The 2012 BPHC Welcome Packet for Newly Funded Health Centers

This packet provides several valuable resources to assist with next steps after becoming a HRSA grantee and to help you take advantage of all the benefits of being a Federally Qualified Health Center (FQHC).

Inside this document you will find:

BPHC General Information and Technical Assistance Resources

The Health Resources and Services Administration (HRSA) Health Center Program website:
http://bphc.hrsa.gov/

The Bureau of Primary Health Care (BPHC) Technical Assistance homepage:
http://bphc.hrsa.gov/technicalassistance

General HRSA Help:
Callcenter@HRSA.gov
877-464-4772, M-F 9a – 5:30p EST
The HRSA Contact Center can assist with: EHB login/security issues, creating EHB accounts, username/password issues, EHB roles and/or privileges.

BPHC Helpline:
bphchelpline@hrsa.gov
1-877-974-BPHC
The BPHC Helpline can assist with: BPHC grant funding opportunities, Uniform Data System (UDS), Changes in Scope (CIS), Federal Tort Claims Act (FTCA) coverage, deeming/redeeming, and claims.

Program Requirements:
Health centers must meet a strict set of requirements, which are summarized at: http://bphc.hrsa.gov/about/requirements.htm. For additional information on these requirements, please also review:

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. §254b) http://bphc.hrsa.gov/about/legislation/section330.htm

Payment Systems and Program Enrollment:

Enroll in Medicare. The Internet-based Provider Enrollment, Chain and Ownership System (Internet-based PECOS) can be used in lieu of the Medicare enrollment application (i.e., paper CMS-855) to enroll. PECOS is found at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp. Alternatively, as soon as the NOA is received, submit a completed standard Medicare 855A application, along with other supporting documentation. You can retrieve the standard Medicare 855A application form and directions for completing it from the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicareProviderSupEnroll/. Please also refer to BPHC Program Assistance Letter 2011-04, "Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit," for more information: http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html.

Enroll in Medicaid. You must enroll with your state Medicaid office in order to be eligible for reimbursement for visits by Medicaid patients to your facility. As an FQHC, you will be eligible for special enhanced reimbursement from Medicaid. You should contact the state Medicaid office right away in order to obtain the enrollment forms and to fill out as much as possible in advance. Information on your state agency can be found at: http://www.aphsa.org/Links/links-state.asp

Enroll in the HHS Payment Management System. Payment of grants to grantees occurs through the HHS PMS, a fully automated and full service centralized grants payment and cash management system. If you have not done so already, contact your Grants Management Specialist (listed on your NOA) to begin setting up your PMS account. http://www.dpm.psc.gov

Enroll Providers and Facilities Under the Federal Tort Claims Act (FTCA). Under the Act, health centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer. You must enroll in this program to be covered. For more information, go to: http://bphc.hrsa.gov/ftca/.

Become a National Health Service Corps (NHSC) Site. Your health center can become NHSC-approved. Dentists, dental hygienists, primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, and mental health professionals who are eligible for loan repayment funding or have received scholarships can fulfill their service obligation. For more information, go to: http://nhsc.hrsa.gov/

Take Advantage of 340B Drug Pricing. The 340B Program limits the cost of covered outpatient drugs to certain federal grantees, including section 330-funded health centers. To enroll in the 340B program, health centers must submit a request to the HRSA Office of Pharmacy Affairs (OPA) with Medicaid billing information and the appropriate form, available at: http://www.hrsa.gov/opa/.

BPHC-related Acronyms

A

AAAHC	Accreditation Association for Ambulatory Health Care
AAPCHO	Association of Asian Pacific Community Health Organizations
ACA	Affordable Care Act (see also PPACA)
AHEC	Area Health Education Center
ARRA	American Recovery and Reinvestment Act
ASPR	Assistant Secretary for Preparedness and Response (HHS)
ASTHO	Association of State and Territorial Health Officials

B

BCRS	Bureau of Clinician Recruitment and Service (HRSA)
BHPr	Bureau of Health Professions (HRSA)
BPHC	Bureau of Primary Health Care (HRSA)
BPR	Budget Period Renewal

C

CA	Cooperative Agreement
CAH	Critical Access Hospital
CAN	Common Accounting Number
CD	Capital Development
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHC	Community Health Center
CHPFS	Community Health Partners for Sustainability
CIHS	Center for Integrated Health Solutions (SAMHSA/HRSA)
CIO	Chief Information Officer
CIP	Capital Improvement Program awards
CIS	Change in Scope
CMS	Centers for Medicare and Medicaid Services (HHS)
CSD	Central Southeast Division (BPHC)
CY	Calendar Year

