**Supporting Statement**
**Health Resources and Services Administration: Uniform Data System**

## A. JUSTIFICATION

### 1. Circumstances of Information Collection

This is a request for a revision of OMB approval to collect a revised Uniform Data System (UDS), the annual reporting requirement for health centers funded under Section 330 of the Public Health Service (PHS) Act. The Health Resources and Services Administration (HRSA), has responsibility for the administration of the health center programs under Section 330. An extension of the UDS was recently approved under OMB No. 0915-0193 and expires on 7/31/2010.

The significant growth of the Health Center Program, the advent of incentive-based payment for performance initiatives, and the proliferation of information technology (IT) enhancements within health centers are major factors that have heightened the need to evaluate and revise the performance reporting requirements of the Health Center Program. As health centers receive reimbursement and support through multiple funding streams, improving performance reporting can also reduce the reporting burden of the Health Center Program grantees by aligning health center reporting requirements on clinical performance measures with those of major national quality improvement organizations. Furthermore, enhancing performance reporting will result in the ability to make evidence-based statements about the impact of the Health Center Program on improving access to cost-effective primary care to the nation's underserved populations.

A key component of success of the Health Center Program has been the ability to demonstrate to payers and patients the value of care delivered to those receiving health center services. The expansion of the Health Center Program and the resulting growth in the number of health center patients and services, along with provider incentive programs and technological advances, have underscored the importance of demonstrating health centers' high quality care to underserved populations. This long-standing emphasis on demonstrating value is consistent with the Department of Health and Human Services initiatives to increase transparency in health care and promote value-based purchasing; transparency and information technology are essential facilitators of increasing value in health care. However, the proposed measures are now aligned to the quality measures that are being harmonized under the leadership of Secretary Leavittt.

HRSA has adopted a set of 12 nationally-standardized (i.e. HEDIS, AQA, NQF, NCQA) clinical core measures as the basis for an Agency-wide quality improvement initiative to span grantee delivery sites that provide clinical care and/or provide referrals for clinical care. HRSA adopted these measures after a year-long period of study.

The measures encompass six key areas that cut across multiple bureaus, programs and health service delivery grantees: prenatal care, HIV perinatal care, cancer, immunizations, cardiovascular hypertension and diabetes.

The BPHC subset of HRSA core measures were selected as a "starter set", with the

understanding that there are many other areas of importance to BPHC and the people and programs we serve. Most of the measures chosen are commonly used by Medicare and healthcare insurance/managed care organizations to assess the quality of healthcare services, and are likely already familiar to, and may already be in use by HRSA grantees. The quality measures including those recently selected – blood pressure control, diabetes control, appropriate childhood immunizations, and female cancer screening ( entry into prenatal care, and birth weight were previously implemented measures) span the life cycle, represent clinically important conditions and services to program populations, and assess program impact.

The modifications to the UDS will result in the ability to better demonstrate the quality and value of the health center program through the use and reporting of well accepted evidence based measures of quality and other performance measures. While collection and reporting of the new measures increases the burden of UDS reporting, the benefits to grantees and the agency are considered to outweigh this additional burden. In addition, HRSA initially proposed to reduce the burden by removing several tables/data elements from the UDS reporting requirement. However, the response from grantees was in favor of retaining the data/tables so that the program could continue to portray specific clinical characteristics of health center patients. The program is submitting a revised UDS for review and approval, in order to provide sufficient notification to health centers for this calendar year system. The current version of the UDS, recently approved as an extension, will be used by grantees for the full 2007 calendar year, to be reported to HRSA in early 2008.

The Bureau of Primary Health Care (BPHC) in HRSA has the responsibility for and oversight of programs designed to provide health services to medically underserved and vulnerable populations. These populations include the poor and near poor, migrant and seasonal farm workers, the homeless, and residents of public housing. The overall mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

Health centers receive funding and support from a variety of sources, and HRSA grant dollars represent approximately 25% of health center revenues. Federally qualified health centers include centers that receive federal grants under Section 330 of the PHS Act and centers that qualify for special payment rates from Medicare and Medicaid because they meet the 330 grant requirements.

