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INTRODUCTION

This manual presents a new, integrated reporting system, the Uniform Data System (UDS), that will be used by all grantees of the following primary care system development programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration:

- **Community Health Center Program**, Section 330 of the Public Health Service Act
- **Migrant Health Center Program**, Section 329 of the Public Health Service Act
- **Health Care for the Homeless Program**, Section 340 of the Public Health Service Act
- **Outreach and Primary Health Services for Homeless Children Program**, Section 340(s) of the Public Health Service Act
- **Public Housing Primary Care Program**, Section 340A of the Public Health Service Act

Reporting systems for these programs evolved over time, as new legislation was enacted and new information requirements identified. A comprehensive review of these different reporting requirements, conducted during 1993-1994, found at least five different reporting systems with a total of 29 tables or exhibits. Some reports included more detail than others and definitions for basic data elements were inconsistent.

These different reporting requirements impose burdens on grantees while failing to meet the information needs of BPHC or the organizations it supports. Grantees have been expected to complete separate reports for each Bureau grant they received, resulting in duplicative efforts. Current reports are also not consistent with those required by major payors. From the Bureau's perspective, the separate systems make it difficult to report on the overall characteristics of its populations, or improvements in access and clinical outcomes achieved through its multiple programs.

RATIONALE FOR DEVELOPING A NEW SYSTEM

BPHC collects data on its programs to ensure compliance with legislative mandates and to report to Congress and policy makers on program accomplishments. To meet these objectives, BPHC requires a core set of information collected annually that is appropriate for monitoring and evaluating performance and reporting on annual trends. At present, these data are collected from grant applications, an automated data system--the Bureau Common Reporting Requirements (BCRR) applicable to some but not all programs--and various other systems and profiles developed for specific programs. This method of reporting creates duplication for grantees, particularly those with multiple BPHC grants. It also limits the Bureau's ability to compile information and report on accomplishments across all BPHC programs.

There are several issues that the new UDS attempts to address. First, there is difficulty reporting on overall characteristics of the population served. It is possible, for example, to report on the total number of homeless persons served with grants under the Health Care for the Homeless program, but consistent data have not been available on the total number of homeless served through all BPHC programs. Second, there has been difficulty unduplicating users across all programs, in part because the programs have used different definitions of key data elements, such as users and age categories. Third, while the majority of persons served receive services supported by Community Health Center (Section 330) funding, this program's reporting systems provide the least amount of clinical information. Fourth, the financial reporting forms are inconsistent with definitions and categories used by Medicare and Medicaid, and do not reflect recent trends in reimbursement or the growth of managed care. Alternatively, reporting systems in use for other programs provide little financial information.

Limitations of current systems make it difficult to respond to a number of emerging and critical policy and management questions, such as:

- What is the total number of low income and/or uninsured people served by BPHC programs?
- Who are the users of BPHC programs; what services do they use and what are their diagnoses?
- What specific services offered by BPHC programs distinguish them from other providers of primary care?
- Are BPHC programs cost effective compared with other providers?
- What is the impact of managed care on BPHC programs?

THE UNIFORM DATA SYSTEM

In response to the limitations of current data systems, and with input from the organizations included, BPHC has developed a new reporting system, the UDS, that will be used by its five primary care system development programs. The UDS is capable of responding to emerging information needs of the health care marketplace and changes the information paradigm from “grant-driven” to “market-driven”.

The UDS:

- Provides uniformly-defined data for major BPHC grant programs.
- Yields consistent information on patient characteristics and clinical conditions that can be compared with other national and state data.
- Eliminates duplication and inconsistency in reporting, reducing the burden on grantees.
- Builds on data requirements of major payors, promoting and expanding the use of market-driven rather than grant driven data.
- Will allow electronic submission of a single set of consistent data on a standardized schedule.

The UDS includes two components:

- The **Universal Report** consists of nine tables and it is completed by all grantees. This report provides data on services, staffing, and financing **across all five primary care system development programs**. The Universal Report is the source of unduplicated data on BPHC programs.
- The **Grant Reports** repeat three of the Universal Report tables to provide comparable data on characteristics of users whose services fall within the scope of a **project funded under a particular grant**.

Exhibit A outlines the contents of UDS reports, identifying tables included in the Universal Report and those included in Grant Reports.

The UDS is structured to balance the need for historical continuity that enables continued trend analyses with the need for consistent information across all programs. Because Grant Reports consist of a subset of the tables from the Universal Report, consistent data will be obtained across all major programs. The UDS replaces existing reporting requirements for Community and Migrant Health Centers, the Comprehensive Perinatal Care Program, the Special Infant Mortality Reduction Initiative, the Health Care for the Homeless Program, Outreach and Primary Health Services for Homeless Children Program, and the Public Housing Primary Care Program.

Implementation of the UDS is planned to facilitate an easy transition. The reports add few new data elements to those already collected through the Bureau's current multiple systems. Duplicative data exhibits currently in the grant application will be removed and grant applications will refer to information reported through the UDS.

Subsequent sections of this manual provide general instructions and more detailed instructions along with each table. This manual also includes Appendices dealing with personnel and service definitions.

EXHIBIT A: UDS
OVERVIEW OF UNIVERSAL AND GRANT REPORTS

TABLE	UNIVERSAL REPORTS	GRANT REPORTS
Center/Grantee Profile		
Cover Sheet	X	
Table 1: BPHC Resources	X	
Table 2: Services Offered	X	
User Profile		
Table 3 (A-B): User Demographics	X	X
Table 4: Socioeconomic Characteristics	X	X
Staffing and Utilization		
Table 5: Staffing and Utilization	X	
Table 6: Selected Diagnoses and Services	X	X
Table 7: Perinatal Profile	X	
Financial		
Table 8(A-B): costs	X	
Table 9(A-C): Revenues and Reimbursement	X	

SECTION A. GENERAL INSTRUCTIONS

This section provides instructions applicable to all reports. Grantees should follow the instructions for specific tables to determine applicable users and activities covered by the report.

SCOPE OF **ACTIVITIES** INCLUDED IN **REPORTS**

The **Universal Report** is intended to provide a comprehensive picture of all activities within the scope of BPHC-supported projects. In this report grantees should report on the total unduplicated number of users and activities **within the scope of projects supported by any of the five BPHC primary care system development programs covered by the UDS.**

For individual **Grant Reports**, grantees should report on the total unduplicated number of users and activities within the scope of the project **funded under the particular grant.** Because a user can be served by more than one type of BPHC grant, user totals from the Grant Reports cannot be summed to generate totals in the Universal Report. The specific content of each Grant Report is explained further below.

Grantees that receive only one BPHC grant or that receive only 329 and 330 grants are required to complete only the Universal Report. Multiple-grant grantees other than **329/330** grantees complete a Universal Report for the combined projects and a separate grant report for each Homeless, Homeless Children or Public Housing program grant.

Examples

- **A Section 330 grantee that has a Section 329 grant and no other applicable BPHC grant completes only a Universal Report.**
- **A Section 330 grantee that has a Section 340 grant completes a Universal Report and a Section 340 Grant Report--but does not complete a Grant Report for the Section 330 grant.**
- **A Section 330 grantee that also has Section 329 and Section 340 grants, completes a Universal Report and a Grant Report for the Section 340 grant.**
- **A Section 340 grantee that also has a Section 340(A) grant completes a Universal Report and Grant Reports for the Section 340 grant and for the Section 340(A) grant.**

DEFINITION OF ENCOUNTERS

Encounter definitions are needed both to determine who is counted as a user and to report total encounters by type of staff (Table 5). In general, encounters are defined to include a documented, face-to-face contact between a user and a provider who exercises independent judgement in the

provision of services to the individual. Appendix A provides a list of health center personnel and the status of each as a provider for purposes of UDS reporting.

The criteria for encounters are given below.

1. To meet the encounter criterion for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample **is not** credited with a separate encounter. A nurse utilizing standing orders or protocols, who sees a patient to monitor physiological signs, provide medication renewal, etc., without the patient also seeing the physician during the same visit, **is** credited with a medical encounter.

Encounters also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay, as physician of record or consult. A provider may not generate more than one inpatient encounter per patient per day.

2. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may be accompanied by services performed by medical, dental, or other health providers that do constitute encounters.
3. The patient record does not have to be a full and complete health record in order to meet the encounter criteria, if a patient receives only one, or minimal, services and is not likely to return to the health center. For example, if a patient not normally eligible for services receives services on an emergency basis and these services are documented, the encounter criteria are met even though a complete health record is not created. Provision of HIV counseling and testing meets the encounter criteria so long as services are documented. The same is true for services, such as employment physicals, sports physicals, etc., which are rendered to persons who do not regularly use the center. However, **the services rendered must be documented.**
4. A patient may have more than one encounter with the health center per day. The number of encounters per site per day is limited as follows:
 - One medical encounter (physician, nurse practitioner, physicians assistant, certified nurse midwife, or nurse);
 - One dental encounter (dentist or hygienist); and
 - One other health encounter for each type of other health provider (family planning or HIV counselor, nutritionist, psychologist, podiatrist, speech therapist, etc.)

