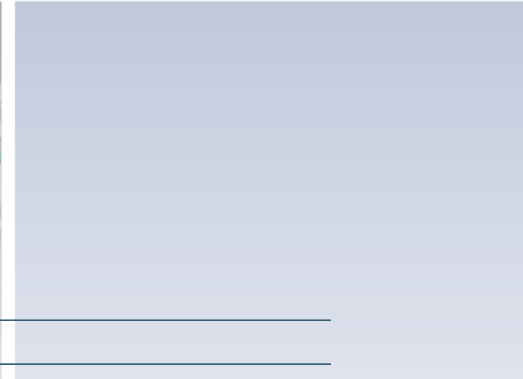
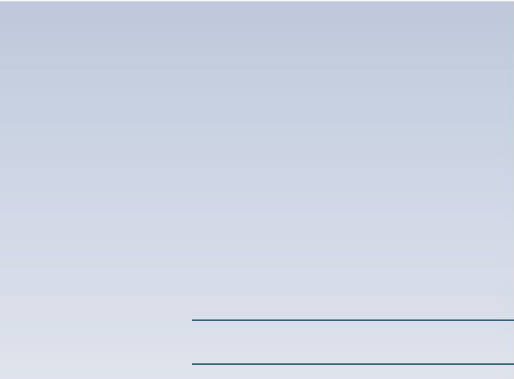


UNIFORM DATA SYSTEM

Reporting Instructions for the **2019** Health Center Data



For Reports Due by February 15, 2020

Bureau of Primary Health Care

Uniform Data System Reporting Instructions for 2020 Health Center Data



Letter from the Associate Administrator

Dear Health Center Program Participant:

The Health Resources and Services Administration's (HRSA) Health Center Program has continued to thrive for over 50 years because of your dedication and efforts to deliver primary health care services to underserved and vulnerable populations. More than 28 million people received high-quality, affordable, cost-effective health care from community-based and patient-directed health centers. Over 92 percent of health centers met or exceeded at least one or more Healthy People 2020 goals, and over half (52 percent) of health centers delivered more cost-effective care compared to national benchmarks.

With over 1,400 health centers and over 12,000 delivery sites in the U.S., the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin, collectively, your work and dedication to the communities you serve reaches far and wide. Health centers are making a significant impact on the nation's health as you deliver care to our most vulnerable populations, including 1 in 3 families living in poverty, 1 in 5 rural residents, and 1 in 9 children in the country, nearly 1.4 million people experiencing homelessness, 4.5 million patients served at health center sites that are in or immediately accessible to public housing, almost 1 million agricultural workers, and more than 385,000 veterans.

Through new and ongoing investments, an increasing number of health centers are able to deliver comprehensive health care services, including oral health, mental health, and substance use disorder services. Advances in the adoption and utilization of health information technology have increased access through telehealth, promoting the interoperability of health information, and improving the quality of care across the nation.

The data we receive through the Uniform Data System (UDS) is vital to further expand access, address health disparities, improve quality, and reduce the costs of health care. We have updated the 2020 UDS Manual in response to your input at trainings, conferences, and conversations with me and my staff. The Manual aligns with national measures and reporting standards and includes new appendices to capture the changing landscape of health care data collection, as outlined in the [Program Assistance Letter 2019-05](#). The UDS' clinical quality measures have been revised to align with the Centers for Medicare & Medicaid Services electronic-specified Clinical Quality Measures (eCQMs), capture more detail on depression, HIV, and breast cancer, and this year we will collect information on social determinants of health and Prescription Drug Monitoring Programs.

We continue to [modernize the UDS](#) reporting process to increase data standardization across national programs, reduce reporting burden, increase data quality, and expand data use to improve clinical care and operations to benefit you and the patients you serve. Your insights are critical to further advance the Health Center Program, and I encourage you to continue [providing feedback](#).

I would like to extend my gratitude once again for your commitment to underserved communities and vulnerable populations across our country through the Health Center Program.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jim', is positioned above the typed name.

James Macrae
Associate Administrator, Bureau of Primary Health Care

Bureau of Primary Health Care

Uniform Data System Reporting Instructions

For Calendar Year 2020 UDS Data

**For help contact: 866-837-4357 (866-UDS-HELP) or
udshelp330@bphcdata.net**

Health Resources and Services Administration

Bureau of Primary Health Care

5600 Fishers Lane, Rockville, Maryland 20857

DRAFT



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PUBLIC BURDEN STATEMENT

The Uniform Data System (UDS) provides consistent information about health centers including patient demographics, services provided, clinical processes and health outcomes, patients' use of services, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0193 and it is valid until 03/31/2022. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (. paperwork@hrsa.gov HYPERLINK "mailto:paperwork@hrsa.gov" 42 U.S.C. 254b HYPERLINK "http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section254b&num=0&edition=prelim"

42 U.S.C. 254blook-alikes

Program Assistance Letter (PAL)
2019-05Appendix B1

- list of personnel
- FAQs
- issues that affect multiple tables
- Sampling methods
- Health Information Technology (HIT) Capabilities Form
- Other Data Elements Form
- Workforce Form
- resources
- glossary

Bureau of Primary Health Care
(BPHC) website

udshelp330@bphcdata.net

EHBs¹

Appendix G: Health Center Resources

¹recommended settings

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providerAppendix A

Clinic Visits, Column B

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Form 5BVirtual Visits

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Form 5A *Form 5A*

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FAQs for Tables 3A and 3B

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Form 5B

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⁴Department of Housing and Urban Development

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⁵criteria permanent supportive housing

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FAQs for Table 4

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Appendix A

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National Health Service Corps (NHSC)