The term “health center” refers to a variety of different organizations and programs covered by subsections of Section 330. There is no “model” for health centers, yet all health centers share similar attributes, including the goal of providing primary and preventive health care services to underserved populations, and the delivery of high quality clinical services to those they serve.

Health centers are authorized to provide primary and preventive services to medically underserved and vulnerable populations. These populations face great barriers in accessing and obtaining primary and preventive services. Funded health centers form an integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, and public housing residents. Over14 million people are served annually by health centers that would otherwise lack access to primary care providers.

The UDS is the annual reporting requirement for HRSA grantees that receive funding under the following primary care programs:

- Community Health Center (CHC) Program, Section 330(e) of the Public Health Service Act.
- Migrant Health Center (MHC) Program, Section 330(e) of the Public Health Service Act.
- Health Care for the Homeless Program, Section 330(h) of the Public Health Service Act.
- Other 330 funded Grantees

Annual data are required from these grantees to ensure compliance with legislative mandates, to report to Congress and policy makers on program accomplishments and performance, and to prepare HRSA's annual performance plan and budget. No substantive changes have been made to the current UDS. Several minor revisions have been made and are detailed in the Appendix.

## 2. Purpose and Use of Information

A core set of data are required annually to administer the grant programs funded under Section 330. The UDS is the tool that is used for monitoring and evaluating health center performance, and for ensuring compliance with legislative mandates. The UDS yields consistent information on patient characteristics and clinical conditions that can be compared with other national and state data. These data are also essential in assuring compliance with legislative mandates, facilitating reports to Congress, confirming accomplishments under the President's Health Center Initiatives, and reporting on the Government Performance Review Assessment (GPRA). The UDS is the mechanism used by HRSA to obtain these standardized data elements from funded health centers.

A key component of success of the Health Center Program has been the ability to demonstrate to payers and patients the value of care delivered to those receiving health center services. The expansion of the Health Center Program and the resulting growth in the number of health center patients and services, along with provider incentive programs and technological advances, have underscored the importance of demonstrating health centers' high quality care to underserved populations.

The type of data requested in the UDS provides program information on the following: the total number of low income and/or uninsured people served; services utilized and diagnoses made; services offered that are distinct from other providers of primary care (e.g., enabling services); and, staffing for major service categories.

In addition to program data, the UDS will collect a small set of clinical measures that emphasize clinical performance and health outcomes. The set of clinical measures relate to:

- Newborn low birth weight
- Childhood immunization*
- Childhood blood lead levels*
- Entry into prenatal care
- Cervical cancer screening*

- Adult Hypertension (blood pressure levels)*
- Adult Diabetes (HbA1c levels)*

*New clinical measures

These measures support BPHC its effort to improve the program's ability to demonstrate its impact and effectiveness for patients, payers, and the American public, as well as provide guidance for program improvement.

The measures are aligned with national quality standards for ambulatory care programs, i.e., those of the Ambulatory Quality Alliance AQA), the National Quality Forum (NQF), and the National Committee for Quality Assurance (NCQA). They represent clinical care across the patient life cycle (i.e., newborn, childhood, and adult life cycles); and are indicative of the most prevalent conditions and preventive services addressed within the health center patient population. They were carefully selected through a deliberative process that included substantial input from HRSA staff, and were vetted with grantees and partners. Several of the clinical measures are aligned with HEDIS measures that are used by managed care organizations and payors that seek to tie clinical performance and quality with payment for patient services. The measures for immunizations, cervical cancer screening, diabetes control, and blood pressure control have been tested with health centers participating in the Health Disparities Collaboratives (HDC) Program since its inception in the late 1990s.

The program data and the clinical measures are used to track health center performance and monitor use of grant funds. They also will result in HRSA's ability to make stronger statements about the Health Center Program through performance measurement, as well as, provide trend statistics related to underserved populations served within the Health Center setting.

