: WHERE IN THE UDS ARE NON-PATIENT INFORMATION INCLUDED AS IT RELATES TO COVID TESTING / VACCINATION / ETC.?

A: Table 9D charges or collections for screening and reimbursement for non-health center patients should be reflected in Table 9D because it's in-scope. Note: HRSA survey completed weekly is not apples to apples with the UDS report.

Q: WHICH CATEGORY OF RACE WILL PEOPLE FROM HAITI, DOMINICAN REPUBLIC BE PLACED INTO?

A: Race, ethnicity, sex assigned at birth are all self-reported. Guidance is as follows:

- Haiti: report as Black/Non-Hispanic/Latino/a (unless otherwise identified as Hispanic/Latino/a), Line 3 (col a or b)
- Dominican Republic: this race doesn't naturally fall into a race category on Table 3B but falls into Hispanic/Latino/a. Recommend reporting as unreported race/ethnicity and hispanic/latino/a - Line 7 col b

Q: SEXUAL ORIENTATION AND GENDER IDENTIFY (SOGI)

Resource: <https://fenwayhealth.org/the-fenway-institute-released-new-tools-to-help-healthcareorganizations-collect-sexual-orientation-and-gender-identity-data-to-improve-quality-of-careand-reduce-lgbt-health-disparities/>

Q: DO WE HAVE TO COLLECT PAY STUBS OR DOCUMENTS TO SUPPORT THEIR STATED INCOME EVEN IF THEY ARE NOT APPLYING FOR A SLIDING FEE SCALE?

A: If patients are not applying for a sliding fee scale, you do not need to collect documentation, and income can be self-reported. Note: Each health center will have a sliding discount policy that might include additional guidance.

Q: HOW DO YOU FIND YOUR COMPARISON REPORT IN THE ELECTRONIC HANDBOOK (EHB)?

A: If you have EHBs (Electronic Handbook) access, you can access your health center's comparison reports by following the guidance here; p. 11-14:

https://massleague.org/Calendar/LeagueEvents/UDS/2021/7_UserGuideforAccessingtheUDSinEHBs.pdf

Note: Your health center CEO or others with access can change your permission level within the EHB.

Q: IS THERE A PLACE TO STORE DOCUMENTS FOR OPERATIONAL SITE VISIT (OSV)?

A: As OSVs occur every three years, reviewers will be looking for recent examples of your sliding fee discount policy, approved by your Board of Directors, and want you to have personally selected recent examples. It is more of a review and a pull and might be helpful to put them in a file share system for the OSV. To prepare in advance, you may want to pre-select the patients.

Q: IF A PATIENT NEEDING TO APPLY FOR A SLIDING SCALE FEE IS UNABLE TO PROVIDE PROOF OF INCOME ON THE DAY OF SERVICE, ARE WE ABLE TO BACKDATE A SLIDING SCALE FEE TO THAT DATE OF SERVICE ONCE VERIFICATIONS ARE PROVIDED?

A: This would defer back to your health center's Board of Directors approved Sliding Fee Discount policy. If the policy doesn't exclude that backdate, you can rely on that to define your ability to retroactively adjust for a sliding fee scale.

Q: UNHC - SCO (EVERCARE) IS FOR 65+ OVER MEDICARE PATIENTS THAT ARE MEDICAID ELIGIBLE. WOULDN'T THAT BE REPORTED ON Line 9A?

A: Senior care options through Medicare are reported on line 9 (dually eligible), and also reported on line 9A (a subset of 9).

Q: HOW IS WORKER'S COMP CATEGORIZED?

A: Worker's Comp is considered to be a form of liability insurance for employers, and is not considered health insurance. Patients usually have primary health insurance and this should still be reported in the health insurance Table 4 as primary insurance, even if you are not billing their health primary insurance.

Q: FOR TABLE 4 MANAGED CARE, ARE THE MEMBER MONTHS AS OF 12/31/21?

A: Yes, the whole report is for 1/1/2021 - 12/31/2021. Patients do not have to be there for the entire duration to be included.

Q: WE ARE WITHIN WALKING DISTANCE TO SEVERAL PUBLIC HOUSING BUILDINGS AND ON A BUS ROUTE TO MANY MORE, THEREFORE WE HAVE ALWAYS BEEN TOLD TO REPORT 100% OF PATIENTS ON LINE 26.