5. A provider may be credited with no more than one encounter with a given patient during that patient's visit to the center in a single day, regardless of the type or number of services provided. If a student provider sees patients in conjunction with a non-student provider, only one encounter, credited to the non-student provider, is counted.
6. An encounter may take place in the health center or at any other location in which project-supported activities are carried out. Examples of other locations include mobile vans, hospitals, patients' homes, schools, homeless shelters, and extended care facilities.
7. When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person if the provision of services is noted in *each* person's health record. Examples of "group encounters" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. Patient education or health education classes (e.g., smoking cessation) are not credited as encounters.
8. The encounter criteria are not met in the following circumstances.
 - When a provider participates in a community meeting or group session that is not designed to provide health services. Examples of such activities include information sessions for prospective users, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
 - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
 - When a provider is primarily conducting outreach and/or public education sessions, not providing direct services.

Further definitions of encounters for different provider types follow:

Physician Encounter. An encounter between a physician and a user.

Nurse Practitioner/Physicians Assistant Encounter. An encounter between a Nurse Practitioner or Physicians Assistant and a user in which the practitioner acts as an independent provider.

Certified Nurse Midwife Encounter. An encounter between a Certified Nurse Midwife and a user in which the practitioner acts as an independent provider.

Nurse Encounter (Medical). An encounter between an R.N., or L.P.N., and a user in which the nurse acts as an independent provider of medical services. The service may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician or mid-level practitioner who has no direct contact with the patient during the visit.

Dental Services Encounter. An encounter between a dentist or dental hygienist and a user for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

NOTE: A dental hygienist is credited with an encounter only when (s)he provides a service independently, not jointly with a dentist. However, two encounters may **not** be generated during a patient's visit to the dental clinic in one day.

Mental Health Encounter. An encounter between a mental health provider (e.g., psychologist) and a user during which mental health services (i.e., services of a psychological, sociopsychological, or crisis intervention nature) are provided.

Substance Abuse Encounter. An encounter between a substance abuse provider (e.g., rehabilitation therapist, psychologist) and a user during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

Other Professional Encounter. An encounter between a provider, other than a physician, a mid-level practitioner, dental provider, or other professional listed in Appendix A and a user during which health services, other than medical or dental, are provided.

Case Management Encounter. An encounter between a case management provider and a user during which services are provided that assist patients in the management of their health and social needs, including patient assessments, home visits, the establishment of treatment plans, and the maintenance of referral, tracking, and follow-up systems.

Education Encounter. An encounter between an education provider and a user in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, and specific diseases). Classes are not counted as encounters.

DEFINITION OF A PROVIDER

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during an encounter. The provider who exercises independent judgment is credited with the encounter, even when two or more providers are present and participate. Where health center staff are following a patient in the hospital, the primary responsible center staff person is the provider (and is credited with an encounter), even if other staff from the hospital are present. (Appendix A provides a listing of personnel, indicating whether or not they are considered a provider that can generate encounters for purposes of UDS reporting.)

DEFINITION OF A USER

Users are individuals who have at least one encounter during the year, as defined above. As described under "Scope of Activities Included in Reports, " tables in the Universal **Report** include as users all individuals who receive at least one encounter during the year within the scope of activities supported by any BPHC grant covered by the UDS (i.e., unduplicated users). For each **Grant Report**, users include individuals who receive at least one encounter during the year within the scope of project activities supported by the specific BPHC grant. For either type of report, users do not include individuals who only have encounters such as outreach, community education services, and other types of community-based services not documented on an individual basis. See "Definition of Encounters" for further discussion of contacts included as encounters.

WHO SUBMITS REPORTS

Reports should be submitted by the BPHC grantee. The **grantee** is the direct recipient of one or more BPHC grants.

REPORTING PERIOD AND REPORT DUE DATE

All reports cover a calendar year. Reports should be forwarded to the Regional Office within three months following the end of the calendar year (by March 31 of the subsequent year). Organizations whose first year grant awards start during the calendar year will be informed as to which portion of the year, if any, should be included in UDS reports.

WHERE TO SUBMIT REPORTS

BPHC is planning to make provisions for electronic submission of UDS reports with input from grantees. When plans for electronic submission are completed, grantees will be informed in an addendum to this Manual. Until they are so informed, grantees should submit three copies of each applicable report to the Data Manager in the appropriate Regional Office.

Data Manager
PHS/DHHS Region I
John F. Kennedy Federal Building, Room 1826
Boston, MA 02203

Data Manager
PHS/DHHS Region II, Room 3377
26 Federal Plaza
New York, NY 10278

Data Manager
PHS/DHHS Region III
Rm. 10140, Mail Stop 14
P.O. Box 13716
Philadelphia, PA 19104

Data Manager
PHS/DHHS Region IV
101 Marietta Tower, Suite 1206
Atlanta, GA 30323

Data Manager
PHS/DHHS Region V
105 W. Adam Street, 17th Floor
Chicago, IL 60603

Data Manager
PHS/DHHS Region VI
1200 Main Tower Building, Room 1860
Dallas, TX 75202

Data Manager
PHS/DHHS Region VII
Federal Building
601 East 12th Street, Room 501
Kansas City, MO 64106-2802

Data Manager
PHS/DHHS Region VIII
Federal Building
1961 Stout Street, Room 498
Denver, CO 80294-3203

Data Manager
PHS/DHHS Region IX
Federal Office Building
50 United Nations Plaza
San Francisco, CA 94102

Data Manager
PHS/DHHS Region X
Blanchard Plaza
2201 Sixth Avenue, Mail Stop RX-23
Seattle, WA 98121

SUBMITTING REVISED REPORTS

Submit three copies of only those report tables that have been revised, together with a completed Grantee Profile Cover Sheet. Indicate that the table is a revised submission by checking the appropriate box at the top of the relevant table. Also indicate whether or not the revised table is part of the Universal Report or a Grant Report, when appropriate, and indicate the grant type for all revisions to Grant Reports.

SECTION B. CENTER/GRANTEE PROFILE

This section provides a description of the grantee agency, and includes:

Cover Sheet, with identifying information on the reporting grantee

Table 1. BPHC Resources Received

Table 2. Services Offered and Delivery Method

Most of the information in this section is currently available only in grant applications and is not reported in a uniform format. These data permit BPHC to document the scope and location of services without resort to special surveys or lengthy review of individual grant applications. Questions that may be addressed with information in Section B include the following:

- ***What are the characteristics of the areas served by BPHC programs and the sites at which services are delivered?*** This section provides consistent information on the variety of traditional and nontraditional service delivery sites within which BPHC programs provide services. The site-specific information permits cross-referencing data on service locations with available geographic databases on primary care resources and health care needs. As a result, the data enhance **BPHC's** ability to identify characteristics of areas served by their programs and the extent to which these programs improve access for underserved and vulnerable populations residing in those areas.
- ***What are the range of services offered by BPHC programs?*** Table 2 documents the unique type and breadth of BPHC services, permitting description of the full range of enabling and support services as well as preventive and primary care services rendered by the programs. The list of services is a comprehensive compilation reflecting the wide variety of special services provided by all programs. Completing the table only requires a simple check off by the grantee and it is not expected that a single grantee would offer all of the listed services.

INSTRUCTIONS FOR COMPLETING CENTER/GRANTEE PROFILE COVER SHEET

This form provides identifying information for each grantee and grantee sites. It must be completed and attached to the Universal Report. It must also be submitted with each set of revised tables; indicate whether the submission is the initial report or a revision.

Date of Submission: the date the report is submitted.

Initial Submission or Revision: an initial report is the first report for the reporting period; revisions are subsequent, corrected, submissions.

Reporting Period: the time period covered by the report. All reports cover an entire calendar year. Agencies receiving grants mid-year should file first-year reports covering all activities from the grant start date through December 31 of the applicable calendar year.

BCRR Number: the number assigned to the grantee by the Regional Office.

Grantee Legal Name and Address of Grantee Administrative Offices: name of the legal recipient of the BPHC grant, and address of associated administrative offices, with nine digit zip code.

CEO/Executive Director or Project Director: name of the CEO, Executive Director, or Project Director of the grantee organization.

Clinical Director: name of the Clinical Director for the grantee organization.

Chairperson, Governing Board or Health Officer: name of the Chairman of the grantee organization's Governing Board (e.g. Board of Directors or other governing board meeting BPHC grant requirements). State and local health departments receiving grants that do not include requirements for a Governing Board (e.g., Health Care for the Homeless grantees) should provide the name of the State Health Officer or Local Health Officer, as appropriate.

Name of Grantee Contact Person: name of the grantee staff person with primary responsibility for preparing the report (do not include contractors or contracted employees).

Address and Phone and Fax Numbers of Contact Person: business address with nine digit zip code, and business phone and fax numbers, including area code, for the person listed as the Grantee Contact Person.

Medicaid Provider Number: the number(s) used to identify the grantee when submitting claims or other data to Medicaid. (If you have multiple numbers, provide all of them.)

Medicaid Pharmacy Number: the number(s) used to identify the grantee when submitting claims for pharmacy services to Medicaid. Grantees who do not have a separate identifier for pharmacy services should enter their general Medicaid provider number.