As required by the Government Performance and Results Act (GPRA), BPHC has developed annual program goals and objectives and related performance indicators. Examples of GPRA indicators that the UDS addresses are: services provided to low income individuals; services provided to minority individuals; and, percent of low birth weight births to health center patients. The UDS provides data for these and other performance indicators. In addition, the UDS provides information to address the following OMB approved efficiency measures, common measures used for certain health systems in the Department of Health and Human Services:

- OMB Efficiency Measure: Sustain the average cost per individual served at Health Centers.
- OMB Efficiency Measure: Sustain the number of annual encounters per medical worker.

As part of the 2007 PART reassessment, two new clinical outcome measures (% of adult patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 140/90) and % of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (≤ 9%).), were added. The anticipated reporting date for the two new measures is August 2009 (for CY 2008 data). This is consistent with the reporting of other existing UDS data used to inform PART measures. Ability to report these data by the anticipated date included in the final 2007 PART is contingent upon receipt of OMB approval in time to add the clinical measures to the UDS for CY 2008 data collection.

The UDS provides uniformly defined data for HRSA's health center grant programs using standard formats and definitions. In addition, it yields consistent information on patient characteristics and clinical conditions that can be compared with other national and state data.

The UDS consists of two separate components. The first component is the *Universal Report,* which is completed by all grantees and contains nine tables. This report provides data on services, staffing, and financing across the five primary care system development programs included in the UDS. The second component is the *Grant Report,* which provides information on the characteristics of users whose services fall within the scope of a project funded under a particular grant. Each Grant Report includes three basic tables that employ the same formats and definitions as the Universal Report.

Grantees that receive only one BPHC grant or that receive only CHC and MHC grants are required to complete only the Universal Report. Multiple-award grantees other than C/MHC grantees complete a Universal Report for the combined projects and a separate grant report for each Homeless or Public Housing program grant.

**3. Use of Improved Information Technology**

UDS reporting is completed by grantees using a web based data collection system that is completely integrated with HRSA Electronic Handbooks (EHBs). HRSA EHBs already provides authentication and authorization services to all HRSA customers, and integration with that system means that the applicants or grantees will not have to remember multiple usernames and passwords.

Respondents submit UDS data using standard web browsers through a Section 508 compliant user interface. The system provides electronic UDS data tables that clearly communicate what is required and guide the respondents in completing their UDS reporting requirement. Usability features such as those that pre-fill data from prior year grant applications based on business rules prevent redundant data entry while other features such as calendar controls to enter date speed up the data entry process. Respondents will be able to work on the forms in part, save them online and return to complete them later. The approach allows applicants to distribute the data entry burden amongst multiple users if required. Business rules that check for quantitative and qualitative edit checks are applied to ensure that the data submitted meets the legislative and programmatic requirements. Respondents are provided with a summary of what is complete and what is incomplete along with links to jump to the appropriate sections to correct the identified incomplete parts.

In addition, BPHC has a toll free hot line on the BPHC ACCESS Bulletin Board to address questions and provide assistance, including MIS concerns and constraints; submit330uds@bphcdata.net and 1-866-uds-help.

**4. Efforts to Identify Duplication**

HRSA explored alternative sources for the cost information and found that, because of differences in coverage and definitions, there are no other existing sources that could be used for grant monitoring and administration.

## 5. Involvement of Small Entities

Every effort has been made to ensure that the UDS contains the minimum amount of data necessary to meet important legislated monitoring and reporting requirements. Duplicative reporting has been eliminated. The UDS builds on data currently collected and maintained by grantees for internal administrative and clinical needs. As such, the UDS imposes few additional data collection demands on its grantees beyond what they are already collecting for internal purposes.

## 6. Consequences if Information Were Collected Less Frequently

Grant dollars are awarded annually; therefore, the UDS data are required annually in order to monitor program compliance and administer program funds.

## 7. Consistency with Guidelines in 5 CFR 1320.5(d)(2)

The data are collected in a manner consistent with guidelines contained in 5 CFR 1320.5(d)(2).

