2022 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 2022 UDS sessions. Please view the 2022 UDS Manual and other complementary HRSA materials as the ultimate source of truth.

DAY 1:

Q: IS THERE A CROSSWALK AVAILABLE OF THOSE TABLE RELATIONSHIPS?

A: Alec to ask about this, but could possibly come up with one. Table 4 – 9D. Zip code table to insurance section of table 4. Managed care section of Table 4 and 9D. Table 5 staffing costs and staffing categories. In the manual, Appendix B has a crosswalk.

- Zip code with Insurance
- Table 5 and table 8 a - cross walk for staffing and cost
- Table 4 with 9D - Specific relationship. No. of people to be uninsured in table 4 is often higher than table 9D. Table for only looking for full coverage but also other public coverage.
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There's not really a report-wide list of cross walk and table relationships.
Appendix B. covers most problematic issues on the UDS. Includes unique and often complicated situations.
https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf

Q: LAST YEAR WE (NUMBER OF FQHCs) HAD MAJOR ISSUES WITH MANAGED CARE (13a-13c). WE WERE NOT ABLE TO OBTAIN DATA FROM SOME PAYERS, AS THEY DIDNT HAVE THIS DATA AVAILABLE. WE ALSO DONT HAVE SYSTEMS THAT KEEP COUNT OF MEMBERS MONTHS.

A: This is a common problem across all states. Do some probing beforehand and talk to colleagues if they've been able to get this. If you cannot get the data, document in the EHB what you have done to try to get the data and your challenges. Table 9D captures charges related to this, HRSA can get a rough sense of whether you've been able to capture this data historically. *Ask other health centers via the Mass League's UDS online community.*

TABLE 4 TIP RE: INCOME: If the unknown category is 30%+ as a general rule (5-10% above the state average, and if significantly changed from previous year's submission), it will flag for the UDS reviewer. You might want to provide training for intake staff to address if high.

Q: DO MOST CHCS' INTAKE FORMS OBTAIN INFORMATION ON BROAD RACE/ETHNICITY CATEGORIES, OR JUST THE CATEGORIES LISTED ON TABLE 3B?

A:

- It is broad for GLFHC.
- For Duffy, just table 3B, but people sometimes just write in what they want.
- FHCW - we previously had broad categories and changed it to just table 3b. I think we have user defined fields for nationality or something.
- Brockton - our Race and Ethnicity tables look like the 3B UDS categories (with the option to select multiple races), but we have a separate User defined field for Nationality where we capture more info.
- Community Health Connections has narrowed it down to just what is asked in the 3B table. We have found if we make it open, we get an incredible amount of responses.

Q: IF/WHEN A RACE WOULD NOT FALL IN THOSE CATEGORIES. FOR EXAMPLE, "PERUVIAN". IS THAT UNREPORTED OR SHOULD WE TRY OUR BEST TO REGROUP IT UNDER A DIFFERENT CATEGORY?

A: Intake staff need to make a point that race is different than ethnicity. Clarify distinction of U.S. Census definition of race and ethnicity. It is a self-reported table, so it is based on what patients say. It can be reported as Hispanic, but unreported race. If you don't know their race or Hispanic identity, then they go under Column C, line 7. For next year's UDS (not this year), the race/ethnicity categories are proposed to be expanded. The proposed PAL: 2023udspal202203508c.pdf (hrsa.gov)

Q: WE HAVE A "ASSIGNED SEX AT BIRTH" FIELD IN OUR EHR, BUT IT IS BLANK OR UNKNOWN FOR MOST PATIENTS. WOULD WE REPORT THESE PATIENTS IN TABLE 3A BASED ON THE "PATIENT SEX" FIELD THAT WE HAVE ON FILE, OR SOME OTHER WAY?

A: Use the sexual orientation field for now, but check back on your systems.

Q: WHAT DO WE DO IF PATIENT AGE/DOB IS MISSING? SOMETIMES PATIENTS DO NOT SHARE IT WHEN ASKED, OR IT MAY BE A TYPO.

A: Make sure to have policies and processes in place to prevent blanks. It would need to be estimated because there is no row for unknown.

TABLE 3A TIP/CHANGE: Age "as of date" has changed from June 30 to December 31 to align with other measures.