A: It is up to your health center to determine whether a site is immediately accessible to public housing. If it is designated as such, you should report 100% of the patients seen at your health center on Line 26 (Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site).

12/2/2021 QUESTIONS:

Q: WOULD THE COVID-19 TEST CONSTITUTE A SERVICE OR VISIT?

A: If a patient received only a test and no other information was given except for the test = No. But there are examples (e.g. patient has symptoms; triaged) where a testing service could turn into a visit?

Q: THIS INCLUDES FOLLOW-UP CALL THAT WAS MADE TO CONVEY THE TEST RESULT?

A: Yes, similarly to a COVID test. A call to follow-up on a COVID-19 test on its own is not a visit. If the phone call meets all of the other visit requirements (e.g., documented in the chart, provided by a credential. Licensed provider, through a face to face visits, where the provider provided full, independent, professional judgment then it could meet the definition of a visit. For example, if a nurse is communicating positive results for someone who is symptomatic and is looking for nurse triage support then this might qualify as a visit if it met all of the other visit requirements. However, communicating the results on their own is not sufficient.

Q: RE: Prenatal Measure. Can you clarify what specifically is needed for a FORMAL referral agreement, or if perhaps it's one of those areas that is somewhat open to our discretion?

Short answer: Only those patients who are provided prenatal services directly by the health center or by one of their formal referral partners should be included in the UDS.

Longer answer: On p. 87-88 of the [2021 UDS manual](#), it states that CHCs should:

- ...Report on all patients who are either provided direct prenatal care or referred for prenatal care.
- ... DO NOT include patients who did not receive prenatal care from a health center provider or who were not referred by the health center to another provider for prenatal care.
- DO NOT include patients who chose to receive all their prenatal care outside of the health center's referral network.

On p. 14 of the UDS Manual, it states that CHCs should “data that reflects activities in the HRSA health center project, as defined in approved applications and reflected in the official Notice of Award/Designation.” Meaning, patients should be those who receive in-scope services as listed in [HRSA's Form 5A](#).

Q: IN THE LAST MEETING, YOU MENTIONED THERE WOULD BE A MASSACHUSETTS PAYER / CATEGORIZATION LIST FOR TABLE 4. WILL THAT APPEAR ON YOUR WEBSITE WHEN IT'S AVAILABLE?

A: Yes, it will. We currently have the one we created for 2020. In the 2021 version, we will review it with Amanda and see if there are any changes. You can use 2020 as a starter and wait for the 2021 version, which will be available soon. To access last year's UDS clarification memo (note that we will be updating it for 2021 shortly) can be found here:

<https://www.massleague.org/Calendar/LeagueEvents/UDS/2020/MassachusettsHealthCentersJSMemo-2020.pdf>

Q: WHAT IF PATIENT REFUSES LANGUAGE? WHERE TO PLACE THAT?

A: Table 3b, line 12. You are only reporting # patients served in a language other than English.

Q: IS THERE A LIST OF TABLES FOR WHICH WE CAN DO AN EXCEL UPLOAD?

A: You can do the Excel upload for all of the tables and forms.

Q: ARE WE GOING TO HAVE A UDS FORUM? LIKE WE DO FOR COVID-19 VAX PEERTO-PEER FORUM?

A: Yes, we will launch it next week. Everyone who is registered for this training will automatically be added to the forum. It will be monitored by Mary Ellen McIntyre and members of the Health Informatics Team.

Q: CAN VISITS BE NON-BILLABLE OR DO THEY HAVE TO BE BILLABLE VISITS TO BE COUNTED IN THE UDS?

A: Billable and non-billable visits are not a factor for counting visits in the UDS. Resource:

<https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2021-uds-countablevisits.pdf>

Q: ARE NURSING VISITS WHERE VACCINES ARE ADMINISTERED COUNTABLE? THERE IS PATIENT EDUCATION THAT GOES ON IN THESE VISITS.

A: Vaccine administration alone is not a countable visit if there were no other services provided.

Q: CAN YOU DESCRIBE WHY THIS CHANGE WAS MADE FOR INTEGRATED SUD IN MH VISIT?

A: Change was added in 2019 because there was no way to show that these integrated services were happening in Table 5 (they were being significantly underrepresented).