## 8. Consultation Outside of the Agency

The notice required by 5 CFR 1320.8(d) was published in the Federal Register on April 13, 2007. Two comments were received and are briefly discussed below. The comments received and detailed responses are attached separately.

Representation from the National Association of Community Health Centers (NACHC), and Health Center grantees were consulted in the review of the UDS tables and instructions.

The following individual from NACHC provided review:

John Ruiz and Freda Mitchum
Health Systems Specialist
National Association of Community Health Centers
202-659-8008

The following Health Centers tested the new clinical performance measures and provided comment on the UDS reporting:

Ray Otake
Community Health Center Network
510-769-2288

David Campbell
Community Health Network of West Virginia
304-201-5700

Paul Kaye, MD
Hudson River Health Center

914-734-8747

Dexter Pearce
Community Health Centers Inc. of Utah
801-891-5362

Janice Bacon West, MD
G.A. Carmichael Family Health Center
601-859-5213

Debra Gott
East Tennessee State University Health Center
423-439-4068

Anne Evans, Ph.D and LeTesia Guinn
Bethel Family Clinic
907-543-3773

Carla Flaim
Health Care for the Homeless, Inc.
Baltimore,MD
410-837-5533 x335

Additionally, Arthur Stickgold of Stickgold & Associates and John Snow Inc. Mathematical Statistician will provide technical assistance to grantees and their vendors on their data systems and provided consultation and review of the UDS materials; instructions and definitions. The sources consulted determined that the annual burden estimate was reasonable and the instructions were clear.

HRSA received 2 comments for the 2008 Uniforms Data System 60 day Federal Register Notice from The National Center for Farmworker Health Association and the California Primary Care Association. The overall concern was that that HRSA significantly underestimated the annualized reporting burden hours associated with proposed new UDS reporting requirement.

Response: HRSA recognizes that some grantees may indeed experience additional burden. HRSA intends to mitigate the burden to Health Center grantees by offering expanded forms of technical support and broadening existing vehicles of communication through :

advance grantee notification , additional regional field training sessions, telephonic and electronic accessibility to information (e.g, toll-free telephone line, email address box, and website), Webex training sessions and Webcast play back.

If OMB approves the collection of the new clinical measures then HRSA will:

- Officially notify the 330 funded organizations in the fall of 2007.
- Make the 2008 UDS Reporting Manual available to Health Centers via the UDS Web site.
- Introduce the new reporting data elements in the 2007 UDS training to be held in fall and winter 2007. These sessions will offer a question and answer period in which grantees

can pose specific inquiries .

- HRSA will start the trainings for the 2008 UDS reporting late summer/early fall of 2008. HRSA will offer five additional field trainings
- In addition to the field training there will be 3 Webex trainings with Web Cast replay. These additional web-based trainings will allowalternate training opportunities to Health Centers staff unable to attend the field trainings.
- HRSA will offer a toll-free line 8:00am - 5:30 pm, Eastern Standard time to address reporting questions and a voice mail will be available for after hours.

**9. Remuneration of Respondents**

Respondents will not be remunerated.

**10. Assurance of Confidentiality**

No patient/user level information is reported. Only aggregate data are collected. The UDS does not involve the reporting of personally identifiable information about individuals. The UDS specifies the reporting of aggregate data on users and the services they receive, in addition to descriptive information about each funded grantee and its operations and financial systems.

**11. Questions of a Sensitive Nature**

There are no questions of a sensitive nature. All information is reported in an aggregate format. Individuals cannot be identified based on these aggregate totals. Grantees leave blank any cells where the total is less than five.

**12. Estimates of Annualized Hour Burden**

The burden is as follows:

| Type of Report | Number of Respondents | Hours per Response | Total Burden Hours | Wage Rate | Total Hour Cost |
|---|---|---|---|---|---|
| Universal Report | 1,076 | 62 | 66,712 | $18 | $1,200,816 |
| Grant Report | 150 | 18 | 2,700 | $18 | $ 48,600 |
| Total | 1,076 | | 69,412 | | $1,294,416 |

Basis for the estimates:

The UDS includes two components:

- The **Universal Report** is completed by all grantees. It consists of all 9 tables captured in

UDS reporting. This report provides data on services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.