Q: FOR REPORTING TOTAL PATIENTS BY ZIP CODE OF RESIDENCE AND PRIMARY INSURANCE, AS OF WHEN SHOULD PRIMARY INSURANCE BE REPORTED? THEIR LAST COUNTABLE VISIT, WHAT WE HAVE DOCUMENTED AT REPORT RUN TIME? INSURANCE STATUS IS IMPERMANENT AND CAN CHANGE.

A: Insurance status needs to be updated at every visit. It is whatever their insurance was at their last visit.

Q: WHAT IF A PATIENT COMES FOR CASE MANAGEMENT ONLY (ALL VISITS ARE NON_BILLABLE) DOES IT COUNT?

A: Case management is a UDS countable service – 1 of 7 enabling services

Q: IF PERSON COMES ONLY FOR VACCINE/COVID-19 TEST, DO THEY COUNT AS PATIENT?

A: If this is the only thing the person is receiving, it does not count. If it is part of a larger visit, it would count (e.g., physical)

Q: CAN CLINICAL PHARMACY BE COUNTED IF IT IS IN PARTNERSHIP WITH A PROVIDER ONE TO ONE WITH A PATIENT?

A: If it the same type of service, you are only counting the primary care visit. Anything that is ancillary to primary care probably isn't counted.

TIP: it is important to remind CHC staff that the questions in the EHB UDS come once submitted, so CHCs should submit DAYS earlier to allow amply time to address any flags raised.

Q: ALL CLINICAL PHARMACIST VISITS SHOULD NOT BE COUNTED, CORRECT?

A: Not counted in the UDS, but may be helpful for you as a CHC to know. UDS does not require you to count visits, just FTE.

Q: WHAT IS THE VALUE OF USING THE OPTIONAL PRELIMINARY REPORTING ENVIRONMENT (PRE)? I DON'T SEE ANY REASON TO USE IT AND UPLOAD DATA EARLY SINCE THE REPORTING PERIOD WILL NOT END UNTIL 12/31.

A: To get familiar with UDS and capture information for first 6 months or quarterly. There is also a comparison tool. It can also be a quality performance tool. Static Excel templates that can be uploaded and automated (online Excel tables) that update EHB automatically.

Q: WE HAVE TO DO ALL OF THE TABLES AS UNIVERSAL, JUST NOT INDIVIDUAL GRANT REPORTS UNLESS WE GET MULTIPLE 330 GRANTS. RIGHT?

A: Correct.

Q: WHY HAS THE DEADLINE CHANGED TO A HARD DEADLINE?

A: HRSA allowed some flexibility historically for this one and only report. More about technology shift and that 6 weeks is after January 1st is ample time to submit.

Q: IF WE RECEIVE A SPECIFIC 330 GRANT (HOMELESS, MIGRANT, ETC), WE DO HAVE TO COMPLETE ALL OF THE TABLES, JUST NOT MULTIPLE TIMES PER GRANT TYPE.

A: 11 + 3 + clinical tables for your special populations

Q: FOR THE CY2022, DO WE NEED TO REPORT DATA ON CASH BASIS OR ACCRUAL? DOES IT DEPEND ON OUR ACCOUNTING METHOD?

A: To be covered in Finance session. Revenues you receive are reported on a cash basis, regardless of when the service was provided. The cost is on the accrual basis. So, it's a bit of a mix.

Q: WHICH ROLE AT YOUR CHC ENTERS DATA IN EHB?

A:

1. CHC1 – someone on the analytics team
2. CHC2 – CFO
3. CHC3 – Director of Development & Grants
4. CHC4 – Controller/CFO
5. CHC5 – Director of Accounting
6. CHC6 – Director of Quality and Patient Safety
7. CHC7 – COO
8. CHC8 – TBD
9. CHC9 – COO after working with CFO & Quality
10. CHC10 – CFO & team

Q: I DID NOT GET THE MATERIALS WHERE DO WE GO TO GET THEM?

A: Materials are available on the League's UDS webpage. We will also post a link to this webpage in the UDS Higher Logic community. In addition, we will post the recordings to these sessions on the League's UDS webpage as well: https://massleague.org/Calendar/LeagueEvents/UDS.php

Q: AT MY CURRENT ORGANIZATION, IT SEEMS THAT WE HAVE RECORDS FROM 2000 TO NOW, HOW LONG DO WE HAVE TO KEEP RECORDS FOR UDS REPORTING PURPOSES?? 5, 7, 10 YEARS???

A: Keep documentation on process of collecting data for minimum of 3 years, but you will have access to all of your past data in EHB.

