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. The UDS was approved under OMB No. 0915-0193 and expires on 1/31/2011.

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 which 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, enhanced 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.

HRSA has six nationally standardized (i.e., NQF, CHIPRA) clinical performance measures in the UDS which serve 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. These measures encompass six key areas which cut across multiple bureaus, programs and health service delivery grantees: prenatal access to care, low birth weight babies, Pap test cancer screening, childhood immunizations, hypertension blood pressure control, and diabetes HbA1c levels.

These measures were selected as a "starter set" in 2008 with the understanding that there are many other areas of importance to BPHC and the people and programs we serve. The quality measures span the life cycle, represent clinically important conditions and services to program populations, and assess program impact. For the two years of data reporting of these measures to date (2008 and 2009), grantees have provided information that is valuable to them for continuous quality improvement and to HRSA for benchmarking and performance monitoring. All six of the current performance measures are proposed to be retained in the UDS going forward. Four new clinical measures are proposed for the calendar year (CY) 2011 UDS. In addition, HRSA is proposing revisions to two of the current clinical measures – those for diabetes and childhood immunizations.

Proposed New Measures:

1. **Weight Assessment and Counseling for Children and Adolescents:** Percentage of patients age 2 to 17 years who had a visit during the current year and who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

2. **Adult Weight Screening and Follow-up:** Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months ***and,*** if they were overweight or underweight, had a follow-up plan documented.

3. **Tobacco Use Assessment and Counseling.**
   a. **Tobacco use Assessment:** Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months.
   b. **Tobacco Cessation Counseling:** Percentage of patients age 18 years and older who are users of tobacco and who had a visit during the current year who received (charted) advice to quit smoking or tobacco use.

4. **Asthma – Pharmacological therapy:** Percentage of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative pharmacological therapy (leukotrene modifiers, cromolyn sodium, nedocromil sodium, or sustained released methylxanthines) during the current year.

Proposed Revised Measures:

1. **Diabetes HbA1c Control:** Proposed to include HbA1c levels < 8 percent in addition to readings less than or equal to 7 percent and > 9 percent.

2. **Childhood Immunizations 2 years:** Proposed to add two Hepatitis A shots, two or three Rotavirus shots and two influenza shots; and to reduce the number of H influenza type B shots from 3 to 2. (HRSA continues to recommend that the required three shots be given if the HiB vaccine is used.)

Rationale:

The proposed new and revised clinical measures were selected because they are Department of Health and Human Services priorities (adult weight screening and follow up, weight assessment and counseling for children and adolescents, tobacco use assessment and counseling) and because they are highly relevant to patients served by health centers (asthma pharmacologic therapy, diabetes HbA1c control, childhood immunizations).

All of the proposed new and revised measures are Meaningful Use measures that eligible providers will report on starting in 2011. (These measures are described in the Medicare and Medicaid EHR Incentive Program Final Rule dated July 28, 2010).

- Two of the measures (adult weight screening and follow up, tobacco use assessment and counseling) are included in the three core measures that all eligible providers are required to report.
- Two of the measures (weight assessment and counseling for children and adolescents, childhood immunizations) are included in the three alternate core measures.
- The remaining two measures are among the other 38 measures from which eligible providers must select three to report.

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. 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 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 improve the health of the Nation's underserved communities and vulnerable

populations by assuring access to comprehensive, culturally competent, quality primary health care services.

Health centers receive funding and support from a variety of sources, and HRSA grant dollars represent approximately 20% 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 quality primary and preventive health care services to underserved 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, farm workers, homeless individuals, and public housing residents. Nearly 19 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
- Public Housing Primary Care, Section 330 (i) of the Public Health Service Act
- Other Section 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 tables. Several minor revisions have been made and are detailed in Appendix 1.

In addition, commencing with reporting for CY 2010, it is proposed that grantees respond to a limited set of questions regarding their Electronic Health Record capabilities. Despite the importance of rapidly emerging health technologies (described in subparagraph 3 below), basic information on the Electronic Health Record (EHR)

capabilities of all health centers is not available. In order to facilitate the implementation of EHRs and provide training and technical assistance to health center grantees, data are needed on health center EHR capabilities and use. The questions set forth in Appendix 2 provide basic information that will be valuable to HRSA as it acts timely to prepare health centers to meet short and long term Meaningful Use requirements to receive incentive payments for use from the Centers for Medicare and Medicaid Services (CMS).