D

DFI	Division of Financial Integrity (HRSA)
DGMO	Division of Grants Management Operations (HRSA)

E

EHB	Electronic Handbook
EHR/EMR	Electronic Health Record/Electronic Medical Record
EMC	Expanded Medical Capacity

F

FFR	Federal Financial Report
FIP	Facility Investment Program awards
FJ	Farmworker Justice
FLEX	Medicare Rural Hospital Flexibility Grant Program
FLRP	Faculty Loan Repayment Program

FOA	Funding Opportunity Announcement
Form 5A	UDS Form 5A (Services)
Form 5B	UDS Form 5B (Sites)
Form 5C	UDS Form 5C (Other Activities)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FQHC LA	Federally Qualified Health Center Look-Alike
FRN	Federal Register Notice
FRP	Financial Recovery Plan
FSR	Financial Status Report
FTCA	Federal Tort Claims Act
FTE	Full Time Equivalent
FY	Fiscal Year

G

GMS	Grants Management Specialist
GMO	Grants Management Officer

H

HAB	HIV/AIDS Bureau (HRSA)
HC	Health Center
HCCN	Health Center Controlled Network
HCQR	Health Center Quarterly Report (ARRA)
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HOP	Health Outreach Partners
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSB	Healthcare Systems Bureau (HRSA)

I

IDS	Increased Demand for Services awards
IHS	Indian Health Service (HHS)

L

LGBT	Lesbian Gay Bisexual Transgender
LRP	Loan Repayment Program

M

MCHB	Maternal and Child Health Bureau (HRSA)
MCN	Migrant Clinicians Network
MHC	Migrant Health Center
MHP	Migrant Health Promotion
MIS	Management Information System
MOU/MOA	Memorandum of Understanding/Agreement
MSFW	Migrant and Seasonal Farmworker
MU	Meaningful Use
MUA	Medically Underserved Area

MUP	Medically Underserved Population

N

NACHC	National Association of Community Health Centers
NAM	North American Management
NAP	New Access Point
NASBHC	National Assembly on School-Based Health Care
NCA	National Cooperative Agreement
NCD	North Central Division (BPHC)
NCFH	National Center for Farmworker Health
NCQA	National Committee for Quality Assurance
NDA	Notice of Deeming Action (with FTCA)
NED	Northeast Division (BPHC)
NELRP	Nursing Education Loan Repayment Program
NHAS	National HIV/AIDS Strategy
NHCHC	National Health Care for the Homeless Council
NHDP	National Hansen's Disease Program (BPHC)
NHSC	National Health Service Corps (HRSA)
NHSC LRP	National Health Service Corps Loan Repayment Program
NHSC SP	National Health Service Corps Scholarship Program
NNOHA	National Network for Oral Health Access
NOA	Notice of Award
NOSORH	National Organization of State Offices of Rural Health
NPRM	Notice of Proposed Rulemaking
NPDB	National Practitioner Databank (HRSA)

O

OAA	Office of the Associate Administrator (BPHC)
OAM	Office of Administrative Management (BPHC)
OASH	Office of the Assistant Secretary for Health (HHS)
OC	Office of Communications (HRSA)
OCR	Office for Civil Rights (HHS)
OFAM	Office of Federal Assistance Management (HRSA)
OGC	Office of the General Counsel (HHS)
OHITQ	Office of Health Information Technology and Quality (BPHC)
OIG	Office of the Inspector General (HHS)
OIT	Office of Information Technology (HRSA)
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology (HHS)
ONAP	Office of National AIDS Policy
OO	Office of Operations (HRSA)
OPAE	Office of Planning, Analysis and Evaluation (HRSA)
OPPD	Office of Policy and Program Management (BPHC)
OQD	Office of Quality and Data (BPHC)
ORHP	Office of Rural Health Policy (HRSA)
ORO	Office of Regional Operations (HRSA)
OSD	Office of Shortage Designation (BHPr, HRSA)
OSPH	Office of Special Population Health (BPHC)
OTC	Over the Counter
OTTAC	Office of Training and Technical Assistance Coordination (BPHC)