- **Q: IS IT JUST PSYCHOLOGISTS OR SOCIAL WORKERS AS WELL?**

- A: It includes licensed social workers

- Resource: <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2021-udsselected-service-detail-guidance.pdf>

Q: IF A PARTNER OF A PATIENT IS GIVEN PREP, BUT NO OTHER SERVICES, THEY DO NOT COUNT, CORRECT?

A: Yes, that is correct.

Q: DOCUMENTING FOLLOW-UP PLAN ON DAY OF VISIT. IF SOMEONE HAS A VISIT LATE ON A FRIDAY AFTERNOON, BUT DOCUMENTATION OF VISIT WITH FOLLOW UP PLAN IS COMPLETED ON MONDAY, DOES THAT STILL COUNT?

A: The requirement is that the follow up plan is documented on the day of the visit. There is no flexibility in that. The level of documentation is determined by the provider.

Q: PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN- WE HAVE SEEN A DIP IN THIS MEASURE, VERY CONFUSING SEE CHANGE -PREVIOUSLY, A FOLLOW-UP NEEDED TO BE DOCUMENTED WITHIN 12 MONTHS BEFORE A QUALIFYING ENCOUNTER WHERE AN ABOVE OR BELOW NORMAL BMI WAS ALSO DOCUMENTED WITHIN 12 MONTHS BEFORE THAT ENCOUNTER. FINALLY, A FOLLOW-UP REASON NOW NEEDS TO BE DOCUMENTED FOR ORDERED AND PERFORMED INTERVENTIONS AS WELL AS FOR REFERRALS. PREVIOUSLY, A FOLLOW-UP REASON WAS REQUIRED ONLY FOR REFERRALS. COULD YOU DISCUSS?

A: We have heard this from multiple CHCs. You can add a comment on your report on Table 6B to let your reviewer know that your care plans have not changed, but it is due to the changes in the CQM logic.

Q: DEPRESSION AND SCREENING: TO CLARIFY THIS IS LOOKING FOR ONE SCREENING FOR THE YEAR AND IS NOT LOOKING AT MOST RECENT VISIT

A: This is looking at the most recent screening for the year. If screening at multiple visits multiple times a year, you would use the most recent screening.

Q: DEPRESSION REMISSION - WHAT WOULD THE MEASURE CONSIDER A POSITIVE SCORE VALUE, 9 OR 10?

A: To be included in the denominator, it is a score greater than 9.

Q: WE ARE STARTING A PROGRAM TO GIVE PATIENTS BP CUFFS THAT USES BLUETOOTH. THE PATIENT WILL BE TAKING TWO READINGS THAT WILL LOAD INTO A DASHBOARD, 2 IN THE AM, 2 IN THE PM. FOR THESE TO COUNT, DOES THE PROVIDER NEED TO SEE THE PATIENT TAKING THE BP?

A: Device needs to directly transmit data into the system. RPM is permissible if it is transmissible to where a provider can see it - no video component required. If the provider is watching the patient take BP (usually the device is not capable of transmitting reading), then it can count.

Q: IF A NURSE WAS HIRED FOR TWO ROLES: NURSE AND CASE MANAGEMENT OR MAYBE NURSE AND COMMUNITY HEALTH EDUCATOR FTE SPLIT 50/50; SAY THE NURSE HAD 150 VISITS, 50 OF THEM WERE CASE MANAGEMENT ONLY, SHOULD WE SPLIT THIS NURSE VISITS AND COUNT THEM ON EACH CORRESPONDING LINE? E.G. LINE 11 = 100 AND LINE 24 = 50?

A: If the staff person has a significant part of their time dedicated to a separate service category, then health centers should parse that out. So, for example, if half of their FTE is dedicated to case management and half dedicated to medical care services (nursing), they should separate out that FTE on Table 5. Please note that splitting FTE across multiple lines on Table 5 means that the same proportional allocation must be used for that individual's personnel costs on Table 8A. It sounds like that is the case in this specific example. Note that if this is more of an ad-hoc service provided or PART of their day to day job, I would not recommend splitting the FTE (and therefore the visits, etc.) up. You should not try and parse out different parts of the same visit. Whilst the personnel is working as a case manager, report visits as case management and vice versa for nurses. If there are 50 case management visits that were generated while working in the case management role, those should be reported on Line 24 in the enabling section.