- The **Grant Reports** are completed by a sub-set of grantees **who receive multiple BPHC grants**. It consists of Tables 3A, 3B, 4, 5, 6A. These reports cover all or part of the elements of five of the Universal Report tables. They provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant.** Separate Grant Reports are required for the Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *unless* a grantee is funded under one and only one of these programs. No Grant Report is submitted for the portion of multi-funded grantee's activities supported by the Community Health Center grant.

Estimates of burden for the proposed UDS including the five new clinical and outcome measures were obtained from consultation with grantees and other sources cited in item 8, above. The health centers that participated in the pilot reported a range of burden estimates for reporting on the new measures, and the table provides an estimate of the average time for reporting on the measures. The centers utilized electronic reports from existing systems or sampled medical charts to report the new measures. The table averages the reporting time in hours across the eight centers that participated in the pilot They reported that they expect the burden estimates to increase for the Universal Report by approximately 35hours. The increase in burden includes time for programming, chart abstracting, inputting data, computing, and quality control. The burden per respondent is expected to vary across grantees, particularly in the first year of reporting the new measures. Health Centers with multiple funding streams will not be required to submit a report a on the new clinical and outcome measures. This burden variation is tied predominantly to the type of data system(s) used by grantees and whether or not the grantee has an Electronic Medical Records (EHR). While nearly all grantees use an automated system to generate the required reports, systems vary in their ease of use and flexibility. Some grantees have hierarchically-structured systems requiring time-consuming processes for retrieving data in required formats. Others have relational databases that can easily accommodate the specifications. The majority of grantees, however, are expected to experience a level of burden near the averages cited.

The data reports for Table 3A, 3B, 4, 5, 6A, 8, Part of 7 and 9D and 9E are generated automatically via Practice Management Information Systems, so the work can be performed by a mid-level staff person with an average wage rate of $18 per hour. The data reports for Table 6B and Part of 7 will require a systematic sample chart audit, which can also be performed by a mid-level staff person with an average wage rate of $18 per hour.

The number of charts selected for chart review will be based upon the patient population of the specific condition. The number of charts sampled and audited for any measure will not exceed 67 charts. To minimize the burden associated with sample size determination and ensure that all grantees are using standard processes, the UDS reporting framework will include an electronic interface that auto-calculates the appropriate sample size for each measure based on the size of the grantee's patient population. For those grantees that are paper-based, the BPHC will distribute hardcopy reference material that illustrates sample size indexed by patient population. Regardless of whether or not a grantee uses EHRs or has to manually perform chart reviews, the formula used to draw the sample for the measures will be the same. Information pulled manually from charts will utilize instructions that match the programmed methodology utilized

by the automated system.

The burden here will differ based on the size of the patient population, the number of grant reports an organization must complete or if the inclusion criteria of the measure relates to the grantee's patient population. The burden on respondents is expected to decrease over time, following the first year of reporting the new measures.

## 13. Estimates of Annualized Cost Burden to Respondents

The proposed 2008 UDS consists of old or existing tables and data elements and the new clinical measures. There are no capital or start up costs for the old or existing UDS data tables (Tables 3A, 3B, 4, 5, 6A, Part of 7, 8A and 9E). Most grantees currently use their automated data systems to maintain data that are reported in the UDS and for reporting to other funding sources.

It is expected that grantees will experience cost "economies" from reporting the new clinical and outcome measures (Table 6B and Part of 7) as they are consistent with those currently endorsed by national standard setting organizations. Further more, upon vetting with our grantees and partners, it was found that grantees already collect and report such measures to payors and other organizations.