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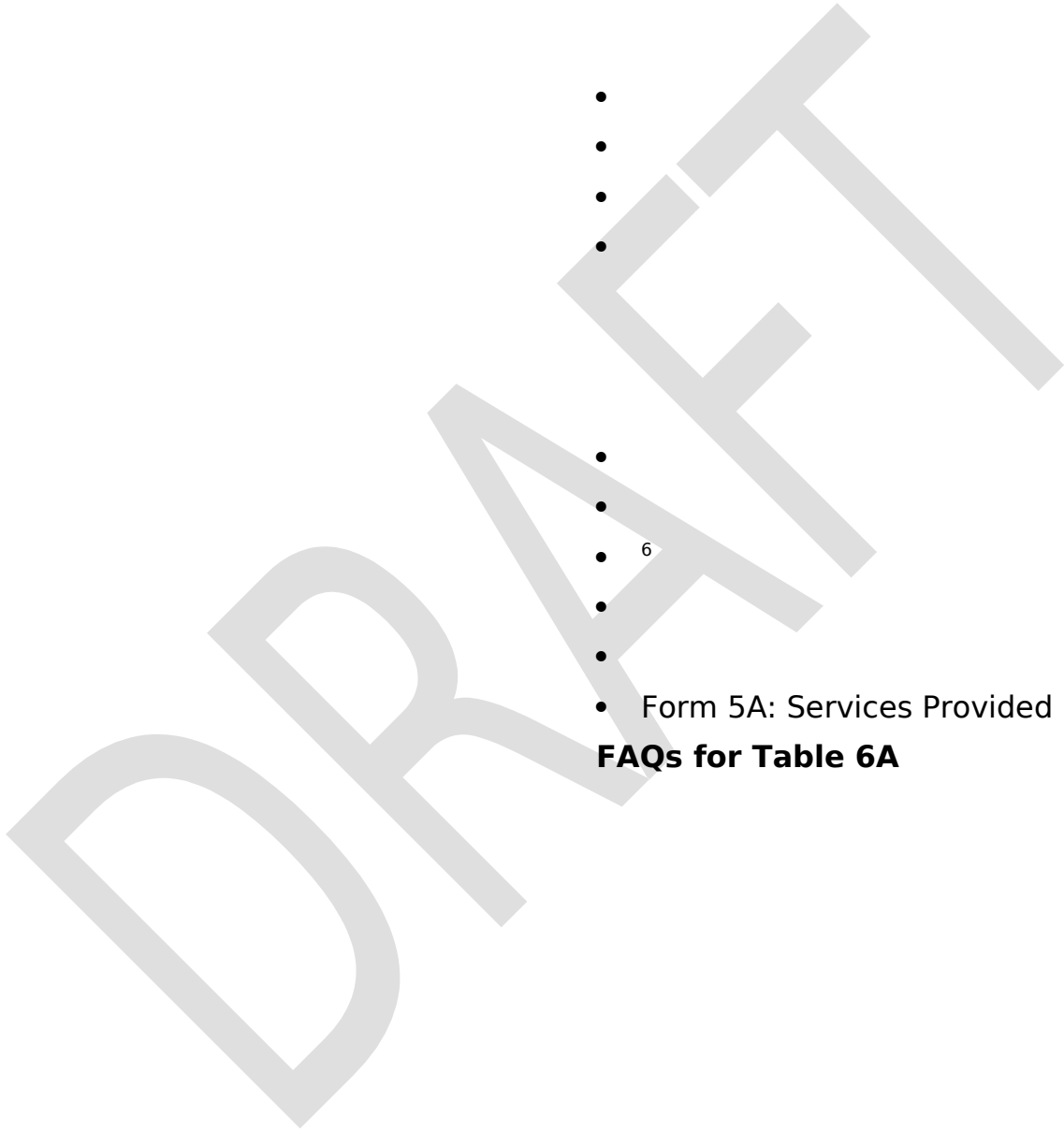
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Appendix B

FAQs for Table 5

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• Form 5A: Services Provided
FAQs for Table 6A

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National Quality Strategy CMS electronic Clinical Quality Measures

CMS' eCQI Resource Center Appendix G Value Set Authority Center (VSAC)⁷
Clinical Quality Language (CQL)



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- Appendix C

random sample

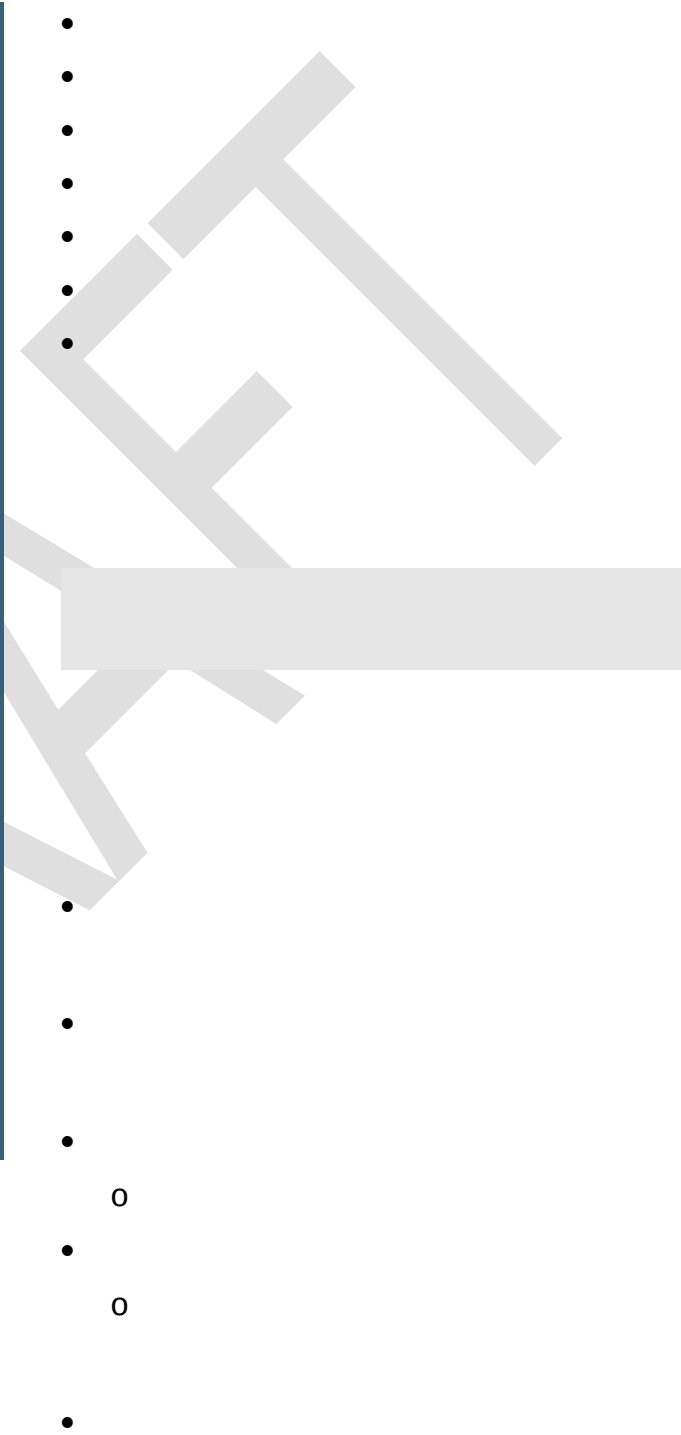
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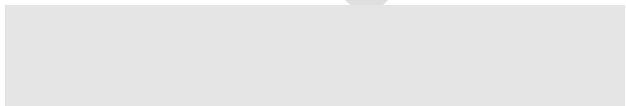


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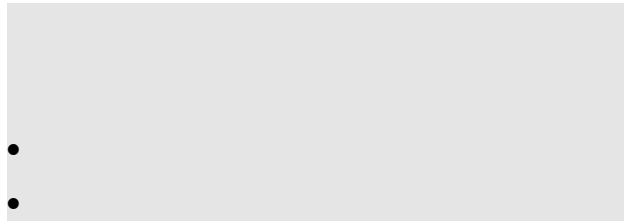
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HYPERLINK
["https://ecqi.healthit.gov/ecqm/ep/2020/cms155v8"](https://ecqi.healthit.gov/ecqm/ep/2020/cms155v8)

Measure Description

Percentage of patients 3–17 years of age who had an outpatient *medical* visit and who had evidence of height, weight, and body mass index (BMI) percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 3 through 17 years of age with at least one outpatient *medical* visit during the measurement period.