Number of Delivery Sites: report the total number of delivery sites supported by BPHC grant(s)

Delivery Sites: report the name and address of each site, including the g-digit zip code. For each delivery site, also indicate

- whether the site operates year-round or on a seasonal basis;
- the location or type(s) of facility, using codes listed at the bottom of the third page of the Cover Sheet. These codes provide information on the type of facility in which the site is located, not the specific services offered at the site. Examples of coding are shown below.
 - A community-based primary care site not located in a health department or substance abuse treatment clinic/facility should be coded as "1".
 - A primary care site located in a health department should be coded "5"-- Health Department clinic".
 - A primary care site located in a substance abuse clinic would be coded "6".
 - A community-based homeless grantee site located in a mental health clinic operated by a local health department would be coded "5" and "8".
- service area: the census tracts, whole or partial counties, or Minor Civil Divisions included in the site's service area.

**CENTER/GRANTEE PROFILE
COVER SHEET**

Date of Submission: _____ Check One: Initial Submission
Reporting Period: _____ 199_ through _____ 199_ Revision

UDS (Old BCRR #): _____

Grantee Legal Name: _____

Address of Grantee
Administrative Offices: _____

CEO/Executive Director
or Project Director: _____

Clinical Director: _____

Chairperson, Governing Board;
or Health Officer: _____

Name of Grantee Contact Person
(Person Completing Report): _____

Address, Phone and Fax
Numbers of Contact Person: _____

Medicaid Provider Billing Number(s): _____

Medicaid Pharmacy Number: _____

Number of delivery sites supported by BPHC Grant(s): _____

NOTE: Use Location Codes listed below to describe the location of the facility in which the site is located. More than one location code may apply for a given site. Please attach additional page(s) as needed to include all sites supported by BPHC grants. Include g-digit zip code for each site.

SITE #1: MAIN OR CENTRAL SITE	SITE #2
<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____	<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____
Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____	Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____
SITE #3	SITE #4
<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____	<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____
Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____	Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____

SITE #5	SITE #6
<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____	<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____
Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____	Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____
SITE #7	SITE #8
<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____	<input type="checkbox"/> Year-round <input type="checkbox"/> Seasonal Name: _____ Address: _____
Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____	Location Code(s): <input type="checkbox"/> <input type="checkbox"/> Service Areas _____

Location Codes for Site Locations:

- | | | |
|--|--|------------------------------|
| 1. Community-based primary care clinic | 5. Health Department clinic | 9. Public housing |
| 2. Hospital | 6. Substance abuse treatment clinic/facility | 10. Migrant camp or worksite |
| 3. Fully equipped mobile health van | 7. HIV/AIDS medical care clinic/facility | 11. School |
| 4. Community-based social service center | 8. Mental health clinic | 12. Homeless shelter |
| | | 13. Other-identify |

INSTRUCTIONS FOR CENTER/GRANTEE PROFILE TABLE 1: BPHC RESOURCES RECEIVED

This table shows the types of grants/funding and other resources received directly by grantees from BPHC. It is included only in the Universal Report.

Funding or Resources Received During the Current Reporting Year: Place a check in boxes associated with all *direct* grants/funding/resources received by the grantee during the applicable reporting year. Leave blank those boxes associated with sources not received or received through a subcontract. Do **not** include dollars received on this table.

Grants from the five primary care system development programs covered by the UDS are included, as well as grants from the Ryan White Title III(b) program and the Healthy Schools, Healthy Communities demonstration which are not part of the UDS at this time; and providers placed under the National Health Service Corps.

UDS (Old BCRR Reporting No.) _____

Date Submitted: _____

Reporting Period: _____ 199__ through December 31, 199__

c I Initial Submission Revision

TABLE 1
BPHC RESOURCES RECEIVED

FUNDING OR RESOURCES RECEIVED DURING THE CURRENT REPORTING YEAR	BPHC SUPPORT RECEIVED DURING THE CURRENT REPORTING YEAR [Check (✓) the appropriate box]	
	Yes	No
I Section 329 Migrant Health Center		
Section 330 Community Health Center		
Comprehensive Perinatal Care Program		
Health Care for the Homeless (Section 340)		
Homeless Children (Section 340(s))		
Public Housing Primary Care (Section 340A)		
Special Infant Mortality Reduction Initiative		
Healthy Schools, Healthy Communities		
Ryan White Title IIIB HIV Early Intervention		
National Health Service Corps Placements (all types)		
Other BPHC Resources		

INSTRUCTIONS FOR CENTER/GRANTEE PROFILE TABLE 2: SERVICES OFFERED AND DELIVERY METHOD

This table shows the types of services provided by the grantee, and whether these services are provided directly or through formal referral arrangements. It is included only in the Universal Report.

Table 2 serves two purposes. First, it provides information on the range and scope of services provided or arranged for by grantees. Second, it describes the extent to which grantees are financially responsible for services rendered through referral. Only services included within the scope of the project(s) should be reported. This table is a compilation of the wide array of services provided through different BPHC grants. Individual grantees will rarely provide or refer for all of the services listed in this table.

1. **Service Type:** this table lists services that may be provided by BPHC grantees. Service definitions appear in Appendix B.
2. **Delivery Method:** check the delivery method(s) applicable to the particular service type. More than one method may apply for a given service. If the service is not offered, leave the row blank.
 - **Provided by grantee** includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as outstationed workers who render services in the grantee's name.
 - **By referral-grantee pays** includes services provided by another organization under a written formal arrangement, only when the grantee pays or bills third party reimbursement sources for provision of the service. The arrangement may involve discounted payment (Le., payment less than cost). These services are generally provided off site. Agreements must be formal and in writing and include provisions whereby the grantee receives written information regarding follow up of the referred patient that allows the grantee to track the patient and assures continuity of care.
 - **By referral--grantee does not pay** includes services that are provided by another organization or individual under a written formal referral arrangement (as defined above) but where the grantee DOES NOT pay or bill for the service.

UDS (Old BCRR Reporting No.) _____

Date Submitted: _____

Reporting Period: _____ 199__ through December 31, 199__

Initial Submission Revision

**TABLE 2
SERVICES OFFERED AND DELIVERY METHOD**

SERVICE TYPE (See Appendix B for definitions)	DELIVERY METHOD Check (✓) if Applicable <i>[More than one method may apply for a given service]</i>		
	PROVIDED BY GRANTEE	BY REFERRAL/ GRANTEE PAYS	BY REFERRAL/ GRANTEE DOESN'T PAY
PRIMARY MEDICAL CARE SERVICES			
General Primary Medical Care (other than listed below)			
Diagnostic Laboratory (technical component)			
Diagnostic X-Ray Procedures (technical component)			
Diagnostic Tests/Screenings (professional component)			
Urgent medical care			
24-hour coverage			
Family Planning			
HIV testing			
Immunizations			
Following hospitalized patients			

TABLE 2 (continued)

SERVICE TYPE (See Appendix B for definitions)	DELIVERY METHOD Check (✓) if Applicable <i>[More than one method may apply for a given service]</i>		
	PROVIDED BY GRANTEE	BY REFERRAL/ GRANTEE PAYS	BY REFERRAL/ GRANTEE DOESN'T PAY
OBSTETRICAL AND GYNECOLOGICAL CARE			
Gynecological Care			
Obstetrical care (other than listed below)			
Prenatal care			
Antepartum fetal assessment			
Ultrasound			
Genetic counseling and testing			
Amniocentesis			
Labor and delivery professional care			
Postpartum care			
SPECIALTY MEDICAL CARE			
Directly observed TB therapy			
Other Specialty Care			
DENTAL CARE SERVICES			
Dental Care - Preventive			
Dental Care - Restorative			
Dental Care - Emergency			

TABLE 2 (continued)

SERVICE TYPE (See Appendix B for definitions)	DELIVERY METHOD Check (✓) if Applicable <i>[More than one method may apply for a given service]</i>		
	PROVIDED BY GRANTEE	BY REFERRAL/ GRANTEE PAYS	BY REFERRAL/ GRANTEE DOESN'T PAY
MENTAL HEALTH/SUBSTANCE SERVICES			
Mental Health Treatment/Counseling			
Developmental Screening			
24-hour Crisis Intervention/Counseling			
Other Mental Health Services			
Substance Abuse Treatment/Counseling			
Other Substance Abuse Services			
OTHER PROFESSIONAL SERVICES			
Environmental Health Risk Reduction (via detection and/or alleviation)			
Hearing Screening			
Nutrition Services Other Than WIC			
Occupational or Vocational Therapy			
Physical Therapy			
Pharmacy			
Vision Screening			
WIC Services			

TABLE 2 (continued)

SERVICE TYPE (See Appendix B for definitions)	DELIVERY METHOD Check (✓) if Applicable <i>More than one method may apply for a given service]</i>		
	PROVIDED BY GRANTEE	BY REFERRAL/ GRANTEE PAYS	BY REFERRAL/ GRANTEE DOESN'T PAY
ENABLING SERVICES			
Case management			
Child Care (during visit to center)			
Discharge planning			
Eligibility Assistance			
Employment/educational counseling			
Food bank/delivered meals			
Health Education			
Homemaker/aide assistance			
Housing Assistance			
Interpretation/Translation services			
Nursing home and assisted-living placement			
Outreach			
Transportation			
Other (specify)			
Other (specify)			
Other (specify)			

SECTION C. USER PROFILE

This section provides information on the demographic and socioeconomic characteristics of users of BPHC programs. The section includes:

Table 3: Part A: Users by Age and Gender
Part B: Users by Race/Ethnicity

Table 4: Socioeconomic Characteristics

At present, data on program users are collected in the BCRR and in various user profiles. Information on socioeconomic characteristics, demographics, and race/ethnicity is primarily obtained from grant applications. Tables in this section have been designed to assure consistency across BPHC programs and to facilitate comparison of BPHC data with state and national data sources.