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 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 which can be compared with other national and state data. These data are also essential in assuring compliance with legislative mandates, facilitating reports to Congress, reviewing program accomplishments, 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 which 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 set of clinical measures that emphasize clinical performance and health outcomes. The set of clinical measures relate to:

- Newborn low birth weight
- Childhood immunizations
- Entry into prenatal care
- Cervical cancer screening
- Adult Hypertension (blood pressure levels)
- Adult Diabetes (HbA1c levels)
- Weight Assessment and Counseling for Children and Adolescents*
- Adult Weight Screening and Follow Up*
- Tobacco Use Assessment and Counseling*
- Asthma Pharmacological Therapy*

* Proposed new clinical measures

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

The measures are aligned with national quality standards for ambulatory care programs, e.g., 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 input from HRSA staff, and were vetted with grantees and partners.

The low birth weight and prenatal access to care measures have been reported by grantees in the UDS since 1996, and are included in measures recognized under the Children's Health Insurance Program Reauthorization Act (CHIPRA). The measures for childhood immunizations, cervical cancer screening, diabetes control, and blood pressure control have been reported by health centers in the UDS since 2008. These measures are all Meaningful Use measures. The four proposed new measures --- Weight Assessment and Counseling for Children and Adolescents, Adult Weight Screening and Follow Up, Tobacco Use Assessment and Counseling, and Asthma Pharmacological Therapy --- also are Meaningful Use measures developed by national standard setting organizations and endorsed by the National Quality Forum in accordance with its protocols for measures approval.

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 accurate statements about the Health Center Program through performance measurement, as well as provide 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 measure:

- Percent increase in cost per patient served at health centers compared to the national rate.

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 which employ the same formats and definitions as the Universal Report.

Grantees that receive only one BPHC grant are required to complete only the Universal Report. Multiple-award grantees complete a Universal Report for the combined projects and a separate grant report for each Homeless, Migrant or Public Housing program grant.

3. Use of Improved Information Technology

Advancements in Electronic Health Record (EHR) technology have been proceeding at a rapid pace. In an effort to improve quality, safety and efficiency of care, EHR incentive programs provide a financial reward to eligible providers practicing in health centers. EHRs can help grantees achieve larger quality and efficiency goals, and the use of EHR can also streamline and simplify health center reporting to UDS measures. Once data are extracted from an EHR, they can be readily entered into the Electronic Handbook (EHB), bypassing the need for manual chart reviews and random sampling. The Electronic Handbook is the mechanism for grantee reporting.

UDS reporting is completed by grantees using a web based data collection system which is completely integrated with HRSA Electronic Handbooks (EHBs). HRSA EHBs provide authentication and authorization services to all HRSA customers, and integration with that system means that the applicants or grantees do 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 are 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 to address questions and provide assistance, including EHB concerns and constraints. The BPHC Help Desk is at bphchelpline@hrsa.gov or 877-974-2742, Monday through Friday (except federal holidays) 8:30 AM to 5:30 PM (ET).

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 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 already collect 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 performance 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 July 9, 2010 (Volume 75, page 39535). The 30 day notice was published on November 8, 2010 (Volume 75, page 68610). Three requests for additional information were received and information was provided. No public comments were received in response to the notice.

On August 30, 2010, Program Assistance Letter 2010-12 was sent to all health center grantees and partners. This letter described the proposed clinical measures and changes to UDS tables for these measures, and invited comments on the impact of the changes. To date, only a few comments have been received. These are briefly summarized below:

Comment: The diabetes and child immunization measures are inconsistent with evidence based medicine requirements. Specifically, the 8% HbA1c blood level criterion is not

meaningful and the one visit criterion for childhood immunizations does not present an accurate picture of immunization compliance.

Carolyn Marquart
Director of Quality Improvement
Marana Health Center
Marana AZ

HRSA Response: The Meaningful Use measure specifies Hemoglobin A1c Control < 8.0%. The one visit criterion for childhood immunizations is also consistent with the Meaningful Use measure specifications. While the grantee is expected to report using this specification, he/she has the opportunity to use other measures for performance monitoring and quality control purposes.

Comment: Vendors need to provide front end functionality to capture measures specifications to reduce data collection and reporting burden (especially for diabetes, childhood immunization, and asthma pharmacologic therapy measures.) Extensive and ongoing retraining is required of point of care providers and IT staff.
Nutrition and weight counseling in pediatric patients is not included in the grants of a few health centers, and obesity diagnoses are not reimburseable.

Colleen Lynch
Director of Performance Measurement and Improvement
Community Care Network of Virginia

HRSA Response: We agree that EHR vendors need to capture front end functionality for the listed measures and that staff training may be needed to report these and other measures properly in EHRs. Grantees that serve pediatric patients are expected to report on nutrition and weight counseling. Even though obesity diagnoses are not reimburseable, it is reasonable to collect data on the number of patients with obesity in Table 6A.

Comment: The Rotavirus Vaccine should not be on the list of required vaccines because it has a narrow window of application, 6-14 weeks of age and final vaccine 8 months. It does not carry the same level of disease prevention and control for the general population as for the other vaccinations.