However, since this is the first reporting year for these new measures it is anticipated that grantees will require additional processing time to develop their reporting methods. To effectively report on the new measures grantees are expected to utilize their existing clinical data sources – be it paper based charts, patient registries, electronic health records or any combination of data sources. Therefore, during the initial reporting year there will be grantees that will incur costs in the form of additional staff time. It is estimated that the additional costs related to data abstraction from paper charts and/or electronic systems to report the new measures will amount to approximately $292,672 (two business days) x 1076 grantees x $17/hour (GS-8 step 1 2007) The cost estimates are based on the 8 health centers that participated in a test of the new clinical measures. The test group varied in data capability where a few centers had electronic IT capacity, others had disease registries or paper-based data capacity.

As grantees develop reporting proficiencies and advance from initial start up activities to establishing routine data abstraction methods for the new measures, it is expected that the reporting time and associated costs will decrease by 20% each year.

It is estimated that 40 percent of these grantees will incur programming or re-programming costs for generating the new clinical measures data in the required format. There costs are estimated to average $700 per center for generating the new clinical measure tables for a total of $301,280(700 X 430 grantees). Costs will be incurred only during the first year of reporting for those grantees that are new and require programming.

HRSA anticipates reducing the average time for a Health Center to report the UDS data by offering significant technical assistance in the manner of advanced notification, training, toll-free telephone line, email address box, Webex training sessions and Webcast play back.

If OMB approves the collection of the new clinical measures then HRSA will:

•Officially notify the all 330 funded organizations in the fall of 2007.
•The 2008 UDS Reporting Manual will be made available to Health Centers via the UDS Web site.
•Introduce the new reporting data elements in the 2007 UDS training to be held in fall and winter 2007. The will offer a question and answer session.
•HRSA will start the trainings for the 2008 UDS reporting late summer early fall of 2008. In addition, HRSA will offer and additional 5 more trainings in the field as well as 3 Webex trainings and Web Cast replay so Health Centers can hear the trainings over.
•HRSA will offer a toll-free line 8:00am - 5:30 pm, Eastern Standard time to address reporting questions and a voice mail will be available for after hours.

## 14. Estimated Cost to the Federal Government

The estimated annual contract cost to the federal government for Technical Assistance; training and data reporting support, data processing, editing, and verification $550,000. In addition, costs include one FTE at 10% time at a GS 13 level for $9,350. Total costs to the government are $559,350.

## 15. Changes in Burden

The current OMB Inventory contains 32, 150 burden hours for this activity. This request is for 69,412 hours, for an increase of 37,262 hours. The change is due to the following: 1) a revision in the burden estimate for the Universal report, increasing the burden from 28 to 62 hours per response; 2) an increase of approximately 21 new respondents completing the Universal Report and 5 new respondents completing the grant report. The total increase in burden is a program change of 37,262 hours. The proposed new clinical performance measures are particularly beneficial to grantees and the government. The clinical measures were chosen carefully to represent most types of health center patients, across the life cycle, for preventative screenings, perinatal care and chronic conditions. Health centers will benefit from improved information and feedback to respond to changing conditions in the health care market. Since the measures are aligned with those of national standard setting organizations, many grantees already or soon will report these measures to demonstrate quality and value to payors, state agencies, and the general public. The measures lay the foundation for making quality operational. In order to promote continuous quality improvement, the data resulting from this effort will be utilized by BPHC to provide better and more effective technical assistance, as well as, identify best practices within health centers.

Overall health center program effectiveness can be better demonstrated to responsible federal government agencies using improved outcomes measures. This was evident in HRSA's recent negotiations with OMB in the development of the 2008 Program Assessment Rating Tool (PART) analysis of the Health Center Program. As a result of the PART discussions, three of the UDS clinical outcomes measures were selected to be included in the Health Center PART to demonstrate current and future program performance and effectiveness.

## 16. Time Schedule, Publication and Analysis Plans

The grantees are required to submit the reports 61 days after the end of the calendar year. No statistical analyses are planned; only summary descriptive reports from the tables will be prepared.

## 17. Exemption for Display of Expiration Date

The expiration date will be displayed.

## 18. Certifications

This project fully complies with CFR 1320.9. The certifications are included in this package.