12/6/2021 QUESTIONS:

Q: WILL THE FAQ INCLUDE HELPFUL SCRIPTS STAFF ASKING THE UDS REGISTRATION QUESTIONS COULD REFERENCE WHEN ASKED WHY HEALTH CENTERS ASK THESE QUESTIONS BY PATIENTS?

A: League staff posted a question on this in the newly launched League UDS Online Community.

Q: WHERE DO WE REPORT PPP LOAN FORGIVENESS?

A: PPP Loan administered through the Small Business Administration, even if forgiven, should not be reported on UDS. If interest is paid, it would be included in Table 8A as a cost, but nothing else would be reporting on the UDS.

Q: SHOULD WE USE THE FEDERAL PAYMENT MANAGEMENT SYSTEM (PMS) TO MAKE SURE OUR HRSA RECEIVED FUNDS MATCH THE PMS REPORT?

A: UDS Trainer does not have access to the PMS report or amount received by CHC. The Bureau has access to it and will be looking at it. Funds shouldn't match directly what you received, but should match what you drew down in 2021. Responsibility is on the CHC to ensure the amount is accurate and not overstating the award amount.

Kate T at EMKCHC: "we use cash receipts so it's when it arrives (i.e. drawn 12/31/21, won't receive until 2022)."

Q: WHAT IF WE CONSULT WITH SPECIALISTS VIA SECURE TEXTING? IS THAT CONSIDERED TELEHEALTH (on the Other Data Elements Form)?

A: Yes, if you indicate you provide telemedicine services on this form

Q: REGARDING MULTIPLE VISITS IN ONE DAY - IF ONE VISIT IS TELEHEALTH AND ONE IN PERSON, TO BE COUNTED AS 2 VISITS WOULD YOU NEED 2 DIFFERENT PROVIDERS?

A: That is correct. In person and telehealth are considered two different locations. As long as they are two different providers, they can both count on the same day.

12/9/2021 QUESTIONS:

[Uniform Data System 2021 Health Center Data Reporting Requirements \(hrsa.gov\)](https://www.hrsa.gov/uds)

ZIP CODE TABLE

Note: the data you enter into UDS is used in UDS Mapper to provide resources back to health centers for planning purposes. Link: <https://maps.udsmapper.org/>

Tip: Health Centers can download your excel file from last year as a starting place so they do not need to be re-typed manually.

TABLE 3A: PATIENTS BY AGE & SEX ASSIGNED AT BIRTH

Note: there are no “Unknown” categories on this table.

TABLE 3B: DEMOGRAPHIC CHARACTERISTICS

Q: WHAT IS THE CUT-OFF THAT IS FLAGGED FOR “UNKNOWN” FOR RACE & ETHNICITY, AND SEXUAL ORIENTATION & GENDER IDENTITY?

A: Sexual Orientation and Gender Identity - The “Unknowns” (Line 18A and 25A) would be expected to be higher than the “Other” and “Don’t Know” categories - that is an easy check as a first step. Race and Ethnicity - when patients select a race but not an ethnicity, they should be included in Column B and default into “Non-Hispanic or Latino.” Only the patients that are actively not reporting a Race or Ethnicity should be included in Column c on line 7.

TABLE 4: SELECTED PATIENT CHARACTERISTICS

Q: WHAT IF A PERSON DECLINES TO SHARE INCOME?

A: If people decline income, report them as unknown. Based on your BOD policy, if they are applying for a sliding fee, they will need to provide documentation of income.

Q: IS THERE A FLAG FOR “UNKNOWN” INCOME (LINE 5)?

A: Yes, income is a required field included in the compliance manual. Generally, this field varies a lot state by state. Over 30-40% “Unknown” will likely be raised during the review period. If health centers have over 50% “Unknown” they should provide detailed documentation of the process for collection of this information.

Q: IS THERE ADVOCACY BEING CONDUCTED TO DISTINGUISH BETWEEN UNKNOWN AND DECLINED? (DECLINED = YOU’VE MADE THE ATTEMPT TO ASK BUT THE PATIENT DECLINED VS. UNKNOWN, WHICH SUGGESTS THE QUESTION WAS NOT ASKED.)