Deborah Melke MD
Medical Director
Open Cities Health Center
St. Paul MN

HRSA Response: The Rotavirus Vaccine is included because it is required by the Meaningful Use measure NQF 0038 for Childhood Immunization Status.

Comment: We recommend using only the core Meaningful Use measures with the exact same specifications.
All of the new measures should come from an automated EMR.
Data for the asthma measure will be difficult to collect and report, both with EMR and

manual chart review.
Use a senior population measure: pneumococcal vaccination over age 45.

Fred Rachman, CEO
Timothy Long MD, Chief Clinical Officer
Alliance of Chicago
Chicago, Illinois

HRSA Response: While two of the measures are from the three core MU measures, limiting selection to the these measures is inconsistent with the criteria for measures selection. The clinical performance measures were selected because they are across the life cycles of health center patients, include conditions and services that are important to health center patients, include process and outcome measures, and are consistent with nationally endorsed measures, especially Meaningful Use.
All of the new measures are MU measures. While the asthma measure may be more difficult to collect and report than the other proposed new measures, it provides valuable information about asthma treatment for one of the most prevalent conditions for health center patients.
A senior population measure for pneumococcal vaccination of patients 65 years of age and older was considered, but not selected because the selected measures were considered to be higher priorities.

Comment: Requiring providers to calculate BMI at every visit is inconsistent with current practices to record patient height only once annually.

Linda Ridlehuber, RN MBA
Quality Improvement Specialist
Minnesota Association of Community Health Centers

HRSA Response: Meaningful Use Measure NQF 0421, PQRI 128 requires documentation of calculated BMI in the past six months or during the current visit. BMI documentation includes both height and weight.

Comment: Specifications for the tobacco use and cessation measure should be clear about time frame and office visit by a medical provider.

Christina K. Lee, MD
Medical Director
Waimanalo Health Center
Waimanalo, Hawaii

HRSA Response: Specifications for Meaningful Use Measure NQF 0028 are that patients be seen for at least two office visits and (1) be queried about tobacco use one or more times within the past 24 months, and (2) receive cessation intervention if identified as a tobacco user within the past 24 months. The above comments will be considered in developing measure specifications, but are not considered to be major reasons for revising the proposed new clinical measures.

With the exception of the Alliance of Chicago (regarding the asthma pharmacologic

therapy measure), none of the sources consulted have commented on reporting burden of the new measures.

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 patients 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	1,181	71	83,851	$18	$1,509,318
Grant Report	328	18	5,904	$18	$ 106,272
Total	1,509		89,755		$1,615,590

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 are based on data collection costs for the current UDS, adjusted by an increased burden estimate due primarily to the estimated costs of reporting the four new clinical measures. Comments summarized in Section 8 above were considered in making the burden estimate. The table above estimates the additional burden costs. The burden per respondent varies across grantees. Health Centers with multiple funds streams will not be required to submit a report 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 Health Record (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 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 a measure will not exceed 70 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 few grantees that are paper-based, the BPHC will distribute hardcopy reference material that illustrates sample size indexed by patient population. 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 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 additional questions about EHR capabilities can also be answered by a mid-level staff Information Technology person with an average wage rate of $18 per hour.

13. Estimates of Annualized Cost Burden to Respondents

The proposed 2010 UDS consists of existing tables with updated data elements; in 2011, the proposed four new clinical measures will be added to the six clinical measures already reported. There are no capital or start up costs for the 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 clinical measures as they are consistent with those currently endorsed by national standard setting organizations and are Meaningful Use measures. Furthermore, 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 the four 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 – 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 $212,580 (10 hours x 1,181 grantees x $18/hour (GS-8 step 1 2010). The costs of answering the EHR questions are estimated to be $6,378 (.3 hours x 1,181 grantees x $18/hour).

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 approximately 50 percent of these grantees will incur programming or re-programming costs for generating the new clinical measures data in the required format. These costs are estimated to average $700 per center for generating the new clinical measure tables for a total of $420,000 ($700 X 600 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 proposed UDS data collection and reporting then HRSA will:

- Officially notify the Section 330 funded organizations of the approval.
- Make the 2010 UDS Reporting Manual available to Health Centers via the UDS Web site.
- Introduce the UDS reporting data elements in the 40 trainings to be held at various locations throughout the nation in fall 2010 and winter 2011. These

sessions will offer a question and answer period in which grantees can pose specific inquiries.

- Update all training modules posted on the Web to include the UDS reporting data elements.
- Hold a webinar for grantees on meaningful use and the new clinical measures during summer, 2011.
- Immediately update EHB data entry pages for 2010 UDS reporting; update clinical measures reporting pages for the new clinical measures and implement prior to January, 2012.
- HRSA will offer a toll-free line 8:30 AM - 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 is $900,000. In addition, costs include one FTE at 20% time at a GS 13 level for $ 20,000. Total costs to the government are $920,000.