Note: Include children and adolescents who were born on or after January 1, 2002, and on or before December 31, 2015.

Numerator (Column C)

- Children and adolescents who have had:
 - o Their BMI percentile (not just BMI or height and weight) recorded during the measurement period and
 - o Counseling for nutrition during the measurement period and
 - o Counseling for physical activity during the measurement period.

Exclusions/Exceptions

- Denominator
 - o Patients who have a diagnosis of pregnancy during the measurement period.
 - o Patients who were in hospice care during the measurement period.
- Numerator
 - o Not applicable.

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- Include medical visits performed by any medical provider. Note that this is different from the eCQM, which requires that the visit be performed by a primary care physician or an OB/GYN. For example, include patients who had a medical visit with a nurse practitioner.
- The UDS numerator differs from the eCQM in that the eCQM requires the numerator elements to be reported separately against two age strata (age 3–11; age 12–17). For UDS purposes, the patients must have had all three numerator components completed in order to meet the measurement standard against one age strata (age 3–17).
- Do not count as meeting the performance measure charts that show only that a well-child visit

was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), CMS69v8 [HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms069v8"](https://ecqi.healthit.gov/ecqm/ep/2020/cms069v8)

Measure Description

Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit and when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit

Note: Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 and less than 25 kg/m²

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age or older on the date of the visit with at least one *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 2000, **including** patients who were 18 years of age or older on the date of their last visit.

Numerator (Column C)

- Patients with:
 - o A documented BMI (not just height and weight) during their

most recent visit in the measurement period or during the previous 12 months of that visit, and

- o When the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit.

Note: Include in the numerator patients within normal parameters who had their BMI documented **and** those with a follow-up plan if BMI is outside normal parameters.

Exclusions/Exceptions

- Denominator
 - o Patients who are pregnant during the measurement period.
 - o Patients receiving palliative care during or prior to the visit.
 - o Patients who refuse measurement of height and/or weight or refuse follow-up during the visit.
 - o Patients with a documented medical reason during the visit or within 12 months of the visit, including:
 - Elderly patients (65 years or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
 - Illness or physical disability.
 - Mental illness, dementia, confusion.
 - Nutritional deficiency, such as vitamin/mineral deficiency.

- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

- Numerator
 - o Not applicable.

Specification Guidance

- Report this measure for all patients seen during the reporting period.
- An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits. Do not use self-reported values.
- BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center.
- If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.
- Document the follow-up plan based on the most recent documented BMI outside of normal parameters.

UDS Reporting Considerations

- Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI.
- Do not count as meeting the measurement standard charts or templates that display only height

and weight. The fact that an HIT/EHR can calculate BMI does not replace the presence of the BMI itself.

Preventive Care and Screening:
Tobacco Use: Screening and
Cessation Intervention (Line 14a),
CMS138v8 [HYPERLINK](https://ecqi.healthit.gov/ecqm/ep/2020/cms138v8)
"https://ecqi.healthit.gov/ecqm/ep/
2020/cms138v8"

Measure Description

Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months *and* who received cessation counseling intervention if identified as a tobacco user.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients aged 18 years and older seen for at least two *medical* visits in the measurement period or at least one preventive *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 2000.

Numerator (Column C)

- Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period **and**
- Who received tobacco cessation intervention if identified as a tobacco user.

Note: Include in the numerator patients with a negative screening **and** those with a positive screening who had cessation intervention if a tobacco user.

Exclusions/Exceptions

- Denominator
 - o Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason).
- Numerator
 - o Not applicable.

Clinical Guidance

- If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected.
- If a patient has multiple tobacco use screenings during the 24-month period, use the most recent screening which has a documented status of tobacco user or non-user.
- If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers.

- If the patient does not meet the screening component of the numerator but has an allowable medical exception, remove the patient from the denominator.
 - The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention data elements.
 - If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.
 - Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure.
- o Received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, or
 - o Are on (using) a tobacco use cessation agent.
 - Do not count as meeting the measurement standard written self-help materials.
 - Identify preventive visits using “Preventive Care Services” CPT codes listed in the eCQM.
 - The UDS denominator differs from the eCQM in that the eCQM requires the patient population and numerator to be reported separately; for UDS purposes, the patients must be evaluated as one group.

UDS Reporting Considerations

- Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within 24 months before the end of the measurement period.
- Cessation counseling intervention for a tobacco user must occur at or following the most recent screening and before the end of the measurement year.
- Include patients who receive tobacco cessation intervention by any provider, including:
 - o Received tobacco use cessation counseling services, or

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Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v3

Measure Description

Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period:

- Patients 21 years of age or older previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); or
- Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or
- Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 21 years of age and older who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 1997.

Numerator (Column C)

- Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period.

Exclusions/Exceptions

- Denominator
 - o Patients who have a diagnosis of pregnancy.
 - o Patients who are breastfeeding.
 - o Patients who have a diagnosis of rhabdomyolysis.
 - o Patients with adverse effect, allergy, or intolerance to statin medication.
 - o Patients who are receiving palliative care.

- o Patients with active liver disease or hepatic disease or insufficiency.
- o Patients with end-stage renal disease (ESRD).
- o For patients 40 through 75 years of age with diabetes who have the most recent fasting or direct LDL-C laboratory test result less than 70 mg/dL and are not taking statin therapy.
- Numerator
 - o Not applicable.

Specification Guidance

- Current statin therapy use (including statin medication samples provided to patients) must be documented in the patient’s current medication list or ordered during the measurement period.
- Do not count other cholesterol lowering medications as meeting the measurement standard—only statin therapy meets the measurement standard.
- Ensure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), he/she is included and further risk checks are not needed.
- Intensity of statin therapy or lifestyle modification coaching is not being assessed for this measure—only prescription of any statin therapy.

UDS Reporting Considerations

- Not applicable.

**Ischemic Vascular Disease (IVD):
Use of Aspirin or Another
Antiplatelet (Line 18), CMS164v7**

Measure Description

Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, **or** who had an *active* diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age and older with a *medical* visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement period.

Note: Include patients who were born on or before December 31, 2000.

Numerator (Column C)

- Patients who had an active medication of aspirin or another antiplatelet during the measurement period.

Exclusions/Exceptions

- Denominator
 - o Patients who had documentation of use of

anticoagulant medications overlapping the measurement period.

- o Patients who were in hospice care during the measurement period.
- Numerator
 - o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug.

Colorectal Cancer Screening (Line 19), CMS130v8

Measure Description

Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 50 through 75 years of age with a *medical* visit during the measurement period.

Note: Include patients born on or after January 1, 1944, and on or before December 31, 1968.

Numerator (Column C)

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any *one* of the following criteria:
 - o Fecal occult blood test (FOBT) during the measurement period.
 - o Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period.
 - o Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.
 - o Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period.
 - o Colonoscopy during the measurement period or the 9 years prior to the measurement period.