A: This is a valid point. If health centers have that detailed level of information available, that is something that would be helpful to add to your UDS report. We are not aware of current advocacy or conversations looking at revisions to Table 4 specifically. If you do have suggestions, you can always submit those through the HRSA contact form at [Contact BPHC \(force.com\)](https://www.force.com).

Q: IF A PATIENT ISN'T APPLYING FOR A SLIDING FEE, THEN THE INCOME IS SELF REPORTED CORRECT? NO BACKUP SUCH AS W-2 OR PAY STUBS ARE REQUIRED IF NO SLIDING FEE.

A: Yes, income can be self-reported if a patient is not applying for a sliding fee.

Q: PLEASE EXPLAIN THE DIFFERENCE BETWEEN MEDICAID AND THE OTHER PUBLIC INSURANCES? WHERE WOULD ACO'S FALL?

A: Mary Ellen: The League will be preparing an insurance clarification memo to clarify how things should be classified in the various fields.

Principal Medical Insurance

Q: WE USE OCHIN AND THIS YEAR AND THEY ARE INCLUDING HEALTH SAFETY NET ON LINE 10A AND HAVE A PLACED A REQUEST WITH OCHIN TO BE RECLASSIFIED AS "UNINSURED".

A: League Health Informatics team are in touch with OCHIN EPIC. More information will be provided as available.

Q: IN 2021, WE DID NOT DO A THOROUGH JOB OF COLLECTING INSURANCE INFORMATION FROM DENTAL PATIENTS. OCHIN? DOES NOT MAKE THE PRESUMPTION THAT IS INDICATED IN THE MANUAL THAT IF A PATIENT HAS MEDICAID OR COMMERCIAL DENTAL INSURANCE, YOU MAY PRESUME THAT THEY HAVE THE SAME INSURANCE FOR PRIMARY MEDICAL. THIS IS NOT BUILT INTO THE REPORTING SO OUR "UNINSURED" NUMBERS LOOK HIGHER THIS YEAR. WE ARE LOOKING AT MANUAL WAYS TO PULL IN DENTAL INSURANCE INFORMATION AND REASSIGN PATIENTS WITHIN TABLE 4. IS THIS LOOPHOLE LEGITIMATE?

A: If a patient has Medicaid, Private, or Other Public dental insurance, you may assume they have the same kind of medical insurance. If they DO NOT have dental insurance, you may not assume they are uninsured for medical care. FAQ Page 44 UDS Manual loophole

Note: Line 26 does not require asking patients specifically.

TABLE 5 STAFFING AND UTILIZATION

Q: IF AN EMPLOYEE WAS HIRED FOR TWO ROLES AND THE FTE IS 50/50, HOW DO WE

REPORT THE VISITS ON EACH LINE? (EXAMPLE: .5 FTE NURSING / .5 FTE CASE MANAGEMENT)

A: If a staff person has a significant part of their time split between two roles, you can parse that out. The same proportional reporting needs to be included on Table 8a for costs. Only separate them out if they have DEDICATED portions of their time that are for those distinct positions.

Note: Table 5 is FTE; The Addendum is a head-count / # of staff, as opposed to FTE.

TABLE 6A

Note: COVID Vaccines are reported on Table 6A. Only report those vaccines provided to those individuals who are patients at the health center (had a countable visit on Table 5 during the year). Example: if you had a patient who received their first, second and booster, shots in 2021, they can be counted as 3 visits for one patient on Table 6A - Line 24B.

Q: WHAT IF A PATIENT HAS AN APPOINTMENT WITH A PROVIDER AND IT WAS ABOUT TB SCREENING? WILL THAT BE A COUNTABLE VISIT?

A: A TB screening alone isn't a countable visit but if a patient has a full assessment / consultation it would count as a visit. Clinical assessment and independent decision making = are your providers following an algorithm to make those decisions or are they providing individualized care?

Note: PrEP Management will be looked at closely because of the discrepancy last year that was noted by the CDC - more patients included in UDS PrEP than those who received PrEP Management based on the data. Pay close attention to who is being included on Line 21e; Make sure you are following the guidance for 2021.