15. Changes in Burden

The current OMB Inventory contains 67,988 burden hours for this activity. This request is for 89,755 hours, for an increase of 21,787 hours. The change is due to the following: 1) a revision in the burden estimate for the Universal report, increasing the burden from 61 to 71 hours per response; 2) an increase of approximately 105 new respondents completing the Universal Report and 178 new respondents completing the grant report. The total increase in burden is a program change of 21,787 hours. The increased burden is attributable to two factors, the new clinical measures and the addition of questions about EHR capabilities.

1. New Clinical Measures (increase burden by 10 hours per response)

   The proposed new clinical performance measures are particularly beneficial to grantees and the government. The clinical measures were chosen carefully to reflect key health indicators for health center patients across the life cycle, including 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 and are Meaningful Use measures, many grantees already or soon will report these measures to demonstrate quality and value to payors, state agencies, and the general public. 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 also be better demonstrated to responsible federal government agencies using improved outcomes measures.

2. Electronic Health Record Questions (increase burden by 20 minutes per response)

Rapid advancements in Electronic Health Record (EHR) technology and the advent of CMS incentive payment programs for Meaningful Use necessitate the collection of information on BPHC health centers' use of EHRs. There is no instrument for collecting basic information on EHRs from all BPHC health centers. In order to facilitate the implementation of EHRs and provide training and technical assistance to health center grantees in the area of EHRs and Meaningful Use, documented data is needed on current health center EHR use.

BPHC is responsible for ensuring that grantees adopt HIT and are eligible for Meaningful Use incentive payments in the first year of the program. In order to best serve this goal, it is necessary to collect data on the current capabilities of grantees and their systems. With those data, it will be possible not only to report to Congress and OMB on grantees' progress, but also to target technical assistance and inform the direction of BPHC resources.

16. Time Schedule, Publication and Analysis Plans

The grantees are required to submit the reports within 90 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.

Appendix 1. Modifications to the UDS in the OMB Approval Request

Table 5, Staffing and Utilization (see attached table):
Four data elements for vision services providers are added:

- Line 22a, Ophthalmologist - number of FTEs
- Line 22b, Optometrist - number of FTEs
- Line 22c, Optometric Assistant - number of FTEs
- Line 22d, Total Vision Services - clinic visits and patients

Table 6A- Selected Diagnoses and Services Rendered (see attached table):
Symptomatic and asymptomatic HIV are combined into a single line 1 to eliminate duplicate reporting of patients who go back and forth between symptomatic and asymptomatic during the course of the year.
Diagnoses and tests are reported for Hepatitis B and Hepatitis C. The following data elements for Hepatitis B and Hepatitis C are added:

- Line 4a: Hepatitis B, along with the applicable ICD-9-CM codes. This line provides the number of patients and visits with a primary diagnosis of Hepatitis B.
- Line 4b: Hepatitis C, along with the applicable ICD-9-CM codes. This line provides the number of patients and visits with a primary diagnosis of Hepatitis C.
- Line 21a: Hepatitis B test, along with the applicable CPT codes. The number of visits and patients receiving Hepatitis B tests are reported on this line.
- Line 21b: Hepatitis C test, along with the applicable CPT codes. The number of visits and patients receiving Hepatitis C tests are reported on this line.

Two conditions along with their ICD9 codes are added:

- overweight and obesity as line 14a, and
- tobacco use disorder as line 19a.

Four services along with their ICD9/CPT codes are added :

- childhood lead test screening (9 to 72 months) as line 26a,
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance abuse as line 26b,
- smoke/tobacco counseling and smoking cessation treatment as line 26c, and
- comprehensive and intermediate eye exams as line 26d.

Table 6B. Quality of Care Indicators (see attached table): In order to align with the revised National Quality Forum measure, the numerator and denominator for the Pap test measure are changed

from female patients age 21 to 64 years to female patients age 24 to 64 years. The look back period --- during the measurement year or two years prior --- is not changed. Section D, line 11 is changed to read: Number of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. (Technical note: Women age 21 to 64 years is correct here because the look back period for 24 year olds can capture women that were 21 when they received Pap tests 2 years prior.) Column a is changed to: total number of female patients 24 to 64 years of age.