- The definition of a user has been expanded, to provide a uniform definition appropriate for programs (e.g. Health Care for the Homeless) that provide substantial non-medical services. This change should not result in a measurable increase in the number of users reported, because the preponderance of BPHC program users also receive medical or dental services. Since data on medical and dental users are also included in the UDS, historical trend analyses are maintained.
- Because BPHC grant programs serve different target populations, age categories have been developed that can meet the information requirements of all. For example, the Comprehensive Perinatal Care Program requires data on 15-19 year olds in order to compare with national data on pregnancy and prenatal care. The age categories included in Table 3 can be aggregated to conform with those used in the census and with National Center for Health Statistics data.
- Consistent definitions of race/ethnicity provide an ability to compare BPHC populations with national databases. The terminology used in the UDS is based on OMB guidelines for collecting these data.

The data collected in this section permits BPHC to answer such questions as:

- ***How many users are there? What are their characteristics compared with national or state data?*** Unduplicated data on user characteristics can be compared with census information for each service area.

- ***To what degree are BPHC programs providing services to special populations?*** The UDS provides data on all users, not just those served with special grants (e.g., migrant and seasonal agricultural workers, the homeless, persons speaking languages other than English). This information may be cross-referenced with service area data to determine how well the center is reaching these special populations, and used to determine need for special population support.
- ***To what extent do BPHC programs serve the uninsured?*** Data on users by major payor substantially improve available information on service to the uninsured.
- ***What is the organization's market share for various third party payors?*** These data also facilitate analysis of the role of various private payors (e.g. Medicare, Medicaid, private insurance) in financing care for populations served by BPHC programs.

INSTRUCTIONS FOR TABLE 3

Tables 3 Parts A and B provide demographic data on users of the program and are included in *both* the Universal and the Grants Reports.

For the Universal Report, include as users all individuals receiving at least one face-to-face encounter (as defined on page 7 of the General Instructions) for services within the scope of any of the five programs covered by UDS. The Grant Reports include only individuals who received at least one face-to-face encounter that was within the scope of that project. Users are to be reported only once in each report filed.

PART A: USERS BY AGE AND GENDER

Report the number of total users by appropriate categories for age and gender. *r p o s e s*, use the individual's age on June 30 of the reporting period.

PART B: USERS BY **RACE/ETHNICITY**

This table requests the proportion of users in each racial/ethnic category. The categories are those historically used by BPHC.

The table also requests an estimate of the proportion of users speaking a language other than English at home. This information is intended to provide BPHC with an estimate of the extent to which programs serve clients with limited ability to speak English who may require translation services. The wording of this data element conforms to that used in the census. Estimate the percent of users during the reporting period who do not speak English at home.

Data reported in Table 3 Part B may be estimated or actual. The estimate may be based on a sample.

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TABLE 3 PART A
USERS BY AGE AND GENDER

AGE GROUPS	MALE USERS	FEMALE USERS	TOTAL USERS
Under age 1			
Ages 1-4			
Ages 5-12			
Ages 13-14			
Ages 15-19			
Ages 20-24			
Ages 25-44			
Ages 45-64			
Age 65-74			
Ages 75-84			
Age 85 and over			
Total Users			

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TABLE 3 PART B
USERS BY RACE/ETHNICITY

PROPORTION OF USERS	
RACE/ETHNICITY	PERCENT
Asian/Pacific Islander	
Black (not Hispanic)	
American Indian/Alaska Native	
White (not Hispanic)	
Hispanic (all races)	
Unreported/Unknown	
Total	100%
Proportion of Users Speaking a Language Other Than English at Home _____	

INSTRUCTIONS FOR TABLE 4: SOCIOECONOMIC CHARACTERISTICS

Table 4 provides descriptive data on socioeconomic status of users. This table is included in **both** the Universal Report and the Grant Reports.

For the Universal Report, include as users all individuals receiving at least one face-to-face encounter (as defined on page 7 of the General Instructions) for services within the scope of any of the five programs covered by UDS. The Grant Reports include only individuals who received at least one face-to-face encounter that was within the scope of that project. Users are to be reported only once in each report filed.

INCOME AS PERCENT OF POVERTY LEVEL

This portion of the table provides total users by income ranges relative to the federal poverty guidelines. Grantees are not required to collect a user's income information more frequently than once during the year. However, many grantees update income information throughout the year. In those instances, report the most current information available. In determining a user's income relative to the poverty level, grantees should use official poverty line guidelines defined and revised annually by the federal Office of Management and Budget.

PRINCIPAL **THIRD** PARTY PAYMENT SOURCE

This portion of the table provides total users by principal third party payment sources for **primary care services** provided by the grantee. It is designed to provide data on the types of primary health insurance coverage available to BPHC-supported users, and the number of users without any source of third party health insurance.

A user may have coverage under more than one plan, and this coverage may change over the course of a year. Therefore, the data will provide a snapshot of insurance sources available to BPHC-supported users. Grantees should report the user's **principal health insurance** covering primary care, if any, as of the last visit during the reporting period. **Principal insurance** is defined as the insurance plan/program that the grantee would **bill first** for services rendered. For example, if the user has both Medicare and Medicaid, they would be reported as a Medicare user because Medicare is billed before Medicaid. Grantees should include the user's principal health insurance source even if it was not used to cover services rendered during the user's last visit.

SELECTED USER CHARACTERISTICS

Migrant or Seasonal Agricultural Workers: As defined by Section 329 of the Public Health Service Act, a **migrant** agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establish a temporary home for the purposes of such employment. Migrant agricultural workers are usually hired laborers who are

paid piecework, hourly or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary place of abode.

Seasonal Agriculture Workers are individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary place of abode for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members who have also used the center.

For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, **tillage**, growing, harvesting, preparation, and on-site processing for market or storage.

All grantees are required to report the combined total number of migrant and seasonal agricultural workers. Section 329 grantees are the **only** grantees who are also required to provide separate totals for migrant and for seasonal workers.

Homeless: All grantees are required to report the total number of users served at least once and known to be homeless at some time during the reporting period. Homeless Program (340 and 340(s)) grantees should include here the total number of users considered homeless during the year for purposes of receiving services under the homeless program grant(s).

Homeless individuals are defined as individuals who lack 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.

Section 340 and Section 340(s) Homeless Program grantees are the **only** grantees who are required to provide separate totals for homeless program users by type of shelter arrangement applicable as of the last visit during the reporting period. Street includes living outdoors, in a car, or in a make-shift housing/shelter.

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TABLE 4
SOCIOECONOMIC CHARACTERISTICS

CHARACTERISTIC	NUMBER OF USERS
INCOME AS PERCENT OF POVERTY LEVEL	
100% and below	
101 - 150%	
151 - 200%	
Over 200%	
Unknown	
TOTAL	
PRINCIPAL THIRD PARTY PAYMENT SOURCE	
Medicaid	
Medicare	
Other Public Insurance	
Private Insurance	
None/Uninsured	
TOTAL	
SELECTED USER CHARACTERISTICS	
Migrant or Seasonal Agricultural Worker or Dependent	
Migrant (329 grantees only)	
Seasonal (329 grantees only)	

TABLE 4 (*continued*)

CHARACTERISTIC	NUMBER OF USERS
Homeless	
Homeless Shelter (340 and 340(s) grantees only)	
Transitional (340 and 340(s) grantees only)	
Doubling Up (340 and 340(s) grantees only)	
Street (340 and 340(s) grantees only)	
Other (340 and 340(s) grantees only)	
Unknown (340 and 340(s) grantees only)	

SECTION D. STAFFING AND UTILIZATION

This section includes three tables providing data on staff and utilization of services.

Table 5:	Staffing and Utilization
Table 6:	Selected Diagnoses and Services Rendered
Table 7:	Perinatal Profile

These three tables consolidate information currently obtained from a variety of data sources, including BCRR Table 1 (number of medical and dental users) and Table 3 (staff and encounters); the perinatal profile filed by all C/MHCs as part of the grant application; and grant application information on health problems.

The tables in this section have been designed to enhance the ability of BPHC and the organizations it supports to report on clinical conditions among the user populations and the types of services rendered to users while, simultaneously, maintaining historical data for program management and trend analysis.

- Expanded information on staffing and encounters is included in Table 5, in recognition of the increased role of Medicaid and Medicare reimbursement for mental health and substance abuse, and the need to define enabling services. More detail on physician staffing will enhance BPHC's ability to project needs for additional types of personnel. At the same time, collection of data on medical and dental users maintains a consistent historical database.
- The revised perinatal profile (Table 7) permits identification of the total number of users who are pregnant--and the number of HIV-positive pregnant users--regardless of where the woman received perinatal care, but focuses more detailed information on only those for whom the center assumed primary responsibility.