Exclusions/Exceptions

- Denominator
 - o Patients with a diagnosis or past history of colorectal cancer or total colectomy.
 - o Patients who were in hospice care during the measurement period.
 - o Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
 - o Patients 66 and older with advanced illness and frailty because it is unlikely that

patients will benefit from the services being measured.

- Numerator
 - Not applicable.

Specification Guidance

- Do not count digital rectal exam (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

UDS Reporting Considerations

- There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Tests (FOBT and FIT-DNA) performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.
- FOBTs can be used to document meeting the measurement standard. This test, if performed, is required each measurement year. For example, a patient who had an FOBT in November 2019 would still need one in 2020.
- Collect stool specimens for FOBT and FIT-DNA, as recommended by the manufacturer.
- FOBT and FIT-DNA test kits can be mailed to patients but receipt, processing, and documentation of the test sample is required.

HIV Linkage to Care (Line 20), no eCQM

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis.⁹

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year and who had at least one *medical* visit during the measurement period or prior year.

Note: Include patients who were diagnosed with HIV for the first time ever¹⁰ by the health center between October 1, 2019, and September 30, 2020,¹¹ and had at least one medical visit during 2020 or 2019.

Numerator (Column C)

- Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers, **and:**
 - Had a medical visit with your health center provider who initiates treatment for HIV, or

⁹ Note that this measure does not conform to the calendar year reporting requirement.
¹⁰ "Patients first diagnosed with HIV" is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.
¹¹ Because the measure allows up to 90 days to complete the follow-up, look back 90 days to find the entire universe of patients who should have had a follow-up during the measurement year.

- o Had a visit with a referral resource who initiates treatment for HIV.

Exclusions/Exceptions

- Denominator
 - o Not applicable.
- Numerator
 - o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- *Treatment must be initiated* within 30 days of the HIV diagnosis (not just a referral made, education provided, or retest at a referral site).
- Include patients in the numerator only if they received treatment for HIV care within 30 days of the diagnosis. If the treatment is by referral to another clinician/organization (such as a Ryan White provider), the medical treatment at the referral source must begin and the referral loop must be closed during the 30-day period. Closing the referral loop means the referring provider received documented confirmation that the visit was completed from the provider to whom the patient was referred.
- Identification of patients for this measure crosses years and may include prior-year patients.
- Reactive initial HIV tests and patients who self-identify as being HIV positive without documentation must be followed

by a supplemental test to confirm diagnosis.

- Do not include patients who:
 - o Were diagnosed elsewhere, even if they can provide documentation of the positive test result.
 - o Had a positive reactive initial screening test but not a positive supplemental test.
 - o Were positive on an initial screening test provided by you but were then sent to another provider for definitive testing and treatment.

Note: There are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. It is strongly encouraged that you modify your HIT/EHR to record this information or keep track of the patients who are identified in a separate system.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v9

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool **and** if positive, a follow-up plan is documented on the date of the positive screen.

This is calculated as follows:

Denominator (Universe) (Columns A and B)

- Patients aged 12 years and older with at least one *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 2006.

Numerator (Column C)

- Patients who:
 - o Were screened for depression on the date of the visit using an age-appropriate standardized tool **and**,
 - o If screened positive for depression, a follow-up plan is documented on the date of the positive screen.

Note: Include in the numerator, patients with a negative screening and those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

- Denominator
 - o Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.
 - o Patients:
 - Who refuse to participate.
 - Who are in urgent or emergent situations¹² where time is of the essence and to delay treatment would

jeopardize the patient’s health status.

- Whose cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools.

- Numerator
 - o Not applicable.

Specification Guidance

- The depression screening must be reviewed and addressed in the office of the provider on the date of the visit; the screening must occur on the same date or up to 14 days prior to the date of the visit. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider.
- Standardized depression screening tools are normalized and validated for the age-appropriate patient population in which they are used and must be documented in the medical record.
- Use the most recent screening results.
- Examples of depression screening tools include, but are not limited to:
 - Adolescent Screening Tools (12-17 years)
 - o Patient Health Questionnaire for Adolescents (PHQ-A)
 - o Beck Depression Inventory-Primary Care Version (BDI-PC)

¹² Do not exclude patients seen for routine care in urgent care centers or emergency rooms you operate.

- o Mood Feeling Questionnaire (MFQ)
- o Center for Epidemiologic Studies Depression Scale (CES-D)
- o Patient Health Questionnaire (PHQ-9)
- o Pediatric Symptom Checklist (PSC-17)
- o Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2
- Adult Screening Tools (18 years and older)
 - o PHQ-9
 - o Beck Depression Inventory (BDI or BDI-II)
 - o CES-D
 - o Depression Scale (DEPS)
 - o Duke Anxiety-Depression Scale (DADS)
 - o Geriatric Depression Scale (GDS)
 - o Cornell Scale for Depression in Dementia (CSDD)
 - o PRIME MD-PHQ-2
 - o Hamilton Rating Scale for Depression (HAM-D)
 - o Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- The follow-up plan must be related to a positive depression screening.
- Follow-up for a positive depression screening must include one or more of the following:

- o Additional evaluation or assessment for depression.
- o Suicide risk assessment.
- o Referral to a practitioner who is qualified to diagnose and treat depression.
- o Pharmacological interventions.
- o Other interventions or follow-up for the diagnosis or treatment of depression.

UDS Reporting Considerations

- Do not count patients who are re-screened as meeting the measurement standard as a follow-up plan to a positive screen.
- Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a follow-up plan to a positive depression screening.

Dental Sealants for Children between 6-9 Years (Line 22), CMS277v0

Measure Description

Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation *dental* visit and are at

moderate to high risk for caries in the measurement period.

Note: Include children who were born on or after January 1, 2010, and on or before December 31, 2012.

Numerator (Column C)

- Children who received a sealant on a permanent first molar tooth during the measurement period.

Exclusions/Exceptions

- Denominator
 - o Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing).
- Numerator
 - o Not applicable.

Specification Guidance

- The intent is to measure whether a child received a sealant on at least one of the four permanent first molars.
- “Elevated risk” is a finding at the patient level, not a population-based factor such as low socioeconomic status.
- Look for tooth-level data for sealant placement. Capture sealant application within buccal pits on a first permanent molar in the numerator.

UDS Reporting Considerations

- Include dental visits with the health center or with another dental provider who saw patients through a paid referral.
- Use ADA codes to document caries risk level determined through an assessment.

Note: Although draft eCQM reflects age 5 through 9 years of age, use age 6 through 9 as measure steward intended.