For data collected in 2011 and reported in 2012, four new measures are being proposed for Table 6B. These measures are consistent with diagnostic and service delivery data being collected on table 6A:

1. **Childhood Obesity.** Current follow up plan for all obese children: Percentage of patients age 2 to 17 years seen during the current year with a documented BMI for obesity that have an original or updated follow up plan dated within twelve months of most recently documented visit.
2. **Adult Obesity.** Current follow up plan for all obese adults: Percentage of patients age 18 and older seen during the current year with a documented BMI for obesity that have an original or updated follow up plan dated within twelve months of most recently documented visit.
3. **Tobacco Use.** Provision of advice to tobacco users: Percentage of patients age 18 and older seen during the current year who are smokers or tobacco users who received (charted) advice to quit smoking or tobacco use during the current year.
4. **Asthma – Pharmacological therapy.** Percentage of patients aged 5 through 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative treatment during the current year.

Table 7. Health Outcomes and Disparities (see attached table): There are two types of changes to this table:

1. adult age ranges are specified for the blood pressure control and diabetes measures; and
2. ethnicity columns are revised to coincide with categories for Hispanic and non- Hispanic as specified in Table 3B.

Clinical Measures

The following specifications are made to align better the blood pressure control and

diabetes measures with those of the National Quality Forum.

- Blood pressure control (hypertension): Changed from adults 18+ to adults age 18 to 85 years (Section B line 6)
- Diabetes: Changed from adults 18+ to adults age 18 to 75 years (Section C line 9).

Table 9D – Patient Related Revenue (Scope of Project Only)

- UDS reporting includes lines 7, 8a, 8b and 9, Columns c1 and c2.
  - This change is made to comply with the Children's Health Insurance Program Reauthorization Act (CHIPRA) requirements for managed care.

Table 9E – Other Revenues

- Deleted line 1h, Integrated Services Development Initiative (ISDI) and line 1i, Shared Integrated Management Information Systems (SIMIS). If funds are received from these sources, they are to be reported on line 3, Other Federal Grants.
- Clarified line 1j, Capital Improvement Program Grants, to exclude ARRA grant funds.
- Changed the label for line 2 to read: HIV Part C Early Intervention Services (HRSA).
- Added line 4 for American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS) grant funds. Added line 4a for American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investment Program (FIP) grant funds.

- **Appendix A: Listing of Personnel**

The lines shown for categories of mental health and substance abuse providers are changed to coincide with the line numbers in Table 5, Staffing and Utilization. Line numbers are shown for vision services providers.

TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 – 7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total "Mid-Levels" (Lines 9a - 10)**			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	**Total Medical (Lines 8 + 10a through 14)**			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	**Total Dental Services (Lines 16 – 18)**			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22a	Opthamologists			
22b	Optometrists			
22c	Optometric Assistants			
22d	**Total Vision Services (Lines 22a-c)**			
22	**Other Professional Services (specify___)**			
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			

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
32	Patient Support Staff			
33	**Total Admin** & **Facility (Lines 30 – 32)**			
34	**Total** **(Lines 15+19+20+21+22+23+29+29a+33)**			

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Infectious and Parasitic Diseases				
1, 2.	Symptomatic and Asymptomatic HIV	042.xx , 079.53, V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Sexually transmitted diseases	090.xx – 099.xx		
4.a	Hepatitis B	070.20,070.22, 070.30, 070.32		
4.b	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; 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 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	ICD9CM Code: 278.0 – 278.02 or V85.xx excluding V85.51 and 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 physio-logical development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental develop-ment; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
19a	Tobacco use disorder	305.1		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 308.3, 309.81		
20c.	Attention deficit and disruptive	312.8x, 312.9x, 313.81, 314.xx		

	behavior disorders			
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx; 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81,314.xx)		

TABLE 6A continued – SERVICES RENDERED

Services Rendered		Applicable ICD-9-CM Code	Number of Visits (A)	Number of Patients (B)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	**CPT-4:** 86689; 86701-86703; 87390-87391		
21.a	Hepatitis B test	**CPT-4:** 86704, 86706, 87515-87517		
21.b	Hepatitis C test	**CPT-4:** 86803-86804, 87520-87522		
22.	Mammogram	**CPT-4:** 77055-77057 OR **ICD-9:** V76.11; V76.12		
23.	Pap test	**CPT-4:** 88141-88155; 88164-88167 OR **ICD-9:** V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Influenza virus, Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4:** 90633-90634, 90645 – 90648; 90657 – 90660; 90669; 90700 – 90702; 90704 – 90716; 90718; 90720-90721, 90723; 90743 – 90744; 90748		
24.a	Seasonal flu vaccine	**CPT-4:** 90655-90662		
24.b	H1N1 Flu vaccine	**CPT-4:** 90663; 90470		
25.	Contraceptive management	**ICD-9:** V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99391-99393; 99381-99383; 99431-99433 **OR ICD-9:** V20.xx; V29.xx		
26a	Childhood lead test screening (9 to 72 months)	**CPT-4:** 83655		
26b	Screening, Brief Intervention, and Referral (SBIRT)	**CPT-4:** 99408-99409		
26c	Smoke/tobacco counseling; Smoking cessation treatment	**CPT-4:** 99406 and 99407; S9075		
26d	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014		
Selected Dental Services				
27.	I. Emergency Services	**ADA :** D9110		
28.	II. Oral Exams	**ADA :** D0120, D0140, DO145, D0150, D0160, D0170, D0180		
29.	Prophylaxis – adult or child	**ADA :** D1110, D1120,		
30.	Sealants	**ADA :** D1351		
31.	Fluoride treatment – adult or child	**ADA :** D1203, D1204, D1206		
32.	III. Restorative Services	**ADA :** D21xx, D23xx, D27xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA :** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA : D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Note: Encounters and patients are reported by ***Primary*** Diagnosis ***only*** for lines 1-20d.