TABLES 6B & 7 CLINICAL MEASURES

Q: TABLE 7 - FOR THE DENOMINATOR, SHOULD WE INCLUDE PATIENTS EVER DIAGNOSED WITH A CONDITION, OR JUST PATIENTS WITH THE DIAGNOSIS IN THE REPORTING YEAR. FOR EXAMPLE, A PATIENT WITH HTN DIAGNOSED IN 2020, AND SEEN IN THE HEALTH CENTER IN 2021 FOR A MEDICAL VISIT UNRELATED TO HTN, SHOULD THEY BE COUNTED IN THE DENOMINATOR OF THE HTN MEASURE?

A: In table 7, include patients who have an ACTIVE diagnosis (diagnosis is in their chart & unresolved). *As long as they meet other inclusion criteria.

Q: DOES AZARA ATTEND THESE TRAININGS AND ARE THEY MAKING ADJUSTMENTS?

A: AZARA does keep up to date with all UDS changes. Health centers must also ensure that mapping changes and codes are updated.

TABLE 9E

Note: Line 1o - American Rescue Plan funding was received by all health centers and **all health centers** should report \$ on line 1o.

Note: Line 1p - Other COVID-19 Related Funding from BPHC - There is no additional awarded COVID grant funding and **line 1p should be \$0 for all health centers.**

TABLE 9D

Q: LINE 13 - SELF PAY - FOR HEALTH SAFETY NET, OUR CHARGES ARE SUPPOSED TO GO ON LINE 13, AND ADJUSTMENTS THAT WE TAKE ON HEALTH SAFETY NET WOULD GO ON LINE 13, COLUMN E (SLIDING FEE DISCOUNTS), BUT WE DON'T PUT ANY PAYMENTS FROM HEALTH SAFETY NET, THOSE GO IN TABLE 9 E.

A: If a patient pays any portion of the co-payment, report that in Column B for the Health Safety Net. The total amount received during the calendar year from the State or local indigent care program is reported on Table 9E, Line 6a.

1/18/2022 QUESTIONS:

Q: NEXTGEN USERS - TABLE 9D - WHAT ARE OTHER HEALTH CENTERS DOING?

A: The League's Health Informatics Team has reached out to NextGen and the online communities for NextGen and UDS to ask CHCs to share. The League has heard from a CHC that they use NextGen's standard reports:

- Kathryn Thorsen - EMKCHC - heard there was no way to do this with EPM reports. Not sure what they're going to do. They're evaluating whether they need to get a Crystal Report together, as they were surprised that NextGen was no longer supporting this Table. Their IT stated they received no formal notice from NextGen. In addition, NextGen stopped hosting their monthly CHC calls.
- Sean Kinlin - Holyoke HC - They'll be using some SQL queries to pull 9D data - adapted from queries they used in the past to verify data. They shared that they would be happy to share queries as well, but the queries are not ready yet. Hopefully later this week.
- Michele Sabatino - Harbor Health - They expect to do the same as Holyoke because they have 2 months of NextGen data to pull, despite switching to OCHIN Epic, and are happy to share what they're using.

Q: TABLE 6A AND COVID-19 VACCINES

A: Report COVID-19 vaccines administered on Table 6A. You're reporting only COVID-19 vaccines administered through health center visits (those who have a countable visit on Table 5). It does not have to be administered at a countable visit, just to a patient with a countable visit.

Q: TABLE 6B - ADULT BMI MEASURE

A: To meet the numerator requirements for CMS69v9, the most recent high/low BMI has to be documented during the qualifying encounter or during the previous 12months. However, the follow-up plan/intervention for the most recent high/low BMI must be on or after the most recent high/low BMI. **This differs in the CQL logic compared to the UDS manual and eCQM.**

It is not a requirement to *take* BMI more than once in a year, but if you do, report on the most recent BMI. This guidance remains for 2021 and 2022 reporting.

Please reference our UDS Training recordings to hear this guidance:

- Day 4, Dec. 9: [Overview with Q&A #1](#) - passcode: 1^qP46sr (Addressed this measure at 42:15)
- Day 5, Jan 18th: [Overview with Q&A #2](#) - passcode: #A!M92&p (Addressed this measure at 8:50)

Q: TABLE 6B - TOBACCO MEASURE

A: Tobacco cessation intervention does not need to be on the day or or after the most recent tobacco screen. There just needs to be a screening done in the last 12 months, and, if indicated, cessation intervention is received in the measurement period [calendar year].