Table 6, Selected Diagnoses and Services, substantially improves available clinical data on BPHC populations. The data provide a profile of the prevalence of particular health problems among BPHC-served populations. This assists in developing actuarially sound **capitation** rates and risk adjustments for managed care. In addition, availability of consistent information on diagnoses and services provides, for the first time, a sample frame that can be used for conducting future in-depth studies of clinical conditions.

The format and structure of Table 6 is the result of careful consideration of (1) BPHC's need for improved clinical data and (2) a realistic assessment of grantee data capabilities. The reporting format calls for extracting information from the claims data that grantees maintain for reimbursement purposes.

Specifically:

- Diagnostic and service groupings are defined around ICD-9-CM and CPT4 codes included on claims and encounter forms.
- Grantees are **required** to report on the number of billed encounters within selected categories of primary diagnoses or services. This will allow comparison with similar information from state and national claims data.
- Grantees that have the requisite data capacity are **encouraged**, but **not required**, to report on the number of **users** with a particular diagnosis or service, and to indicate totals for secondary as well as primary diagnosis. This will allow identification of comorbidities believed to be important in underserved populations.

Developing a clinical report that can be produced from existing billing systems involves certain tradeoffs. First, reported data will primarily reflect medical encounters, since these are the services rendered by reimbursable providers and therefore included in billing systems. Second, requesting encounter data only for primary diagnosis may understate prevalence, since a patient with one of the listed diagnoses may have an acute presenting condition that is recorded as the primary diagnosis for the encounter (e.g. an asthmatic with a cut hand). On the other hand, the national **datasets** with which this information is likely to be compared most often report data based on primary diagnosis.

Data collected in this section will enable BPHC to respond to frequently asked questions about the health status of the user population and will provide a baseline for studying outcomes in the future. Such questions include:

- **What are the staffing patterns in BPHC programs?** A thorough description of inputs allows analysis of costs and utilization according to different ways of staffing (e.g., family practitioners versus internists and pediatricians; physicians versus mid-levels).
- **What is the utilization of BPHC providers, by type?** This allows examination of productivity as well as use of various services categorized by provider types.
- **For which conditions do BPHC patients receive service?** With consistent and systematic data on diagnoses and services, BPHC will be able to compare its populations with data on the general population and for similar cohorts.
- **To what extent do BPHC patients receive preventive services?** Services for tracer conditions (e.g., selected immunizations, pap smears) can be documented.
- **To what extent do BPHC programs contribute to national efforts to reduce infant mortality?** Information on birth outcomes is especially useful.

INSTRUCTIONS FOR TABLE 5: STAFFING AND UTILIZATION

This table provides a profile of the number and types of grantee staff. It also provides information on the number of users served and encounters rendered by personnel category. Unlike Table 3 Part A, this will not produce an unduplicated count of users. The table is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories of interest for program planning and evaluation purposes.

This table is included only in the Universal Report. It should include all staff for programs and activities within the scope of the five types of BPHC-supported projects included in the UDS.

STAFF Includes all individuals who work in programs and activities that are within the scope of the project for the five types of projects included in the UDS. Staff must be employed by the grantee on a regularly scheduled basis under any of the following compensation arrangements: salaried full-time, salaried part-time, National Health Service Corps assignees, under contract, under **capitation**, block time or fee-for-service arrangements, or donated time. Staff time is to be allocated by function. If an individual's time is divided among different functions (e.g., nurses who provide medical and case management services or a physician who is also a medical director), their time should be allocated accordingly. The time reported for individuals under contract should reflect the number of hours specified in their contract.

1. *Personnel by Major Service Category:* Staff are distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse specialist services, other professional health services, enabling services, and administration and facility. The contents of major service categories have been defined to be consistent with definitions used by Medicare and Medicaid, and differ slightly from those previously used for BPHC reporting. (See Appendix A for a listing of personnel included in each major service category.)
 - *Medical Care Services:* Include staff time involved in provision of medical care services. Include all staff time for staff listed under this category *except* when such personnel (1) perform administrative duties or (2) provide enabling services identified separately. For example, time for a physician/medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.
 - *Physicians (M.D. or D.O.):* separate totals should be provided for the following subcategories: family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists.

- **Nurse Practitioners/Physician Assistants:** include staff time for physician assistants and nurse practitioners performing medical care services
- **Certified Nurse Midwives:** include staff time for nurse midwives performing medical care services
- **Nurses:** report nurses that are involved in provision of medical care services, including registered nurses, licensed practical nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses. If an individual's time is divided among provision of medical and non-medical services, allocate **FTEs** accordingly to reflect this division of time (e.g., nurses who provide case management or education/counseling services in addition to medical care should be allocated accordingly between medical care and enabling services).
- **Laboratory:** pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
- **X-ray personnel:** radiologists, X-ray technologists, and X-ray technicians
- **Other Medical Personnel:** includes medical assistants, nurses aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse.
- **Dental Services:** includes the services of the following professionals
 - **Dentists:** general practitioners and specialists (including oral surgeons, periodontists, and pedodontists)
 - **Dental Hygienists**
 - **Dental Assistants, Aides, and Technicians**
- **Mental health specialists:** individuals providing counseling and/or treatment services related to mental health, including psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists. Report psychiatrists under physicians, not in this category.
- **Substance abuse specialists:** individuals providing counseling and/or treatment services related to substance abuse, including psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists.
- **All other professional health personnel:** other staff professionals providing health services, including occupational and physical therapists, podiatrists, and optometrists.

- **Pharmacy personnel:** pharmacists and pharmacist assistants
- **Enabling Services**
 - **Case Managers:** staff providing services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. It includes eligibility assistance when provided by staff performing broader case management functions. Staff may include nurses, social workers and other professional staff.
 - **Education specialists:** health educators, and family planning and HIV specialists who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
 - **Outreach workers:** individuals conducting outreach and/or case finding.
 - **Personnel performing other enabling service activities:** all other staff performing services listed in Appendix B as enabling services, such as child care, eligibility assistance, housing assistance, and interpretation/translation.
- **Administration and Facility:** This category includes three groups of personnel, defined to be consistent with staff groupings used by major third party payors (e.g., Medicare).

NOTE: Some grant programs have limitations on the proportion of **grant funds** that may be used for administration. The Administration and Facility category for this report is more comprehensive than that used in grant definitions and includes all personnel working in a BPHC-supported program, whether or not that individual's salary was supported by the BPHC grant. **Limits on administrative costs for those programs that use them are only applied to grant funds, and to information provided in the grant application and FSR.**

- **Administration:** administrative personnel, including the executive director, medical director, physicians or nurses with administrative responsibilities, secretaries, fiscal and billing personnel, and other support staff
- **Facility:** staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, and other maintenance staff
- **Patient services support staff:** includes intake staff, patient transportation personnel, and medical/patient records

-
2. **FTEs:** Report Full Time Equivalentents (**FTEs**) for all staff. Time for personnel performing more than one function should be allocated as appropriate among the major service categories.
 3. **Encounters:** Report encounters rendered during the reporting period by selected staff, as indicated on the table. (Encounters are defined on page 7 of the General Instructions)
 4. **Users:** Report the unduplicated number of users seen during the reporting period for six aggregate service categories: Medical Care Services; Dental Services; Mental Health Specialist Services; Substance Abuse Specialists Services; Other Professional Services; and Enabling Services. (See definition of a user on page 11 of the General Instructions)

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TABLE 5
STAFFING AND UTILIZATION

PERSONNEL BY MAJOR SERVICE CATEGORY	FTEs	ENCOUNTERS	USERS
MEDICAL CARE SERVICES--TOTAL			
Total Physicians			
Family Practitioners			
General Practitioners			
Internists			
Obstetrician/Gynecologists			
Pediatricians			
Psychiatrists			
Other Specialist Physicians			
Nurse Practitioners/Physician Assistants			
Certified Nurse Midwives			
Nurses			
Other Medical Personnel			
Laboratory personnel			
X-ray personnel			
DENTAL SERVICES--TOTAL			
Dentists			
Dental Hygienists			
Dental Assistants, Aides, and Technicians			
MENTAL HEALTH SPECIALIST SERVICES (including clinical psychologists, social workers & other professional mental health workers)			

TABLE 5 (continued)

PERSONNEL BY MAJOR SERVICE CATEGORY	FTEs	ENCOUNTERS	USERS
SUBSTANCE ABUSE SPECIALIST SERVICES (including clinical psychologist, social workers & other professional substance abuse workers)			
OTHER PROFESSIONAL PERSONNEL SERVICES (e.g., services provided by occupational and physical therapists, podiatrist, optometrist)			
PHARMACY PERSONNEL			
ENABLING SERVICES-TOTAL			
Case Managers			
Education specialists			
Homemaker/personal care assistants			
Outreach workers			
Personnel performing other enabling service activities			
TOTAL ADMINISTRATION AND FACILITY			
Administration staff			
Facility staff			
Patient services support staff (e.g., medical records, intake)			

INSTRUCTIONS FOR TABLE 6: SELECTED DIAGNOSES AND SERVICES RENDERED

This table reports data on selected diagnoses and services rendered. It is designed to provide information on diagnoses and services of greatest interest using data maintained for billing purposes (i.e., billable encounters). The selected conditions and services represent those that are (1) prevalent among BPHC users or a sub-group of users or (2) are generally regarded as sentinel indicators of access to primary care.