Note: For ICD-9 and CPR-4 codes, x denotes any number including the absence of a number in that place.

I International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2, 2008. American Medical Association.

II Current Procedural Terminology, CPT 2008. American Medical Association.

III Current Dental Terminology, CDT 2007 / 2008. American Dental Association.

TABLE 6B – QUALITY OF CARE INDICATORS

(NO PRENATAL CARE PROVIDED? CHECK HERE: •)

SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS (GRANTEES WHO PROVIDE PRENATAL CARE ONLY)

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

	AGE	NUMBER OF PATIENTS (a)
1	LESS THAN 15 YEARS	
2	AGES 15-19	
3	AGES 20-24	
4	AGES 25-44	
5	AGES 45 AND OVER	
6	TOTAL PATIENTS (SUM LINES 1 – 5)	

SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE

	TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR	Women Having First Visit with Grantee (a)	Women Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

SECTION C – CHILDHOOD IMMUNIZATION

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

SECTION D – PAP TESTS

	PAP TESTS	TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11	Female patients aged 21-64 who received one or more Pap tests to screen for cervical cancer			

SECTION E – WEIGHT REDUCTION PLAN

Weight Reduction Plans		Total number of Obese Patients (a)	Charts Sampled or EHR Total (b)	Number of Patients With Plan (c)
12	Obese patients aged 2 - 17 with a current weight reduction plan			
13	Obese patients aged 18 and over with a current weight reduction plan			
Section F – Tobacco Cessation Advice				
Tobacco cessation advice		Total Patients who use Tobacco Products (a)	Charts Sampled or EHR Total (b)	Number of Patients Advised to quit (c)
14	Tobacco users aged 18 and above who have been advised to quit			
Section G – Asthma Treatment Plan				
Asthma Treatment Plan		Total Asthmatic Patients aged 5 - 40 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
15	Patients aged 5 through 40 diagnosed with asthma who have an acceptable treatment plan			

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

		Hispanic/ Latino							Non- Hispanic/Latino							Unreported/ Refused to Report	Total
		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/ African American (c)	American Indian/ Alaska Native (d)	White (e)	More than one race (f)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black / African American (c)	American Indian/ Alaska Native (d)	White (e)	More than one race (f)	(g)	
HIV Positive Pregnant Women																	
(NO PRENATAL CARE PROVIDED? CHECK HERE: •)																	
SECTION A: DELIVERIES AND LOW BIRTH WEIGHT BY RACE																	
Deliveries and Babies by birth weight																	
1	Prenatal care patients who delivered during the year																
2	Deliveries performed by Grantee Provider																
3	Live Births < 1500 grams																
4	Live Births 1500 – 2499 grams																
5	Live Births ≥ 2500																
SECTION B: HYPERTENSION BY RACE																	
Patients diagnosed with hypertension whose last blood pressure was less than 140 / 90																	
6	Total patients aged 18 to 85 years with hypertension																

7	Charts sampled or EHR total																
8	Patients with controlled blood pressure																
SECTION C: DIABETES BY RACE																	
Patients diagnosed with Type I or Type II diabetes: Most recent test results																	
9	Total patients aged 18 to 75 years with Type I or II diabetes																
10	Charts sampled or EHR total																
11	Patients with HBA1c < 7%																
12	Patients with 7% ≤ HBA1c ≤ 9%																
13	Patients with HBA1c > 9%																

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

	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)									
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)									
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-									

		Full Charges	Amount Collecte	Retroactive Settlements, Receipts, and Paybacks (c)				Allowanc es	Sliding Discount	Bad Debt Write Off
	service)									
9.	Total Other Public (Lines 7+ 8a +8b)									

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

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)			
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	Total Private (Lines 10 + 11a + 11b)									
13.	Self Pay									
14.	**TOTAL** (Lines 3 + 6 + 9 + 12 + 13)									