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

A: Lynn CHC - we don't do PRE either but do put all CQMs into big spreadsheet that compares to previous year data, and compare current year 2 major reporting systems

DAY 2:

Q: If a patient delivers on January 1, 2022 and we do not have a prenatal visit in 2022, do we count them?

A: CORRECTION...If there is a crossover in 2022 where prenatal services occurred in 2021 (and counted in 6B in 2021), no prenatal visits occurred in 2022, and the delivery is in 2022 regardless of where and by whom (and to one of your Form 5A contracted providers), it is counted on Table 7 and 6B. (Also discussed on page 89 of the manual.)

Q: In order to be included in UDS, must have had a visit in 2022. If they are referred out, you must still report on delivery?

A: If they had a prenatal visit in the calendar year, regardless of whether you provide prenatal care or not, you are responsible to track if they are referred to your prenatal network/defined network or have a relationship that you're responsible to report on Table 6. If they go outside of the network, then you are not responsible for reporting prenatal care visits, birth weight, etc. If they have a prenatal care visit at your HC or in your network in 2022, then you are responsible for reporting on delivery. If you do not have a relationship with whoever they are referred to, then you are not responsible. If you are able to find out the information on delivery, then by all means go for it.

Q: If we had a patient that received prenatal care from us in 2021, we referred them out in 2021, and they didn't see us at all in 2022, do we still have to report on them as a prenatal patient in 2022? They wouldn't be in our universe of patients since they didn't have any UDS qualifying in 2022, so not sure if we should include on 6B and 7 and be tracking them.

A: There are a couple circumstances that this applies. If they are seen for prenatal in 2021 and don't deliver, then you don't see them in 2022, then you don't count them. The deliveries number is the number of people in 6b who deliver. If haven't had a prenatal visit they don't count.

Q: Are we including still birth in Table 6B?

A: If they were born still birth, they are counted as a delivery in Table 7, column 1A. But you are not counting them for birth outcomes/birth weights in column 1B, 1C, and 1D.

Q: There are two additional clinical performance measure that special populations are required to identify. Aren't there a couple more performance measures that I should be reporting on?

A: These are not reportable for UDS, they are just for special populations.

Q: I can't seem to find the CQM quick guide that breaks down the Table 6B&7 lines by numerator, denominator and descriptions. has anyone seen that out?

A: 2022 Clinical Measure slide shared by Alec live. Also linked here: 2022 Clinical Measures Handout (hrsa.gov)

Tip: The more that column A mirrors column B, the better quality the data. You want to make sure that you are not excluding a specific group from your counts. But 80% is the rule.

Q: If someone takes a BMI in January and creates a follow-up plan, then has a visit later in the year. Do they have to show that they updated the follow-up plan in the second visit?

A: Use the last BMI in there and the follow-up plan after that. The follow-up plan must be relevant to the latest BMI.

Q: Did you say this is retired for the year 2022? Or 2023?

A: The measure remains in the UDS for year 2022 and year 2023. The change is that it is no longer accessible online at United States Health Information Knowledgebase (USHIK).

TIP: New line on T6A Line 4d – post COVID condition.

Q: I thought that CHCs could still bill COVID vaccines with the T1015. If that's the case how will people figure out that it isn't a visit for UDS? T1015 is a full visit for billing.

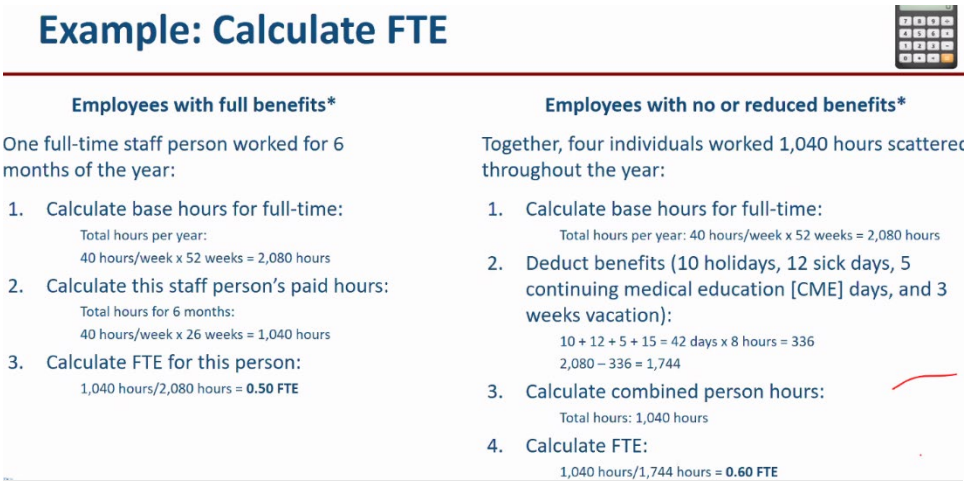
A: Just because you can bill or code for it, doesn't mean it is a UDS visit. Do not confuse coding and payment with respect to determining UDS countable Visit. How you sort this out in a query- we will get back to you!