The table is included in **both** the Universal Report and Grant Reports. The Universal Report includes all individuals who had at least one encounter in the indicated diagnostic or service category within the scope of any of the five types of BPHC-supported projects included in the UDS.

1. **Diagnoses:** lists both the name and applicable ICD-9-CM codes for each diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range is shown, grantees should report the total encounters across all diagnoses included in the range/group. **Services:** lists both the name and the applicable ICD-9-CM or CPT-4 procedure codes.
2. **Encounters:** the total number of encounters during the reporting period for the indicated diagnosis. **All grantees are required to report the number of encounters with a primary diagnosis or service in each of the indicated diagnostic or service categories.**
3. **Users:** For diagnoses, there are two optional user categories. One requests users by primary diagnosis and is counted only once for a single encounter but may have different primary diagnosis during subsequent encounters throughout the year; all these should be counted. A second optional category requests users by secondary diagnosis. Only the secondary diagnosis identified during an encounter should be considered in this column. For services, there is only one optional column to report users with at least one encounter during the reporting period in the listed service categories.

Grantees whose data systems permit them to generate the optimal user information are encouraged to do so.

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**TABLE 6
SELECTED DJAGNOSES AND SERVICES RENDERED**

DIAGNOSTIC CATEGORY	APPLICABLE ICD-9-CM† CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (REQUIRED)	NUMBER OF USERS (OPTIONAL)	
			Primary Diagnosis	Secondary Diagnosis
Selected Infectious and Parasitic Diseases				
HIV infection:				
Symptomatic	042.xx			
Asymptomatic	V08			
Tuberculosis	01 0.xx - 018.xx			
Syphilis and other venereal diseases	090.xx - 099.xx			
Selected Diseases of the Respiratory System				
Asthma	493.xx			
Chronic bronchitis and emphysema	490..xx - 492.xx 496.xx			

†International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Volumes 1 and 2, 1993. Los Angeles, California: Practice Management Information Corporation. Codes for HIV Infection reflect revisions published in MMWR volume 43, no. RR-1 2, September 30, 1994.

TABLE 6 (continued)

DIAGNOSTIC CATEGORY	APPLICABLE ICD-9-CM † CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (REQUIRED)	NUMBER OF USERS (OPTIONAL)	
			Primary Diagnosis	Secondary Diagnosis
Selected Other Medical Conditions				
Abnormal breast findings, female	174.xx; 198.81; 233.0x; 793.8			
Abnormal cervical findings	180.xx; 198.82; 233.1 x; 795.0x			
Diabetes mellitus	250.xx; 775.1 x; 790.2			
Heart disease (selected)	391 .xx - 392.xx 41 o.xx - 429.xx			
Hypertension	401 .xx - 405.xx;			
Contact dermatitis and other eczema	692.xx			
Dehydration	276.5x			
Exposure to heat or cold	991 .xx - 992.xx			

†International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Volumes 1 and 2, 1993. Los Angeles, California: Practice Management Information Corporation. Codes for HIV Infection reflect revisions published in MMWR volume 43, no. RR-1 2, September 30, 1994.

TABLE 6 (continued)

DIAGNOSTIC CATEGORY	APPLICABLE ICD-9-CM† CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (REQUIRED)	NUMBER OF USERS (OPTIONAL)	
			Primary Diagnosis	Secondary Diagnosis
Selected Childhood Conditions				
Otitis media and eustachian tube disorders	381.xx - 382.xx			
Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx - 779.xx (excluding 779.3x)			
Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx - 269.xx; 779.3x; 783.3x - 783.4x;			
Selected Mental Health and Substance Abuse Conditions				
Alcohol dependence	303.xx; 291.xx; 357.5x			
Drug dependence	304.xx; 292.xx; 648.3x; 357.6x			
Other severe mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx - 302.9x; 306.xx - 319.xx; 648.4x (excluding 291.xx, 292.xx, 303.xx, 304.xx, 357.5x, 357.6x, 648.3x)			

†International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Volumes 1 and 2, 1993. Los Angeles, California: Practice Management Information Corporation. Codes for HIV Infection reflect revisions published in MMWR volume 43, no. RR-12, September 30, 1994.

TABLE 6 (continued)

Selected Diagnostic Tests/Screening/Preventive Services				
SERVICE CATEGORY	APPLICABLE ICD-9-CM † OR CPT-4 CODE(S) ††	NUMBER OF ENCOUNTERS	NUMBER OF USERS (OPTIONAL)	
HIV test	CPT-4: 86311; 86689; 86701-86703			
Mammogram	CPT-4: 76090-76092 ICD-9: V76.1			
Pap Smear	CPT-4: 88150; 88151; 88155 ICD-9: V76.2			
Selected Immunizations: diphtheria, pertussis and tetanus (DPT); measles, mumps and rubella (MMR); oral polio vaccine; influenza; hepatitis B; hemophilus influenza B (HIB)	CPT-4: 90701, 90707, 90712, 90724, 90731, 90737			
Contraceptive management	ICD-9: V25.xx			
Health supervision of infant or child (ages 0 through 11)	ICD-9: V20.xx; V29.xx CPT-4: 99391-99393; 99381-99383; 99431-99433			

† International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Volumes 1 and 2, 1993. Los Angeles, California: Practice Management Information Corporation. Codes for HIV Infection reflect revisions published in MMWR volume 43, no. RR-12, September 30, 1994.
 †† Physicians' Current Procedural Terminology, 4th edition, CPT '95, American Medical Association.

INSTRUCTIONS FOR TABLE 7: PERINATAL PROFILE

This table provides detail on pregnant/postpartum women users and their newborn infants, and services rendered by grantees that provide perinatal care. Table 7 is included in the Universal Report, **but** only those grantees who provide prenatal services complete sections A, B, and C.

DATA REPORTED BY ALL GRANTEES

Total Users Known to be Pregnant. Report the total number of users known to be pregnant at some time during the reporting period, regardless of whether the woman received services directly related to the pregnancy from the grantee.

Total Users Known to be HIV-positive and Pregnant. Report the total number of users known to have been both pregnant *and* infected with HIV at some time during the reporting period, regardless of whether the woman received services from the grantee directly related to the pregnancy or to HIV infection.

DATA REPORTED ONLY BY GRANTEES WHO PROVIDE PRENATAL CARE:

The following Sections A, B, and C should be completed *only* by grantees who provide prenatal care directly. Furthermore, these sections apply only to users who received prenatal care services during the reporting period.

A. DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS

Age of Prenatal Care Users. Report the total number of prenatal care users during the reporting period by age group. Include women who began prenatal care during the previous reporting period and continued into the current year. To determine the appropriate age group, use the woman's age on June 30 of the reporting period.

Race/Ethnicity of Prenatal Care Users. Report the *percent* of prenatal care users during the reporting period in each race/ethnicity category. Data may be estimated.

B. TRIMESTER OF ENTRY INTO PRENATAL CARE

Trimester of First Visit. Report the total number of pregnant women users who began prenatal care during the reporting period, by trimester of pregnancy when they began prenatal care *either* at one of the grantee's sites *or* with another provider.

- ***First trimester*** includes women who began prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be 13 weeks after conception or less.

- *Second trimester* includes women who began prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be between 13 and 27 weeks after conception.
- *Third trimester* includes women who began prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be 27 weeks or more after conception.

C. DELIVERY, POSTPARTUM AND INFANT UTILIZATION

Prenatal Care Users Who Delivered During the Year. Report the total number of women that *both* received prenatal care from the grantee during the reporting period *and* who delivered during the year, even if the delivery was assisted by another provider. Include all deliveries, regardless of the outcome.

Birthweight of Infants born to Prenatal Care Users during the Year. Report the total number of live births during the reporting period *for women who received prenatal care from the grantee* during the reporting period, according to the appropriate birthweight group.

For the next 2 items, the follow-up rates will be underestimated. Please report as indicated with the understanding we will be developing an adjustment factor.

Prenatal Care Users who returned for Postpartum Care during the Year. Report the total number of women that *both* received prenatal care from the grantee during the reporting period *and* who returned to the grantee during the reporting period within 8 weeks of delivery for postpartum care.

Infants Who Received a Newborn Visit. Report the total number of infants born to women who received prenatal care from the grantee during the reporting period who also received a newborn care visit (defined as a visit during the first 4 weeks after birth) from the grantee during the reporting period.

D. WIC ENROLLEES

Report the total number of individuals the grantee served during the reporting period who are known to have been enrolled during the reporting period in the Special Supplemental Food Program for Women, Infants and Children (WIC). Further classify WIC enrollees into the following three categories: prenatal care users, infants, and postpartum users. An individual may be reported in more than one category (e.g., an individual may be reported as having been both a prenatal and a postpartum WIC program enrollee).