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)	
1.	**TOTAL BPHC GRANTS** (SUM LINES 1G + 1J)	
OTHER FEDERAL GRANTS		
2.	HIV Part C Early Intervention Services (HRSA)	
3.	Other Federal Grants (specify: _____)	
4.	American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS)	
4.a	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)	

APPENDIX A: LISTING OF PERSONNEL

(ALL Line numbers in the following table refer to Table 5)

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
PHYSICIANS		
• Family Practitioners (Line 1)	X	
• General Practitioners (Line 2)	X	
• Internists (Line 3)	X	
• Obstetrician/Gynecologists (Line 4)	X	
• Pediatrician (Line 5)	X	
OTHER SPECIALIST PHYSICIANS (Line 7)		
• Allergists	X	
• Cardiologists	X	
• Dermatologists	X	
• Ophthalmologists	X	
• Orthopedists	X	
• Surgeons	X	
• Urologists	X	
• Other Specialists And Sub-Specialists	X	
NURSE PRACTITIONERS (Line 9a)	X	
PHYSICIANS ASSISTANTS (Line 9b)	X	
CERTIFIED NURSE MIDWIVES (Line 10)	X	
NURSES (Line 11)		
• Clinical Nurse Specialists	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurse	X	
• Licensed Practical Or Vocational Nurse	X	
OTHER MEDICAL PERSONNEL (Line 12)		
• Nurse Aide/Assistant (Certified And Uncertified)		X
• Clinic Aide/Medical Assistant (Certified And Uncertified Medical Technologists)		X
LABORATORY PERSONNEL (Line 13)		
• Pathologists		X
• Medical Technologists		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Laboratory Technicians		X
• Laboratory Assistants		X
• Phlebotomists		X
X-RAY PERSONNEL (Line 14)		
• Radiologists		X
• X-Ray Technologists		X
• X-Ray Technician		X
DENTISTS (Line 16)		
• General Practitioners	X	
• Oral Surgeons	X	
• Periodontists	X	
• Endodontists	X	
OTHER DENTAL		
• Dental Hygienists (Line 17)	X	
• Dental Assistant (Line 18)		X
• Dental Technician (Line 18)		X
• Dental Aide (Line 18)		X
MENTAL HEALTH (Line 20) & **SUBSTANCE ABUSE** (Line 21)		
• Psychiatrists (Line 20a)	X	
• Psychologists (Line 20a1 or 20c or 21)	X	
• Social Workers - Clinical and Psychiatric (Line 20a2 or 20c or 21)	X	
• Nurses - Psychiatric And Mental Health (Line 20b or 21)	X	
• Alcohol And Drug Abuse Counselors (Line 20c or 21)	X	
• Nurse Counselor (Line 20b or 21)	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
• Audiologists	X	
• Acupuncturists	X	
• Chiropractors	X	
• Herbalists	X	
• Massage Therapists	X	
• Naturopaths	X	
• Occupational Therapists	X	
• Ophthalmologists (line 22a)	X	
• Optometrists (line 22b)	X	
• Optometric assistants (line 22c)	X	
• Podiatrists	X	
• Physical Therapists	X	

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Respiratory Therapists	X	
• Speech Therapists / Pathologists	X	
• Traditional Healers	X	
• Nutritionists/Dietitians	X	
PHARMACY PERSONNEL (Line 23)		
• Pharmacist, Clinical Pharmacist		X
• Pharmacist Assistant		X
• Pharmacy Clerk		X
ENABLING SERVICES		
CASE MANAGERS (Line 24)		
• Case Managers	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
HEALTH EDUCATORS (Line 25)		
• Family Planning Counselors	X	
• Health Educators	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
• Patient Transportation Coordinator		X
• Driver		X
E LIGIBLITY ASSISTANCE WORKERS (Line 27a)		
• Benefits Assistance Workers		X
• Eligibility Workers		X
• Registration Clerks		X
INTERPRETATION (Line 27b)		

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Interpreters		X
• Translators		X
OTHER ENABLING SERVICES PERSONNEL (LINE 28)		X
OTHER RELATED SERVICES STAFF (Line 29a)		
• WIC Workers		X
• Head Start Workers		X
• Housing Assistance Workers		X
• Child Care Workers		X
• Food Bank / Meal Delivery Workers		X
• Employment / Educational Counselors		X
MANAGEMENT AND SUPPORT STAFF (Line 30a)		
• Project Director		X
• Chief Executive Officer/ Executive Director		X
• Chief Financial Officer		X
• Chief Information Officer		X
• Chief Medical Officer		X
• Secretary		X
• Administrator		X
• Director of Planning And Evaluation		X
• Clerk Typist		X
• Personnel Director		X
• Receptionist		X
• Director of Marketing		X
• Marketing Representative		X
• Enrollment/Service Representative		X
FISCAL AND BILLING STAFF (Line 30b)		
• Finance Director		X
• Accountant		X
• Bookkeeper		X
• Billing Clerk		X
• Cashier		X
• Data Entry Clerk		X
IT STAFF (Line 30c)		
• Director of Data Processing		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Programmer		X
• IT Help Technician		X
• Data Entry Clerk		X
FACILITY (Line 31)		
• Janitor/Custodian		X
• Security Guard		X
• Groundskeeper		X
• Equipment Maintenance Personnel		X
• Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
• Medical And Dental Team Clerks		X
• Medical And Dental Team Secretaries		X
• Medical And Dental Appointment Clerks		X
• Medical And Dental Patient Records Clerks		X
• Patient Records Supervisor		X
• Patient Records Technician		X
• Patient Records Clerk		X
• Patient Records Transcriptionist		X
• Registration Clerk		X
Appointments Clerk		X