Additional information is available to clarify reporting. View **FAQs for Table 6B.**

Breast Cancer Screening (Line 11a), CMS125v8 [HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms125v8"](https://ecqi.healthit.gov/ecqm/ep/2020/cms125v8)

Measure Description

Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

This is calculated as follows:

Denominator (Columns A and B)**Universe) (**

- Women 51-74 years of age with a medical visit during the measurement period

Note Include :women who were born on or after January 1, d on or before December 31, 1969.n, a1946

Numerator(Column C)

- Women with one or more mammograms during the 27

months prior to the end of the measurement period

Exclusions/Exceptions

- Denominator
 - o Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.
 - o Patients who were in hospice care during the measurement period.
 - o
 - o Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
 - o Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
- Numerator
 - o Not Applicable

Specification Guidance

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

HIV Screening (Line 20a),
 CMS349v2 [HYPERLINK](https://ecqi.healthit.gov/ecqm/ep/2020/cms349v2)
 "https://ecqi.healthit.gov/ecqm/ep/2020/cms349v2"

Measure Description

Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV

This is calculated as follows:

Denominator (Columns A and B) Universe) (

- Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient medical visit during the measurement period

Numerator (Column C)

- Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

Note: d on or before December 31, 2004n, a1955 who were born on or after January 1, patientsInclude .

Exclusions/Exceptions

- Denominator
 - o Patients diagnosed with HIV prior to the start of the measurement period
- Numerator
 - o Not Applicable

Specification Guidance

- Provider must have documentation of the administration of the laboratory test present in the patient's medical record.
- In cases where the HIV test was performed elsewhere, providers cannot rely on patient attestation or self-report to meet the measure requirements. Providers must request documentation of those test results.

- If such documentation is not available, the patient should be considered still eligible for HIV screening.
- If such documentation is available, but cannot be provided in a standardized, structured format (Laboratory Test LOINC code of the test is not known, the entry should use the more generic code LOINC panel code [75622-1HIV be readily incorporated as structured data within the EHR), providers should enter the information into their EHR as a laboratory test in a manner consistent with the EHR in use. If the specific to].

Depression Remission at Twelve Months (Line 21a), CMS159v8
HYPERLINK

"<https://ecqi.healthit.gov/ecqm/ep/2020/cms159v8>"

Measure Description

The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

This is calculated as follows:

Denominator (Columns A and B) Universe) (

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event. Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit (including the day of the office visit).

Numerator (Column C)

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five

Exclusions/Exceptions

- Denominator
 - o Patients who died
 - o Patients who received hospice or palliative care services
 - o Patients who were permanent nursing home residents
 - o Patients with a diagnosis of bipolar disorder
 - o Patients with a diagnosis of personality disorder

- o Patients with a diagnosis of schizophrenia or psychotic disorder
- o Patients with a diagnosis of pervasive developmental disorder

- Numerator
 - o Not Applicable

Specification Guidance

- (TBD)

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Table 6B: Quality of Care Measures

Reporting Period: January 1, 2020, through December 31, 2020

0 Prenatal Care Provided by Referral Only (Check if Yes)

**Section - Age Categories for Prenatal Care Patients:
Demographic Characteristics of Prenatal Care Patients**

Line	Age	Number of Patients (a)
1	Less than 15 years	[blank for demonstration]
2	Ages 15-19	[blank for demonstration]
3	Ages 20-24	[blank for demonstration]
4	Ages 25-44	[blank for demonstration]
5	Ages 45 and over	[blank for demonstration]
6	Total Patients (Sum of Lines 1-5)	[blank for demonstration]

Section - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	[blank for demonstration]	[blank for demonstration]
8	Second Trimester	[blank for demonstration]	[blank for demonstration]
9	Third Trimester	[blank for demonstration]	[blank for demonstration]

Section - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2 nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2 nd birthday	[blank for demonstration]	[blank for demonstration]	[blank for demonstration]

Section - Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	[blank for demonstration]	[blank for demonstration]	[blank for demonstration]
Line	Breast Cancer Screening	Total Female Patients Aged 51 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Female Patients with one or more mammograms (c)

REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11a	MEASURE: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period			

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Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–17 years of age with a BMI percentile and counseling on nutrition <i>and</i> physical activity documented			

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use <i>and</i> Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, <i>and</i> (2) if identified to be a tobacco user received cessation counseling intervention			

Section for the Prevention and Treatment of Cardiovascular Disease TherapyStatin - H

REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients (a)21 and Older at High Risk of Cardiovascular Events ged A	Numb(b)er Charts Sampled or EHR Total	Number of Patients Pres(c)cribed or On Statin Therapy
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy			

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Section I - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

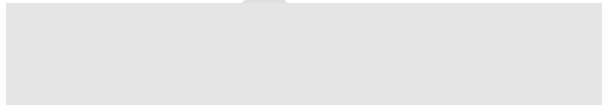
Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer			

Section Measures - HIV LSection * ALPHABETIC - SEQ

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Appendix B

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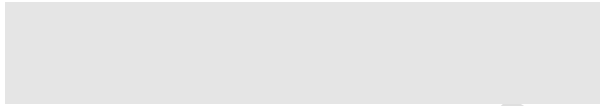
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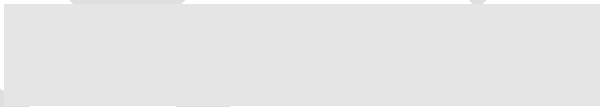
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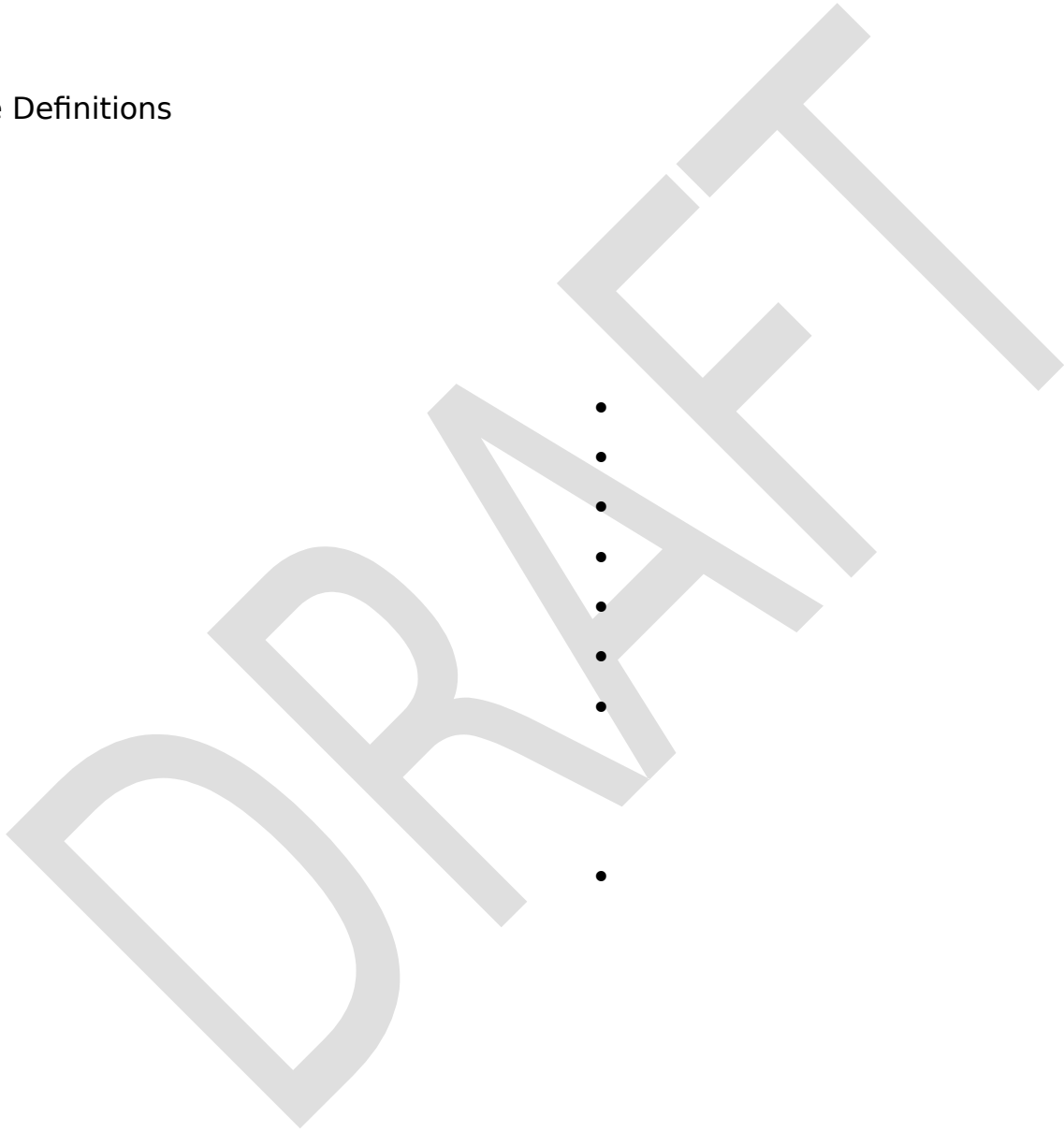
FAQs for Table 7