P

PAC	Progressive Action Condition
PAL	Program Assistance Letter
PAO	Program Approving Official (Division Director or Operations Director – BPHC)
PAR	Program Analysis and Recommendation
PD	Position Description
PCA	Primary Care Association
PCO	State Primary Care Office
PCMH	Patient Centered Medical Home
PCSA	Primary Care Service Area
PHPC	Public Housing Primary Care
PHS	Public Health Service
PIN	Policy Information Notice
PMM	Project Management Module (EHB)
PMS	Payment Management System
PMS	Practice Management System
PO	Project Officer

Q

QA	Quality Assurance
QI	Quality Improvement

R

RAC	Rural Assistance Center
REC	Regional Extension Center
RHC	Rural Health Clinic
RHN	Rural Health Network
3RNet	National Rural Recruitment and Retention Network
R&R	Recruitment and Retention
RRC	Rural Referral Center
RSA	Rational Service Area
RTSC	Recruitment Training and Support Center

S

SAC	Service Area Competition
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SBHC	School-Based Health Center
SCHIP	State Children's Health Insurance Program
SEARCH	Student/Resident Experiences and Rotations in Community Health
Section 330	Section 330 of the Public Health Service Act Statute
SE	Service Expansion
SG	Surgeon General of the United States
SLRP	State Loan Repayment Program
SORH	State Offices of Rural Health
SWD	Southwest Division (BPHC)