**Appendix A: Modifications to the 2008 UDS ( New Data Elements to be collected starting with Calendar Year 2008 Reporting.**

**Center/Grantee Profile: Cover Sheet Table** - Deleted from UDS reporting

**Tables 2: Services Offered and Delivery Method** - Deleted from UDS reporting

**Table 3a and 3B -** No changes

**Table 4, Socioeconomic Characteristics** ---

1. Collapse Table 9C into Table 4 and add new section for managed care utilization by payer, lines 13a to 13c. These managed care member month data by payer were formerly reported in Table 9C. Therefore are not new data collection elements.
2. Add new line 26 Total Veterans (All Grantees)

**Table 5, Staffing and Utilization** ---

1. Rename change family practitioners to family physicians (line 1).
2. Add new line 10 a Total Mid-level Practitioners.
3. Add new line 20 a-1 licensed clinical psychologists
4. Add new line 20a-2 licensed clinical social workers
5. Add new line 27b Interpretation Staff.
6. Add new lines 30a Management and Support Staff,
7. Add a new line 30b Fiscal and Billing Staff
8. Add a new line 30c IT staff.

**Table 6A Selected Diagnosis and Services Rendered -** No new Changes

**Table 6B, Quality of Care Indicators -** Section A of this table are **Not** new reporting data elements. These elements were originally captured on Table 7. The elements below are new data elements to be reported in the Universal report only:

1. **Trimester of Entry into Prenatal Care**, showing women having first visit with grantee or another provider (lines 35-37). These data were formerly reported in Table 7, lines 16-18. These are not new data collection elements.
2. **Childhood Immunization Rate.** This is a new clinical measure. Columns show measure criterion, applicable ICD- 9-CM or CPT-4 Codes, total number of 2 year olds or number in sample, and number of total or sample patients meeting the measure criterion. An explanatory footnote addresses reporting all or a sample of patients, to be explained further in instructions.
3. **Childhood Lead Test Screening Rate.** This is a new clinical measure Columns show measure criterion, applicable ICD- 9-CM or CPT-4 Codes, total number of 3 year olds or number in sample, and number of total or sample patients meeting the measure criterion.
4. **Pap Test Rate.** This is a new clinical measure. Columns show measure criterion, applicable ICD- 9-CM or CPT-4 Codes, total number of female patients age 21 to 64, and number of total or sample patients age 21 to 64 meeting the measure criterion.

**Table 7 - Health Outcomes and Disparities** - Section A of this table are NOT new reporting

data elements. These elements were captured on the old Table 7 - Perinatal Profile. The elements below are new data elements to be reported in the Universal report only:

1. **Hypertension** --- This measure is of adult patients diagnosed with hypertension whose blood pressure was less than 140/90 during the measurement year. The total number of hypertension patients or the number sampled is reported, as is the number of patients whose blood pressure remained less than 140/90 during the measurement year. The numbers of patients are broken down by race/ethnicity categories and total. An explanatory footnote addresses reporting all or a sample of patients, to be explained further in instructions.

2. **Diabetes** --- This measure is of diabetes control- HbA1c measurement for adult patients with either Type I or Type II diabetes. The total number of patients with diabetes or the number sampled is reported. The number of these patients with readings $\leq$ 7%, 7%<HbA1c$\leq$ 9%, 9%<HbA1c is reported. The numbers of patients are broken down by race/ethnicity categories and total. An explanatory footnote addresses reporting all or a sample of patients, to be explained further in instructions.

**Table 8A --- Financial Costs** --- Collapse Table 8B Lines 4 - 13 into 8A. These are not new reporting elements.

**Table 8B Enabling Services** - Delete from UDS reporting

**Table 9C Managed Care Revenue and Expenses** - Delete from UDS Reporting

**Table 9D - No changes**

**Table 9E - Other Revenues**

- Deletion of lines: 1E - Integrated Services Development Initiative, 1I - Shared Management Information System, and 1J - Capital Improvement Program Grants