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Line Definitions

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FAQs for Table 5

FAQ discussion for Table 5

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Table 5 instructions

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Appendix A

Federal Section 340(b) drug pricing program

Appendix B

FAQs for Table 8A

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sliding fee discounts

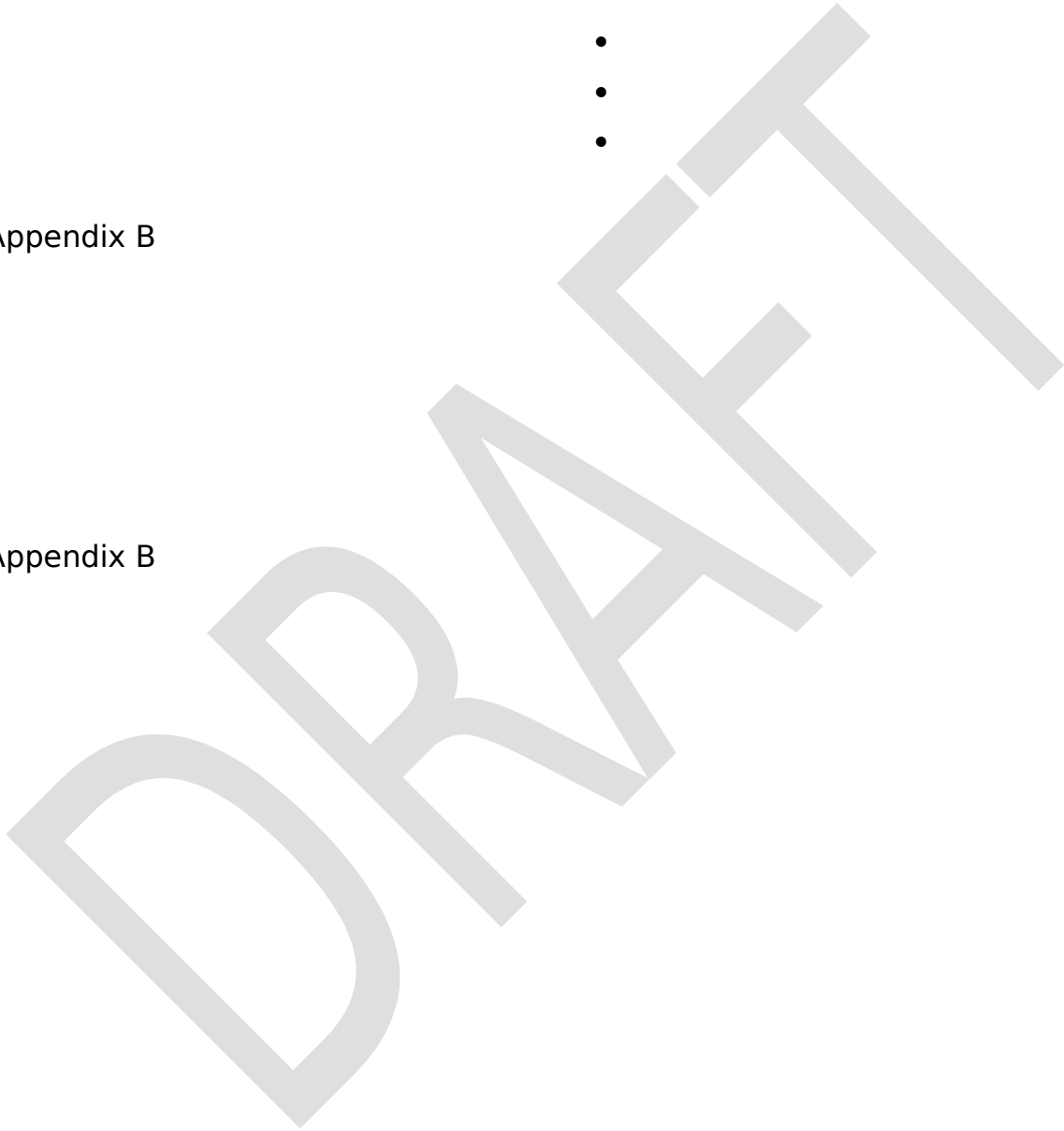
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FAQs for Table 9D

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REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

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Meaningful Use

PL 93-638 Compact funds

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Capital Development Grant

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Appendix B

FAQs for Table 9E

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Revisions to the Standards for the Classification of Federal Data on Race and EthnicityOMB

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2015 Edition Health Information
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Criteria, 2015 Edition Base
Electronic Health Record (EHR)
Definition, and ONC Health IT
Certification Program Modifications

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Appendix B

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udshelp330@bphcdata.net

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ONC Issue Tracking System

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REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