Q: SO THE NUMBER OF VIRTUAL VISITS (B2) IS IN THE NUMBER OF CLINICAL VISITS (B)?

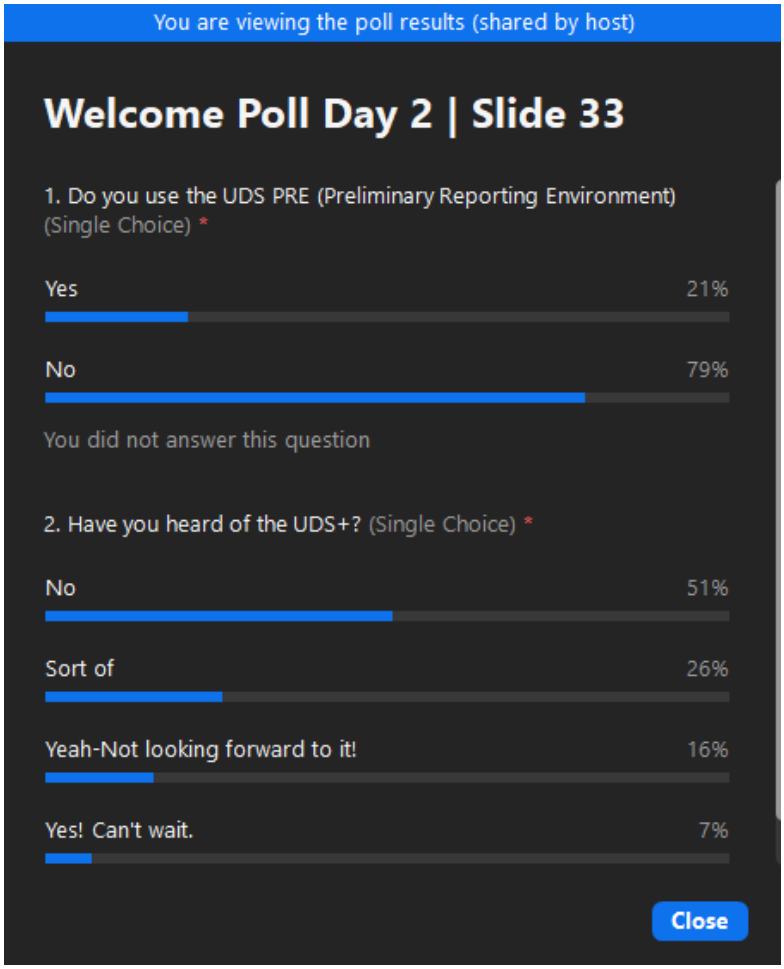
A: No. Column B is in-person visits in the clinic. Column B2 is the number of virtual visits, must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between provider and patient. Column B plus column B2 would give the total number of visits.

Q: WHEN WE SAY FULL TIME, HOW MANY HOURS PER WEEK ARE WE TALKING ABOUT?

A: The organization defines how many hours constitutes full time. Many base full-time on working 40 hours a week. The definition can vary upon different positions within your organization. Presentation slide excerpt below:



Q: POLL QUESTIONS:



n=57 for survey responses

DAY 3:

Q: I had a question about where to report Retention $$?

A: Whoever wrote the check.

Q: IF RYAN WHITE IS PAID THROUGH ANOTHER ENITY, IT DOES NOT GO ON LINE 2, RIGHT?

A: Correct. Some parts of the RW program are paid through other entities.

Q: THE UDS MANUAL STATES THAT PHARMACY SALES TO NON-HEALTH CENTER PATIENTS IS INCLUDED IN 9E. IS THIS CORRECT?

A: Correct.

Q: WILL HSN BE COVERED IN LEAGUE/JSI INSURANCE CLARIFICATION MEMO?