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TABLE 7
PERINATAL PROFILE

CHARACTERISTICS	NUMBER OF USERS
I. ALL GRANTEES	
Total Users Known to be Pregnant	
Total Users Known to be HIV + Pregnant Women	
II. GRANTEES WHO PROVIDE PRENATAL CARE	
A. DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS	
Age - Total	
< 15 years	
15 - 19	
20 - 24	
25 - 44	
45 +	
Race/Ethnicity - Total Percentage	100%
Asian/Pacific Islander (Percent)	
Black (Not Hispanic) (Percent)	
Native American/Alaskan (Percent)	
White (Not Hispanic) (Percent)	
Hispanic (All Races) (Percent)	
Unknown (Percent)	

TABLE 7 (continued)

CHARACTERISTICS	NUMBER OF USERS	
B. TRIMESTER OF ENTRY INTO PRENATAL CARE		
Trimester of First Known Visit for Women Starting Prenatal Care During Reporting Year	Women Making First Visit at Grantee Site	Women Making First Visit at Another Provider
First trimester		
Second trimester		
Third trimester		
C. DELIVERY, POSTPARTUM AND INFANT UTILIZATION		
Prenatal Care Users Who Delivered During Year		
Birthweight of Infants Born to Prenatal Care Users During Reporting Year		
1500 grams and under (very low birthweight)		
1501 - 2500 grams (low birthweight)		
> 2500 grams (normal birthweight)		
Prenatal Care Users who Returned for Postpartum Care During Year		
Infants Who Received a Newborn Visit (within 4 weeks of birth)		
D. WIC ENROLLEES		
Prenatal Care Users		
Infants		
Postpartum Care Users		

SECTION E. FINANCIAL

This section includes the following tables on cost and revenues.

Table 8	Part A: Costs Part B: Mental Health/Substance Abuse and Enabling Services
Table 9	Part A: Revenues Part B: Cost Reimbursement (filed by grantees receiving Medicare or Medicaid cost reimbursement) Part C: Managed Care

These tables replace four tables in the BCRR (Tables 6, 7, 8A, and 8B) and provide data now available only from special surveys. The current reporting tables do not reflect recent trends in reimbursement (e.g., enactment of FQHC), nor do they meet emerging information requirements for managed care. The revised financial reports build upon the information requirements used by major payors, thereby reducing duplication and burden. They also provide critical data that can be used in meeting market demands for information.

- The revised Cost table (Table 8 Part A) builds upon the Medicare cost report and its cost categories, thereby providing credible information consistent with that used by other major payors. Table 8 Part B identifies the costs associated with mental health/substance abuse as well as those for enabling services provided by BPHC programs but not identifiable using the Medicare-related cost categories in Part A.
- The Revenue table (Table 9 Part A) updates revenue categories to more accurately reflect current funding sources for BPHC programs.
- The Cost Reimbursement table (Table 9 Part B) is completed by grantees that have Medicare or Medicaid cost reimbursement rates. This information permits assessment of the extent to which third party payors cover grantee costs, and enables more accurate trend analysis and revenue projections. In addition, availability of data on costs of services reimbursable under state Medicaid plans facilitates assessments of capitation rates under emerging managed care systems.
- The Managed Care table (Table 9 Part C) is designed to reflect the growing importance of capitation and other prepaid payment methods in managed care delivery systems. This report documents the growth of managed care, by payor source, and allows analysis of prepaid risk and the adequacy of rates. Data on enrollees who use a service provide a cross-walk between managed care enrollee data and user counts, enabling determination of the proportion of users enrolled in prepaid plans.

The financial tables are intended to provide appropriate information for today's environment while offering flexibility to adjust as the market changes in the future. Adaptations to reflect new financing trends include the following:

- The Cost table includes all costs associated with the scope of services covered in the grant application, while the Managed Care table covers all expenses for capitated enrollees. Since capitation rates may include specialty referral and/or inpatient services that are not part of the scope of services in the BPHC grant, expenses in Table 9 Part C are not entirely a subset of the Cost table.
- Whereas a prior BPHC table included data that compared charges and revenues, enactment of FQHC--and the trend towards prepayment and managed care--makes established charge schedules less useful than in the past. Assessment of costs, revenues and retroactive adjustments provide more meaningful data in today's payment environment. Data on the number of users by primary payor source (from Table 4) provide a more direct method of documenting service to the uninsured.

Data collected in this section enable BPHC to respond to numerous questions, including:

- ***What are the costs of services in BPHC programs?*** Are BPHC grantees efficient providers of care? Combining data on service costs, visits and users permits analyses that determine the relationship of inputs to outputs. Cost categories that conform to those used by major payors enhances credibility and acceptability of analytic results.
- ***How do BPHC costs and services compare with those reported for Medicare and Medicaid?*** The UDS reconciles these categories and builds on Medicaid and Medicare reports most grantees already submit, allowing comparisons between BPHC and other Medicaid or Medicare providers.
- ***Are BPHC programs part of the financing system in the areas where they are located?*** Revenue data provide the basis for examining the extent to which programs are supported by state and local government and/or third party payors. Managed care data can be used to determine penetration (e.g. the percent of BPHC users enrolled in managed care). These data can also be compared with payor data on enrollment to assess the role of BPHC programs in managed care (e.g., the percent of all managed care enrollees in an area who enrolled with BPHC providers).
- ***What is the relationship of costs and revenues for BPHC programs?*** The information on costs and revenue by payor source will permit these critical comparative analyses and development of more accurate revenue projections for BPHC programs.

INSTRUCTIONS FOR TABLE 8 PART A: COSTS

Table 8 Part A should be completed by all of the five types of BPHC grantees covered by the UDS. It is included only in the Universal Report. The table covers the *total cost* of services within the scope of the project(s) supported, in whole or in part, by any of the five BPHC grants. All costs are to be reported on an accrual basis--the amounts consumed during the period--regardless of when payments were made.

This table is based on the Medicare FQHC/RHC Cost Report. Grantees who file a Medicare Cost Report should refer to their most recent report(s), as discussed in the instructions below. Separate instructions are provided for grantees who do not file a Medicare report.

THE FOLLOWING INSTRUCTIONS ARE FOR GRANTEES WHO FILE A MEDICARE COST REPORT. THERE ARE SEPARATE INSTRUCTIONS FOR GRANTEES WHO DO NOT FILE A MEDICARE COST REPORT ON PAGE 61.

The Medicare Cost Report includes specific cost categories appropriate for Medicare reimbursement purposes. BPHC has interest in functional definitions of services, reflecting the activities of BPHC grantees; hence, BPHC's service cost categories differ slightly from Medicare's categories. Exhibit A below provides a cross-walk between the BPHC Major Categories of Service included in Table 8 Part A and the reporting categories used in the Medicare report.

EXHIBIT A: CROSSWALK OF BPHC MAJOR SERVICE CATEGORIES AND MEDICARE FQHC/RHC REPORT CATEGORIES	
BPHC Major Service Category	Medicare Report Category (and Line #)
Medical Care Services	Total Cost of Services (Line 25) - Facility Health Care Staff (Line 12) - Costs Under Agreement (Line 16) - Other Health Care Costs (Line 24)
Other Professional Services	Cost other than RHC/ FQHC Services (Line 57) - Pharmacy (Line 51) - Dental (Line 52) - Optometry (Line 53) - Other (Lines 54-56)
Enabling Services	Non-reimbursable Costs (Line 61)

There are two major differences between the BPHC service category definitions and those used by Medicare:

- **Laboratory and X-ray:** BPHC includes these costs as *Medical Care Services*; on the Medicare report, some of these costs appear under *Non-reimbursable Costs* and/or under *Cost other than RHC/FQHC Services*.
- **Services of clinical social workers and clinical psychologists.** BPHC includes services of these personnel as mental health services, which are included under *Other Professional Services*. Medicare includes costs associated with these personnel under *Facility Health Care Staff* (Line 12).

BPHC MAJOR CATEGORIES OF SERVICE

Medical Care Services: This category includes costs for medical care staff personnel; services provided under agreement; X-ray and laboratory; and other direct costs wholly attributable to medical care (e.g., equipment, supplies, depreciation, professional liability insurance). It does not include costs associated with pharmacy, dental care, substance abuse specialists, or clinical psychologist and clinical social worker services.

Other Professional Services: This category includes staff and related costs for pharmacy, dental, mental health, substance abuse specialists and other services rendered by professional personnel (e.g. optometrists, occupational and physical therapists, podiatrists).

Enabling Services: This category includes staff and related costs for case management, education, outreach and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. Specific services are listed on Table 8 Part B; for definitions, see Appendix B)

LINE-BY-LINE INSTRUCTIONS FOR GRANTEES WHO COMPLETE A MEDICARE COST REPORT

Line 1: Medicare Cost Report. Enter the amounts from the lines of the *most recent* Medicare Cost Report that correspond to the headings above each cell of Table 8 Part A. Under Total Other Professional, enter the sum of Dental, Pharmacy, and Other Services.

Line 2: Conversion from Fiscal to Calendar Year. Grantees whose most recent Medicare Cost Report covers the calendar year reporting period should skip this Line and go to Line 3.

Grantees whose fiscal year (and Medicare cost report) do not correspond to the calendar year should calculate calendar year costs, using the following method, adapted from the Internal Revenue Service methodology for adjusting corporate fiscal to calendar years.

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. **Example:** A grantee whose fiscal year ends in September, 1994 allocates 75% of costs in each Medicare Cost Report category to the 1994 calendar year.

Step 2: Determine total cost in each category for the remaining portion of the year from grantee accounting data. *Example:* A grantee whose fiscal year ends in September, 1994 uses totals from October-December, 1994. Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.

Step 3: Sum results of Steps 1 and 2 and enter on Line 2.