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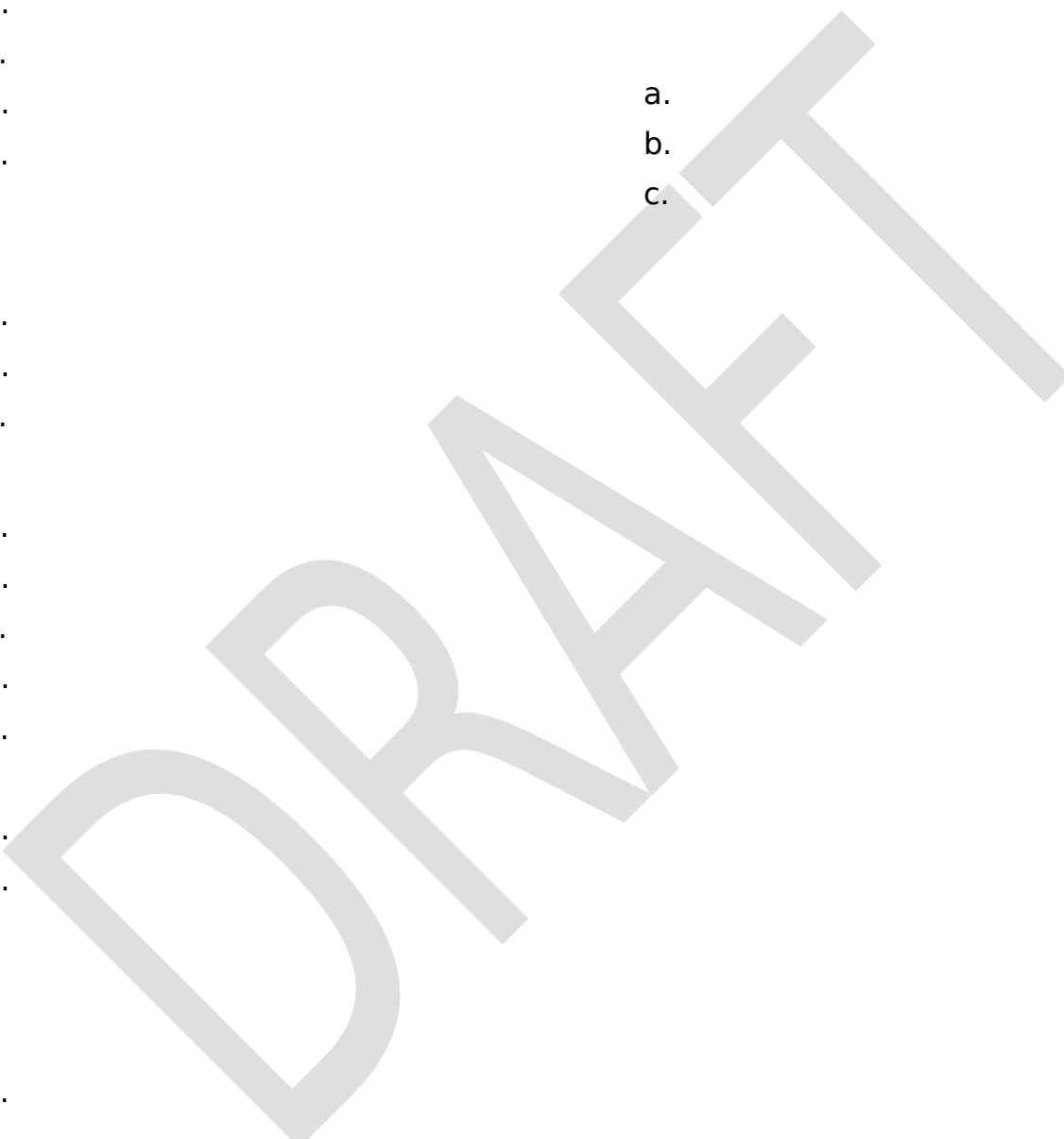
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¹⁵Public Law 114-198

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		udshelp330@bphcdata.net	
		HRSA Call Center	
		HRSA Call Center	

BPHC website UDS Training Website UDS Modernization Initiative
Quality Improvement website

		http://www.nachc.org	cthomas@nachc.com
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		http://nurseledcare.org/	
		http://www.nchph.org	info@nchph.org

		http://www.migrantclinician.org	tlyons@migrantclinician.org
		http://www.ncfh.org	

		http://www.nhchc.org	aboyer@nhchc.org
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	http://www.csh.org		
	http://www.aapcho.org	joelee@aapcho.org	
	http://www.lgbthealtheducation.org	lgbthealtheducation@fenwayhealth.org	
	http://www.medical-legalpartnership.org	ellawton@gwu.edu	
	http://hiteqcenter.org/	hiteqinfo@jsi.com	
	http://www.nnoha.org	executivedirector@nnoha.org	

EHBs web link

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- o BPHC webpages
- o UDS Mapper

eCQI Resource Center Office of National Coordinator Issue Tracking System

			HYPERLINK K "https://ecqi.healthit.gov/ecqm/ep/2020/cms117v8"	n/a	Child Core	n/a	Yes

REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

Table 6B, Line 11	Cervical Cancer Screening	National Committee for Quality Assurance	CMS124v8 HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms124v8"	n/a	Adult Core	C-15	Yes
Table 6B, Line 11a	Breast Cancer Screening	National Committee for Quality Assurance	CMS125v8 HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms125v8"	n/a			
Table 6B, Line 12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	National Committee for Quality Assurance	CMS155v8 HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms155v8"	n/a	Child Core	n/a	Yes
Table 6B, Line 13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	Centers for Medicare and Medicaid Services	CMS69v8 HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms069v8"	421e	n/a	n/a	Yes
Table 6B, Line 14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Physician Consortium for Performance Improvement	CMS138v8 HYPERLINK "https://ecqi.healthit.gov/ecqm/ep/2020/cms138v8"	28e	Adult Core	n/a	Yes

REPORTING INSTRUCTIONS FOR 202019 HEALTH CENTER DATA

Table 6B, Line 17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Centers for Medicare and Medicaid Services	CMS347v3	n/a	n/a	n/a	Yes
Table 6B, Line 18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	National Committee for Quality Assurance	CMS164v7	68	n/a	n/a	Yes
Table 6B, Line 19	Colorectal Cancer Screening	National Committee for Quality Assurance	CMS130v8 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms130v8 "	n/a	n/a	C-16	Yes
Table 6B, Line 20	HIV Linkage to Care	n/a	n/a	n/a	n/a	n/a	No
Table 6B, Line 20a	HIV Screening	Center for Disease Control and Prevention	CMS349v2 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms349v2 "	n/a			
Table 6B, Line 21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare and Medicaid Services	CMS2v9 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9 "	418e	Adult Core	n/a	Yes

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Table 6B, Line 21a	Depression Remission at Twelve Months	Minnesota Community Measurement	CMS159v8 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms159v8 "	710e			
Table 6B, Line 22	Dental Sealants for Children between 6-9 Years	Dental Quality Alliance - American Dental Association	CMS277 (draft)	2508 (claims-based measure)	Child Core	OH-12.2	No
Table 7, Section A	Low Birth Weight	Centers for Disease Control and Prevention	n/a	1382	n/a	MICH-8.1	No
Table 7, Section B	Controlling High Blood Pressure	National Committee for Quality Assurance	CMS165v8 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms165v8 "	n/a	Adult Core	HDS-12	Yes
Table 7, Section C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	National Committee for Quality Assurance	CMS122v8 HYPERLINK " https://ecqi.healthit.gov/ecqm/ep/2020/cms122v8 "	n/a	Adult Core	D-5.1	Yes

Notes: n/a = Not applicable, NQF = National Quality Forum, MIPS = Merit-based Incentive Payment System, QPP = Quality Payment Program

Appendix H: Glossary

Accrual basis: Reported when the expense occurs, not when the cash is received.