Q: TABLE 8A - COST AND SUPPLIES DONATED FROM THE BUREAU IN RELATION TO COVID-19; HOW TO VALUE VACCINES AND TEST KITS

A: It is not a requirement to quantify vaccines as a donation. The federal Government has been paying between \$15-25/dose for the vaccine; it varies on the vaccine and when it was purchased. For test kits are around \$12/kit. For other donations, see this HRSA resource: [Donations Reporting on UDS 2021 \(hrsa.gov\)](https://www.hrsa.gov/ods/2021/donations-reporting)

Q: IF YOU RECEIVED PPE AS A DONATION, CAN YOU COUNT IN TABLE 8A?

A: Yes, count on Table 8A Line 18.

Added since training: As it relates to the donations on Table 8A, health centers should report all in-kind and donated services, facilities, and supplies that are necessary to the health center's operation applicable to the calendar year and within your scope of project. Nearly all health centers report receiving donations during the calendar year and they should report those on the UDS report. The challenge with reporting vaccines accurately is that the COVID vaccines received through the HRSA program carry a **340B** value of \$0.

From market research, the best we can determine is that the government has been paying between \$15 and \$25 per dose depending on which vaccine and when they bought it. So, the takeaway appears to be that there is not a clear, singular valuation, and if health centers want to value the HRSA dose, they should do so at the lower valuation (\$15-\$25) and that would be reported on Table 8A (if they want to value these) -- note that not all health centers will report an amount for COVID vaccines specifically/and that won't be forced.

Q: HOW AND WHERE TO REPORT SPECIFIC FUNDING ON TABLE 9E

A: <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/uds-covid-19-funding-guidance.pdf> All CHCs should be reporting money on American Rescue Plan funding - Line 1O. No money should be reported on Line 1P

Q: DENTAL SEALANT MEASURE - % OF CHILDREN FROM 6 - 9 YEARS OLD

A: Collected on Table 6B, looking at children from 6-9 who are at moderate to high risk for caries who received a sealant on a permanent first molar. Needs to have a dental visit during the year to be considered for measure. Include children with birthdate on or after January 2, 2011, and birthdate on or before January 1, 2015. Birthdates are outlined this way to make sure 9-year olds are not left out.

Q: IN 2019 THE AMERICAN COLLEGE OF CARDIOLOGY (ACC) AND AMERICAN HEART ASSOCIATION (AHA) STOPPED RECOMMENDING ASA FOR PRIMARY PREVENTION FOR CAD/ IVD. THE CURRENT DISEASE DATA SET FOR THE UDS IVD/ANTIPLATELET METRIC DOES NOT REFLECT THESE CHANGES AND HAS DIAGNOSES THAT NO LONGER REQUIRE ASA/ ANTIPLATELET. CAN YOU PLEASE DISCUSS HOW TO ADDRESS THIS DISCREPANCY?

A: Concern with IVD measure is that the specifications have not been updated in several years. Guidance is to report on specifics included in the measure to ensure there is standardization across CHCs reporting this measure. Report on measure as is, although it may result in lower compliance, and the Bureau and your reviewer understands this.

Q: IF PATIENTS REPORT RACE, BUT NOT ETHNICITY

A: Report their race, but report them as non-Hispanic/Latino (column b).

Q: FOR PUBLIC HOUSING QUESTION, IF OUR SITE ARE CONSIDERED IMMEDIATELY ACCESSIBLE TO PUBLIC HOUSING, SHOULD PATIENTS SEEN AT THIS SITE BE COUNTED ON THIS LINE?

A: All patients served at this site should be included on this line. Report public housing as a site-based measure.

Q: CAN YOU PLEASE PROVIDE GUIDANCE ON CIVIL SURGEON (IMMIGRATION PHYSICALS) ARE COUNTABLE VISITS?

A: A physical is a countable visit on Table 5.