Appendix 2. Questions about Grantee Electronic Health Record (EHR) Capabilities

The following questions will be presented on a screen in the Electronic Handbook to be completed before the UDS Report is submitted.

Question 1 determines whether a grantee is using any EHR system, and if so which one and by how many providers. Question 2 covers the 'Core' requirements and the 'Core Quality Measure' elements of Meaningful Use. We believe that this set is a reasonable baseline for assessing grantee progress on implementing EHRs. Question 3 will serve as an indicator to whether grantees are using the capabilities of their EHR to respond to the UDS questionnaire. Grantees who respond that they do not have an EHR in Question 1 will not be asked Questions 2 or 3.

1. Does your Center currently have an Electronic Health Record (EHR) system installed and in use?
    a. All sites and for all providers
    b. At some sites or for some providers
    c. No
        i. Pop-up if (a) OR (b)
            1. Please select your vendor and product from the list of certified systems below. If other, please specify:

                [Full EHRs]

                a. ABELMed EHR - EMR / PM 11
                b. Allscripts Professional EHR 9.2
                c. Aprima 2011
                d. athenaClinicals 10.10
                e. CureMD EHR 10
                f. Doctations 2.0
                g. EpicCare Inpatient - Core EMR Spring 2008
                h. EpicCare Ambulatory - Core EMR Spring 2008
                i. Centricity Advance 10.1
                j. gloEMR 6.0
                k. UroChartEHR 4.0
                l. iPatientCare 10.8
                m. WebChart EHR 5.1
                n. IMS 14.0
                o. NeoMed EHR 3.0

p. NextGen Ambulatory EHR 5.6
q. Nortec EHR 7.0
r. 2011 Pulse Complete EHR 2011
s. SuccessEHS 6.0

[Below are certified modules, not full EHRs]
t. Allscripts ED 6.3 Service Release 4
u. Allscripts PeakPractice 5.5
v. eClinicalWorks 8.0.48
w. HCS eMR 4.0
x. NexTech Practice 2011 9.7
y. nextEMR, LLC 1.5.0.0
z. PeriBirth 4.3.50
aa. ChartAccess 4
bb. SammyEHR 1.1.248
cc. T SystemEV 2.7
dd. Physician's Solution 5.0
ee. MDCare EMR 4.2
ff. WellCentive Registry Version 2.0
gg. Wellsoft EDIS v11

ii. Pop-up if (b)
    1. How many sites have the EHR in use?
    2. How many providers use the EHR system?

2. For each of the core Meaningful Use criteria for computerized capabilities below, please indicate whether your practice has this capability, does not have the capability, or does have the capability but the function is turned off such that it is not used:

Yes/Yes, but turned off or not used/No/Unknown

1. Patient history and demographic information?

    If yes, does this include a patient problem list?
    If yes, does it record and chart changes in vital signs?
    If yes, does it record weight screening and follow-up?
2. Clinical notes?

    If yes, do they include a list of the medications that the patient is taking?
    If yes, does this include a comprehensive list of the patient's allergies (including allergies to medications)?

3. Computerized provider order entry (CPOE)?

    For lab tests?
    For radiology tests?
        If yes, are orders sent electronically?
        If yes, are results incorporated into EHR?
        If yes, are out of range levels highlighted?
4. Electronic entry of prescriptions?

    If yes, are warnings of drug allergies, interactions or contraindications provided?
    If yes, are prescriptions sent electronically to the pharmacy?
5. Reminders for guideline-based interventions or screening tests?

    If yes, does it record smoking status?
    If yes, does it prompt for and record the tobacco cessation intervention?
6. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically?
7. Notifiable diseases sent electronically?
8. Reporting to immunization registries done electronically?
9. Capability to provide patients with an electronic copy of their health information upon request?
10. Capacity to provide clinical summaries for patients for each office visit?

11. Does the system protect electronic health information?

3. Do you use your EHR to compile the data for your UDS reporting?