T

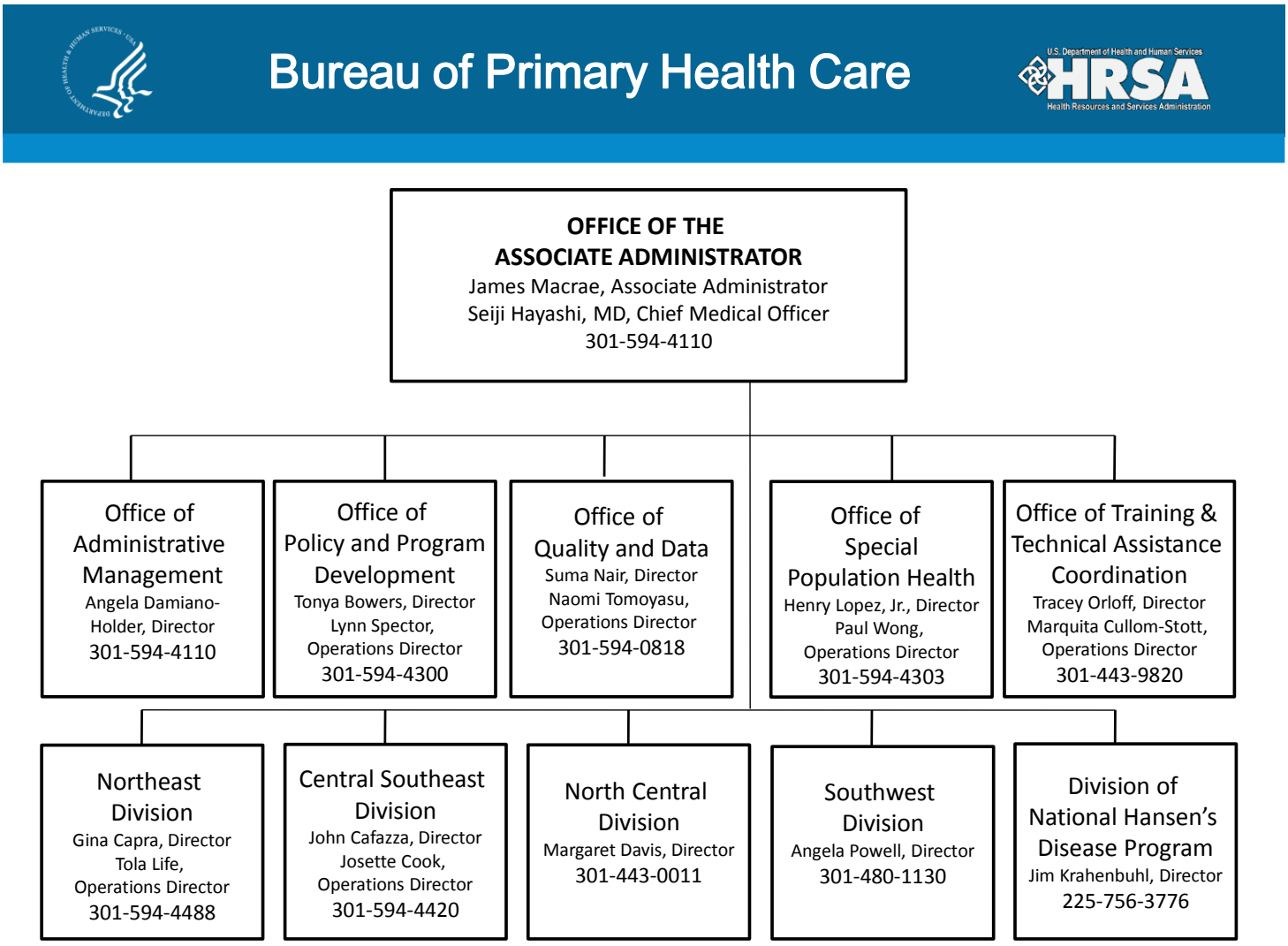
TA	Technical Assistance

TJC	The Joint Commission

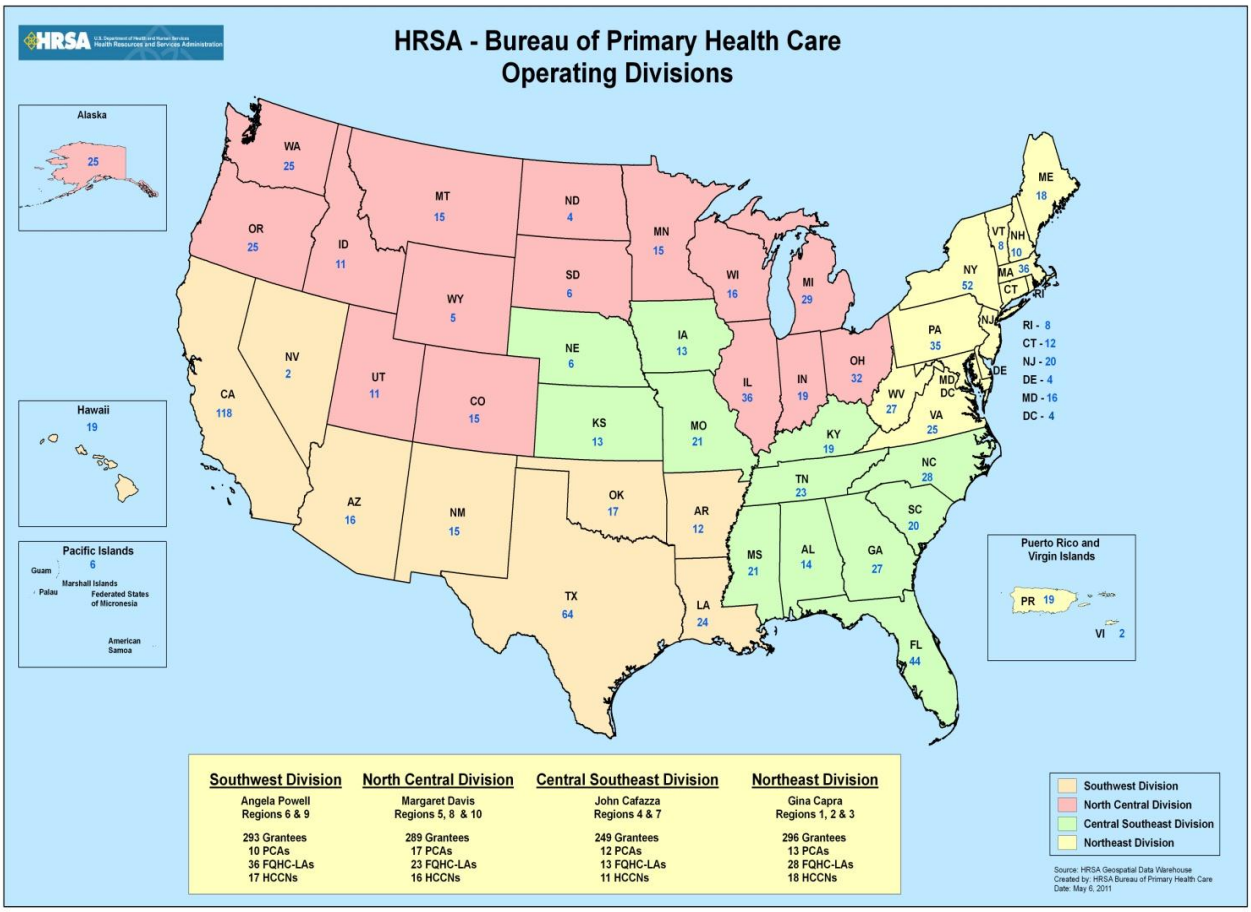
U

UDS	Uniform Data System
UPR	Uniform Progress Report (BHPr)