Q: 6A TB LINE: PLEASE CONFIRM THAT WE CAN ADD ICD-10 CODES USED IN OUR INTERNAL MONTHLY REPORTS TO COUNT PATIENTS WITH TB. (SPECIFICALLY: R76.11, R76.12, Z22.7, Z86.15)

A: If there is a code that maps **directly** to the service included on Table 6A, then you can include it. If these codes are an exact replica of those included on this line, then include it. If they vary slightly, submit this question through the UDS support line: [Uniform Data System \(UDS\) Resources | Bureau of Primary Health Care \(hrsa.gov\)](https://www.hrsa.gov/uds-resources).

Q: MULTIPLE VISITS IN A SERVICE ON THE SERVICE - SEEN BY A NURSE THEN A FAMILY PHYSICIAN, SHOULD THIS BE COUNTED AS ONE VISIT?

A: Should be counted as 1 visit in the medical service category.

Q: IN THE ADDENDUM, IF THERE ARE TWO DIFFERENT PROVIDER TYPES IN THE SAME SERVICE CATEGORY, SHOULD THESE BE COUNTED AS BOTH?

A: Yes, that is correct. For example, if a medical provider provides both mental health and substance use services during their medical visits, the provider should be included in both sections of the addendum.

Q: FOR SUBSTANCE USE, ARE WE COUNTING TOBACCO USE? WHERE DO WE REPORT THIS IN THE ADDENDUM?

A: Table 6A, tobacco use is reported on Line 19a. When these services are performed by medical or mental health providers, also report on the addendum in the Substance Use Disorder Detail Section.

Q: LINE 24B - CORONAVIRUS (SARS-COV-2) VACCINE IN 6A TABLE. HOW DO WE COUNT THIS ONE?

A: Reporting all health center patients who had a countable visit and received a COVID vaccine. First, second, and booster shots can all be counted in Table 6A, column A (each would not be a countable visit on Table 5).

Q: IF PATIENT HAS TELEHEALTH AND IN-PERSON VISIT THE SAME DAY, BUT SEES DIFFERENT PROVIDERS, DO WE NEED TO ONLY COUNT ONE OF THESE?

A: Virtual visit and clinic visit are considered to be different sites and can be counted even if they occur the same day

Q: 6A MAMMOGRAMS: PLEASE CLARIFY HOW TO IDENTIFY:

- **MAMMOGRAMS REVIEWED AT CENTER (DONE ELSEWHERE)**
- **DONE AT CENTER**
- **PAID BY THE CENTER BUT DONE ELSEWHERE**

(CURRENT METHOD IS USING ICD CODES WHICH INCORPORATES EVERYTHING ABOVE AND EVEN MORE)

A: All of these should be included in Table 6A.

Q: IN ORDER TO COUNT IN THE BP MEASURE, IS RPM PERMISSIBLE?

A: RPM is permissible if it is transmissible to where a provider can see it, no video component required. In addition, if the provider or member of the care team is watching the patient take the BP over a video, it can count.

Q: IS THERE A STANDARD TABLE LISTING VALUES (COST) OF STATE-SUPPLIED VACCINES?

A: Not that HRSA is aware of. MLCHC will review this question internally

Q: TABLE 9E:

- Line 1o is American Rescue Plan grant funding, which was received by all health centers (330 funded and LALs). It is expected that all health centers will report dollars on this line. If you do not report on this line, provide an explanation with submission.
- Line 1p, Other COVID-19-Related Funding from BPHC (specify_____) BPHC has not awarded additional COVID grant funding, so no revenue should be reported on this line.

Q: ARE THE FORMS ACCESSED VIA EHB?

A: Yes; all UDS tables and UDS forms are included directly in EHB.

Q: What is the review process?

After February 15, the JSI UDS Reviewer will review your submitted UDS report and develop a letter with observations and any questions related to your submission of data. The letter will be received within 2 weeks of submission. The CHC will be given an opportunity to provide an explanation or changes by an established due date.

Q: Is there a standard table listing values (cost) of state-supplied COVID-19 vaccines?

A: The League will follow up on this and post details in the UDS Higher Logic community.

UDS RESOURCES:

- <https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/fundingopportunities/sac/form5a.pdf>
- <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/uds-covid-19-funding-guidance.pdf>
- <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/uds-crosswalk-standardized-screeners.pdf>
- <https://bphc.hrsa.gov/datareporting/reporting/outreach-enrollment>
- <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2021-forms-fact-sheet.pdf>
- <https://massleague.org/Calendar/LeagueEvents/UDS.php>