Aged and disabled former migratory agricultural workers: As defined in section 330 (g)(1)(B), individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of age or disability.

Allowance: A discount granted to a third-party payer as part of an agreement between the health center and the payer.

Bad debt: Amounts billed to and defaulted by a patient responsible for payment.

Capitation: An agreed-upon amount that a managed care payer pays to the provider (health center) for providing all of the services in an agreed-upon list. The payer/HMO pays the health center a set amount monthly, regardless of whether any services were rendered during the month.

Cash basis: Reported when the cash is received or expended, not when an obligation occurs.

CHIP or CHIP-RA or S-CHIP: The Children's Health Insurance Program Reauthorization Act (CHIP-RA) provides primary health care coverage for children and, on a state-by-state basis, others, especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans.

Contract staff: People who work under contract at the health center, as opposed to being on salary. They may or may not work regular assigned hours and may or may not receive benefits. They do not have withholding taxes deducted from their paychecks, and they have their income reported to the Internal Revenue Service (IRS) on a 1099 form.

Dually eligible: Patient enrolled in both Medicare and Medicaid, with Medicare being the primary insurance.

Electronic health record (EHR): A digital record of a patient's status and interactions with a health center, including real-time, patient-centered information available quickly and securely to authorized users.

Exclusions or exceptions: As used in clinical measure reporting, patients not to be considered or included in the denominator (exclusions) or removed if identified (exceptions).

Federal poverty guidelines: An annual statement of the amount of income below which an individual or family of different sizes are considered to be in poverty.

Fee-for-service: Charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes and the charge associated with each of these services.

Fee schedule: A listing of fixed fees for goods or services.

First trimester (prenatal care):

Women who were estimated to be pregnant up through the end of the 13th week after their last menstrual period.

Full-time equivalent (FTE): One person who works full-time for the year. Fractions of an FTE are used to identify part-time or part-year individuals, and multiples of an FTE are used to identify multiple individuals.

Full-time staff: People generally employed 40 hours per week, but subject to organizational definitions. Full-time staff generally receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract. Staff are full-time when they are so defined in their contract and/or when their benefits reflect this status.

Gender identity: A person's internal sense of their gender as a male, female, a combination of male and female, or another gender; this may or may not align with one's sex assigned at birth.

Gross charges: The full, undiscounted cost of a product or a service.

Hispanic or Latino: Persons of specific Spanish or Latino heritage, lineage, descent, or country of birth.

Homeless: A person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who

reside in transitional housing. May include children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.

Income: Earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income comprises earnings.

Indigent care programs: State or local programs that pay in whole or in part for services rendered to people who are uninsured. Indigent care programs include 638 compact programs for tribal groups.

Last party rule: Reporting of grant and contract funds based on the entity from which the health center received them, regardless of their original origin.

Locum tenens: People who work at the health center on an as-needed basis during a part-time absence of another provider and when the center is unable to hire a full- or part-time staff person until the position is filled. Locums are uniquely identifiable because they work for an agency, and the center pays the agency rather than the individual. They do not receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

Managed care: A system where a premium is paid to an organization that contracts with a health center to provide a range of services to patients assigned to the health center.

Medicaid: Federal and state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

Medicaid expansion: A program that makes Medicaid available to more patients and that requires states to opt-in to participate.

Medicare: Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

Member month: One person enrolled in a managed care plan for one month.

Migratory agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture, who have been so employed within 24 months, and who establish for the purposes of such employment a temporary abode. This includes dependent family members of the individuals described above and individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area.

National Health Service Corps (NHSC) assignees: Members of the NHSC assigned by the Corps to a health center. This includes members of the NHSC Loan Repayment Program. These individuals are employees of the U.S. government.

Numerator: As used in clinical measure reporting, records (a subset of the denominator) that meet the measurement standard for the specified measure.

Off-site contract providers:

Providers who are contracted for the services who work at a location that is not an in-scope site as defined in a health center application.

On-call providers: Providers who fill in briefly when someone is absent but may stay for an extended period if the center is unable to hire a full- or part-time staff person for a position. Unlike locums, health centers pay on-call providers directly. They may or may not receive all the benefits or a salary and may or may not have payroll and income taxes withheld.

Part-time staff: People employed by the health center for fewer than 40 hours per week. They receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract.

Part-year staff: Persons employed or contracted for full or part time for a specific period that may be once or recurring.

Patient: A person who has at least one reportable visit in one or more categories of services: medical, dental, mental health, substance use disorder, vision, other professional, and enabling.

Penalty/paybacks: Payments made by health centers to payers because of overpayments collected earlier or for over-utilization of the inpatient or specialty pool funds in managed care plans.

Performance measure: A quantifiable indicator used to evaluate how well the health center is achieving standards.

Prenatal care (first visit): The date a patient has a visit with a physician, NP, PA, or CNM who conducts a prenatal exam to initiate pregnancy-related health care.

Public housing: Public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

Race: A physical or social categorization of a person, presumably based on inheritance.

Reclassify: Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations: Lump-sum retroactive adjustments based on the filing of a cost report.

Residents/trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) already have licenses.

Sex: The anatomical and physiological biology of a person assigned at birth.

School-based health center: A health center located on or near school grounds (including pre-school, kindergarten, and primary through secondary schools) that provides comprehensive preventive and primary health services.

Seasonal agricultural workers: For the purposes of health centers receiving a Health Center Program

award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker.

Second trimester (prenatal care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.

Sexual orientation: How a person describes their emotional and sexual attraction to others as straight, lesbian or gay, bisexual, or another sexual orientation.

Sliding fee discount: A discount applied to the fee schedule which adjusts fees based on the patients' ability to pay based on their income.

Straight-line allocation: Allocating non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category.

Third trimester (prenatal care): Women who were estimated to be pregnant for 28 weeks or more weeks after their last menstrual period.

Universe (denominator): As used in clinical measure reporting, patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Veteran: Persons discharged from the uniformed services of the United States.

Visit: A documented contact between a patient and a licensed or credentialed provider who exercises his/her independent, professional judgment in the provision of services to the patient. (Virtual visits are allowable for each of the service categories).

Volunteers: People who work at the health center but not paid for their work.

Wrap-around payments: An amount equal to the difference between the usual payment and an agreed-upon flat fee, known as an FQHC or PPS rate.

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