BPHC Organizational Chart



BPHC Operating Divisions Map



Southwest Division	North Central Division	Central Southeast Division	Northeast Division
•DD: Angela Powell •OD: Vacant •**Northern Pacific Branch** (Northern CA, NV) BC: Yuland Daley •**Central Southwest Branch** (TX) BC: Monica Toomer •**Central Valley Branch** (AZ, Central CA, NM) BC: Vanessa Shaw •**East Southwest Branch** (AR, LA, OK) BC: Kimberly Range •**South Pacific Branch** (Southern CA, HI, Pac Islands) Acting BC: Vacant	•DD: Margaret Davis •OD: Vacant •**Eastern Mid-West Branch** (MI, OH) BC: Kelvin Benford •**Central Mid-West Branch** (IL, IN) BC: Von Bailey •**West Central Branch** (OR, ID, CO, UT) BC: George Brown •**Northern Mid-West Branch** (MT, WY, ND, SD, MN, WI) BC: Mylandar Davis •**Northwest Branch** (AK, WA) BC: Tasha Akitobi	•DD: John Cafazza •OD: Josette Cook •**Midwest Branch** (IA, KS, NE, MO) BC: Angela Galloway •**Gulf Coast Branch** (AL, FL) BC: Carolyn Bull •**Mid-South Branch** (KY, TN) BC: Mayra Nicolas •**East Atlantic Branch** (NC, SC) BC: Sarah Samuels •**Southeast Branch** (GA, MS) BC: Darrin Bowden	•DD: Gina Capra •OD: Tola Life •**Northern Branch** (CT, RI, NH, VT, ME) BC: Kate Guzzone •**Eastern Branch** (MA, NJ, VI) BC: April Stubbs-Smith •**Atlantic Branch** (PR, NY) BC: Lynn Van Pelt •**Mid-Atlantic Branch** (MD, PA, DE) BC: Vacant •**Capital Atlantic Branch** (DC, VA, WV) BC: George Kostyk

Key Health Center Program Requirements

NEED

1. **Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

SERVICES

2. **Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act)

Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

3. **Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. Section 330(a)(1), (b)(1)- (2), (k)(3)(C), and (k)(3)(I) of the PHS Act)

4. **Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

5. **After Hours Coverage:** Health center provides professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)

6. **Hospital Admitting Privileges and Continuum of Care:** Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)

7. **Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.
   - This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
   - No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.*

   (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))

8. **Quality Improvement/Assurance Plan:** Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:
   - a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*

- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: *
    - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
    - be based on the systematic collection and evaluation of patient records;* and
    - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated* (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))

MANAGEMENT AND FINANCE

9. **Key Management Staff:** Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2), (3))

10. **Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2)))

11. **Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act)

12. **Financial Management and Control Policies:** Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

13. **Billing and Collections:** Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)

14. **Budget:** Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25

15. **Program Data Reporting Systems:** Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)

16. **Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

GOVERNANCE

17. **Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including:
    - holding monthly meetings;
    - approval of the health center grant application and budget;
    - selection/dismissal and performance evaluation of the health center CEO;
    - selection of services to be provided and the health center hours of operations;
    - measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
    - establishment of general policies for the health center.

    (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))
Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)

18. **Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:
    - Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*
    - The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.*
    - No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).
(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

19. **Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.
    - No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.*

    (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

Health Center Clinical and Financial Performance Measures

In order to support the provision of high quality patient care, HRSA-funded health centers are expected to have ongoing quality improvement/assessment programs that include clinical services and quality management. To this end, the Health Center Program incorporates systems of quality assessment, quality improvement, and quality management that focus provider responsibilities on improving care processes and outcomes.

In concert with performance improvement initiatives within the broader health care community, the Health Center Program incorporates quality-related performance measures that place emphasis on health outcomes and demonstrate the value of care delivered by health centers. These performance measures are selected to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles. Their use is familiar to the majority of health center grantees that have extensive experience working to improve the quality of perinatal, chronic, and preventative care services. Further, the performance measures are aligned with those of national standard setting organizations, and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations to assess quality performance.