A: Yes. it will be.

Azara is prioritizing validation of EPIC data for DRVS centers as soon as you are ready. If you do not have DRVS, please reach out to the Health Informatics team for support.

Q: Q - ACCOUNTING CLOSE - SINCE The UDS is a calendar year report…ANY COMMENTS/ADVICE ON DECEMBER 22 MONTHLY CLOSE? SOURCE DATA

A: Will get back to you.

Q: DO CASE MANAGEMENT VISITS COUNT?

A: Yes, case management visits and individual patient education (as long it's a comprehensive education visit) count. They're the two enabling services that count as visits.

DAY 4:

Q: How do we report post-COVID condition?

A: There is a new line on table 6A for post with specific ICD-10 codes. Look at the updates for that section and make sure that you are coding your patients appropriately. If your clinicians are using a different code for post-COVID, then there is leeway to count them in that space. Here is the code that is designated: https://www.icd10data.com/ICD10CM/Codes/U00-U85/U00-U49/U09-/U09.9, also noted on p.79 of the manual.

Q: We at GLFHC provide services for our OB patients. Those services are usually rendered at our facility at Lawrence General Hospital. Would those services rendered at an Inpatient facility (deliveries, rounding...etc) be counted at Table 5 as a clinical service ?

A: Yes, since you are following up on your patient, even if that site is not formally in your form 5b.

Q: The second question I had was around retention $. Should we be reporting this and if yes where?

A: Please email Alec and he will reach out to his colleagues for additional information and get back to you.

Q: Employees are allowed to draw on their earned time. should we exclude the corresponding $ value and FTEs from wage expense? Vacation, sick. What if they worked 2,080 hours, but earned vacation time, etc.?

A: No, you should be including anything that is paid out. The numerator is paid hours. If you don't pay those hours to some staff, such as unbenefited staff, then you subtract that from the denominator of the total possible. If you have someone who works 40hr/week, then it would be 2080 hours per year. If you have vacation, sick time, etc. of 300 hours, then you subtract that from the denominator of the staff that are not benefited. You would count all hours paid out for in the numerator, so worked hours and earned vacation hours.

Q: Would severance pay be included in the hours calculation?

A: No. However, it should be included in costs (if medical staff, line 1 – personnel costs on Table 8A).

Q: We have a policy to allow employees to cash out vacation hours. For example, we have a doctor who works 2080 hours, but also cashed out 2 weeks of vacation. They are not working, but they want to cash out 80 hours of vacation time.

A: If people work overtime and they are not paid for that time, then that is not counted in FTE. If you are a salaried employee, you can't go over 1.0 FTE. What you are talking about is a payout, not affecting the number of hours worked. So that would not count in the numerator. Salaried

employees can only go over 1.0 FTE if they are paid a bonus for overtime or something similar.

Q: What about a payout of vacation time when someone leaves the organization?

A: Additional information forthcoming.

Q: Table 5: In the last few years, there is a separation between MH and SUD services. But our clinicians do both, often to the same people. I struggle on how to differentiate that. I don't want to suggest we do only one or the other when reporting.

A: We recommended that you put a proportion of people on the MH and the SUD line. The addendum has helped to make the distinction a little less important. Try to keep to a certain method that is consistent- perhaps go by the primary diagnosis to distinguish. If you have anyone with just SUD credentials, that can help separate them out. The question is a bit up in the air when you have dually credentialed staff.

Q: Is there a way to count visitors (tourist, seasonal)?

A: Count where they live (home zip code); migrant workers, count where they live here. Document that you have urgent care visits which may be for transient tourists. If you have people with a second home who stay for significant time periods in the area, then do capture their local address.

TIPS:

- First, look at what is a UDS countable visit. Those are included on the 1st 4 tables. Same totals on (do not count screening or immunization visits/patients only); see presentation slide 45 for more details
- Zip codes: Keep unknowns as low as possible (that intake staff are capturing as best as possible); if >10-15%, would flag for reviewer
- SO/GI - different fields exist for when the patient doesn't know v. if the health center doesn't know; reminder that <18 years old, you are not required to document; will flag if unknowns are zero or unknowns are very high; HRSA will be looking to see if you have captured these questions in a consistent way
- Income: will flag if unknown is >30% (~state average)
- 6A: patients and visits can be on multiple lines
- 6A: Only count PREP re: prevention
- Sampling of clinical measures are no longer allowed; 80% rule still exists