The measures below are to be reported by all grantees in the Uniform Data System (UDS) and are included in the Clinical and Financial Performance Measures for Service Area Competition (SAC) and Budget Period Renewal (BPR) grant opportunities. The UDS Manual is available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html.

The alignment of the performance measures across grant performance reporting (UDS) and the grant application (SAC and BPR) provides grantees with the opportunity to establish quality and performance goals for their organization and patient populations, and assess their progress toward these goals. The alignment furthers HRSA's objective to collect data in a way that minimizes grantee reporting burden, and helps document the value of the Health Center Program.

Below are the clinical performance measures for the 2011 UDS. New or revised measures are identified.

Outreach / Quality of Care

Percentage of pregnant women beginning prenatal care in the first trimester

Numerator: All female patients who received perinatal care during the program year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider

Denominator (Universe): Number of female patients who received prenatal care during the program year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed

Percentage of children with 2nd birthday during the measurement year with appropriate immunizations REVISED

Numerator: Number of children who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2

Hib*, 3 HepB, 1VZV (Varicella), 4 Pneumococcal conjugate, 2 HepA, 2 or 3 RV, and 2 influenza vaccines prior to or on their 2nd birthday whose second birthday occurred during the measurement year, among those children included in the denominator

*Note: While 2 Hib shots are required, HRSA recommends that 3 Hib shots be given per the CDC recommendation.

Denominator: Number of children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine. This includes children who were first seen in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.

Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer

Numerator: Number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator

Denominator (Universe): Number of female patients 24-64 years of age as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday

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 NEW

Numerator: Number of child and adolescent patients age 3 to 17 years who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, among those patients included in the denominator

Denominator: Number of child and adolescent patients age 3 to 17 years as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year

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 NEW

Numerator: Number of adult 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, among those patients included in the denominator

Denominator: Number of adult patients age 18 years or older as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year

Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months NEW

Numerator: Number of patients age 18 years and older who were queried about tobacco use one or more times during their most recent visit or within 24 months of their most recent visit, among those patients included in the denominator

Denominator: Number of patients age 18 years and older who had at least one medical visit during the measurement year and have been seen for at least two office visits ever

Percentage of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use NEW

Numerator: Number of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use during their most recent visit or within 24 months of their most recent visit, among those patients included in the denominator

Denominator: Number of patients age 18 years and older seen identified as users of tobacco during their most recent visit or within 24 months of their most recent visit and who had at least one medical visit during the current year and have been seen for at least two visits ever

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 or an acceptable alternative pharmacological therapy during the current year NEW

Numerator: Number of patients age 5 to 40 years included in the denominator 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 (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained released methylxanthines) during the current year

Denominator: Number of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) and who had at least one medical visit during the current year and have been seen for at least two visits ever

Health Outcomes / Disparities

Percentage diabetic patients whose HbA1c levels are less than 7 percent, less than 8 percent, less than or equal to 9 percent, or greater than 9 percent REVISED

Numerator: Number adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7%, <8%, ≤9%, or >9%, among those patients in the denominator

Denominator: Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had a visit at least twice during the reporting year and do not meet any of the exclusion criteria

Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90

Numerator: Patients 18 to 85 years of age with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg

Denominator (Universe): All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension before June 30 of the measurement year

Percentage of births less than 2,500 grams to health center patients

Numerator: Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery

Denominator (Universe): Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery

Additional Measures

In addition to the above UDS clinical measures, health centers must include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the Health Care Plan.

Financial Viability / Costs

Total cost per patient
Numerator: Total accrued cost before donations and after allocation of overhead
Denominator: Total number of patients
UDS Lines: T8AL17CC/T4L6A for existing grantees

Medical cost per medical visit
Numerator: Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost)
Denominator: Non-nursing medical encounters (excludes nursing (RN) and psychiatrist encounters)
UDS Lines: T8AL1CC + T8AL3CC/T5L15CB – TT5L11CB for existing grantees

Change in net assets to expense ratio
Numerator: Ending Net Assets – Beginning Net Assets
Denominator: Total Expense
Note: Net Assets = Total Assets – Total Liabilities

Working capital to monthly expense ratio
Numerator: Current Assets – Current Liabilities
Denominator: Total Expense / Number of Months in Audit

Long term debt to equity ratio
Numerator: Long Term Liabilities
Denominator: Net Assets