Line 3: *Reallocation of Selected Costs to BPHC Major Service Categories.* Grantees should use this line to reallocate costs as reported on the Medicare report (and on Line 1) to the appropriate BPHC Major Service Category.

- Costs of laboratory services that were *not* reported under Medical Care Services on Line 1 should be reallocated to Total Medical Care Services.
- Costs of x-ray services that were *not* reported under Medical Care Services on Line 1 should be reallocated to Total Medical Care Services.
- Staff and other direct costs associated with services rendered by clinical psychologists and clinical social workers that were reported under Medical Care Services on Line 1, should be reallocated to Total Other Professional Services.

Exhibit B provides instructions for reallocating costs, specifying for each service the categories from which costs should be subtracted--and the categories to which applicable costs should be added. *Grantees should enter on Line 3 the net effect of reallocating costs associated with all three services listed below.*

Exhibit B. Reallocation of Cost from Medicare-Related Categories to BPHC Major Service Categories.		
Service	Allocate Costs to the BPHC Service Category Listed Below	Deduct Costs From Table 8 Part A, Line 1 Categories
Laboratory	Total Medical Care Services	Enabling Services and Total Other Professional
X-ray	Total Medical Care Services	Enabling Services and Total Other Professional
Services of Clinical Psychologists and Clinical Social Workers	Total Other Professional Services	Total Medicare Care Services

Line 4: Total after Reallocation. Total Lines 2 and 3. Because the reallocation only affects Total Medical Care Services, Total Other Professional Services, and Total Enabling Services, all other entries on Line 4 should be identical to those appearing for that category of service on Line 2.

Line 5: Allocation of Facility and Administrative Costs. The total of Administration and Facility Costs on Line 2 should be distributed among Total Medical Care, Dental, Pharmacy, Other [Professional] Services, and Enabling Services. The results of these calculations should be entered on Line 5.

Facility Costs should be allocated based on the amount of square footage utilized for Medical Care, Dental, Pharmacy, Other [Professional] Services, and Enabling Services. Square Footage refers to the portion of the grantee's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. For reporting purposes, the square footage associated with space owned by the grantee and leased, or rented to other parties should not be included. In these cases, revenues associated with rental or lease income for such space owned by the grantee can be used as an offset to facility costs.

Administrative Costs should be allocated by determining the percent of total cost attributable to each service category after facility costs have been distributed. If the grantee does not use its own approved methodology, administrative costs should be distributed based on the percentage of total costs applicable to each cost center after distribution of facility costs.

Line 6: Value of in-kind services and donations. Include here the total imputed value of all in-kind services and donations applicable to the reporting period that are within the scope of the grantees' BPHC-supported projects, using the methodology discussed below. Enter the resulting value on Line 6.

In-kind services and donations include all costs that are necessary and prudent to the operation of the grantee that are not paid for directly by the grantee. This includes the estimated fair market value of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment.

The estimated fair market value (FMV) should be calculated according to the cost that would be required to obtain similar services, supplies, equipment or facilities within the immediate area at the time of the donation. FMV should only be recognized when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the grantee's operation.

The full market value of National Health Service Corps (NHSC) Federal assignee(s) is also included in this category. NHSC-furnished equipment, including dental operatories, should be capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expense should be shown in this category for the reporting period.

Line 7: The value of in-kind services and donations entered on Line 6 should be added to Total costs after allocation of Administrative and Facility Costs, Line 5. The results of this calculation should be entered as Total Cost After Adjustment on Line 7.

THESE INSTRUCTIONS ARE FOR GRANTEES WHO DO NOT FILE A MEDICARE COST REPORT.

Grantees who do not file a Medicare cost report should allocate personnel and associated costs among the Categories of Service in Table 8 - Part A, applying the same rules for allocating staff time by function used in Table 5 - Staff and Utilization. In other words, if an individual's time is divided among different functions (e.g., nurses who provide both medical and case management services) all direct costs should be allocated accordingly between these categories as well. See Appendix A for further detail on staff included in each major service category.

BPHC MAJOR CATEGORIES OF SERVICE

Medical Care Services: This category includes costs for medical care staff personnel; services provided under agreement; X-ray and laboratory; and other direct costs wholly attributable to medical care (e.g., equipment, supplies, depreciation, professional liability insurance). It does not include costs associated with pharmacy, dental care, substance abuse specialists, or clinical psychologist and clinical social worker services.

Other Professional Services: This category includes staff and related costs for pharmacy, dental, mental health, substance abuse specialists and other services rendered by professional personnel (e.g. optometrists, occupational and physical therapists, podiatrists).

Enabling Services: This category includes staff and related costs for case management, education and counseling, outreach and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. Specific services are listed on Table 8-Part B; for definitions, see Appendix B)

Line 1: Costs, by category of service. On Line 1 enter costs as follows:

- **Medical Care Services:** Under *Staff costs*, include all costs for physicians, nurse practitioners/physician assistants, certified nurse midwives, nurses and other medical personnel, laboratory and x-ray personnel supported directly or under contract. Under *Other Direct Costs*, enter other costs wholly attributable to provision of primary medical services (e.g., medical supplies, depreciation, professional liability insurance). Costs of laboratory and x-ray services provided through contractual arrangements should be included under *Other Direct Costs*. Under *Total*, enter the sum of *Staff Costs* and *Other Direct Costs*.

Other Professional Services. Enter staff and other direct costs for Dental services and Pharmacy Services separately. Under *Other Services*, enter the staff and other direct cost of optometry, mental health (except psychiatrist staff costs, included under *Medical Care Services*), substance abuse, and all other professional service provided by medical personnel (e.g., physical therapy). Under *Total Other Professional Services* enter the total of Dental, Pharmacy and *Other Services*.

Enabling Services includes the services listed in Table 8 Part B and defined in Appendix B. Report the total staff and other direct costs for case management, education and counseling, outreach, homemaker/personal care assistants and all other enabling services provided by the grantee.

Facility and Administration costs should include all costs incurred for operating services within the scope of the grantee's BPHC grant(s). Costs of patient services support (e.g., medical records, intake) should be included in Administrative Costs.

Line 2: Conversion from Fiscal to Calendar Year. Grantees whose most recent Medicare Cost Report covers the calendar year reporting period should skip this Line and go to Line 3.

Grantees whose fiscal year (and Medicare cost report) do not correspond to the calendar year should calculate calendar year costs, using the following method, adapted from the Internal Revenue Service methodology for adjusting corporate fiscal to calendar years.

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. *Example:* A grantee whose fiscal year ends in September, 1994 allocates 75% of costs in each Medicare Cost Report category to the 1994 calendar year.

Step 2: Determine total cost in each category for the remaining portion of the year from grantee accounting data. *Example:* A grantee whose fiscal year ends in September, 1994 uses totals from October-December, 1994. Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.

Step 3: Sum results of Steps 1 and 2 and enter on Line 2.

Line 3: Not applicable to grantees who do not file a Medicare Cost Report.

Line 4: Carry the amounts entered on Line 2 for Total; Total Primary Medical; Total Other Health Services; and Enabling Services to Line 4.

Line 5: Allocation of Facility and Administrative Costs. The total of Administration and Facility Costs on Line 2 should be distributed among Total Medical Care, Dental, Pharmacy, Other [Professional] Services, and Enabling Services. The results of these calculations should be entered on Line 5.

Facility Costs should be allocated based on the amount of square footage utilized for Medical Care, Dental, Pharmacy, Other [Professional] Services, and Enabling Services. Square Footage refers to the portion of the grantee's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. For reporting purposes, the square footage associated with space owned by the grantee and leased, or rented to other parties should not be included. In these cases, revenues associated with rental or lease income for such space owned by the grantee can be used as an offset to facility costs.

Administrative Costs should be allocated by determining the percent of total cost attributable to each service category after facility costs have been distributed. If the grantee does not use its own approved methodology, administrative costs should be distributed based on the percentage of total costs applicable to each cost center after distribution of facility costs.

Line 6: Value of in-kind services and donations. Include here the total imputed value of all in-kind services and donations applicable to the reporting period that are within the scope of the grantees' BPHC-supported projects, using the methodology discussed below. Enter the resulting value on Line 6.

In-kind services and donations include all costs that are necessary and prudent to the operation of the grantee that are not paid for directly by the grantee. This includes the estimated fair market value of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment.

The estimated fair market value (FMV) should be calculated according to the cost that would be required to obtain similar services, supplies, equipment or facilities within the immediate area at the time of the donation. FMV should only be recognized when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the grantee's operation.

The full market value of National Health Service Corps (NHSC) Federal assignee(s) is also included in this category. NHSC-furnished equipment, including dental operatories, should be capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expense should be shown in this category for the reporting period.

Line 7: The value of in-kind services and donations entered on Line 6 should be added to Total costs after allocation of Administrative and Facility Costs, Line 5. The results of this calculation should be entered as Total Cost After Adjustment on Line 7.

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FINANCIAL: TABLE 8 PART A
COSTS

Line #	from Medicare Report	Medical Care Services			Other Professional Services				Administration and Facility		
		Staff Costs	Other Direct Costs	Total	Dental	Pharmacy	Other Services	Total Other Professional	Enabling Services	Facility	Adminis- tration
62		(12 + 16)	(24)	(25)	(52)	(51)	(53 + 54 + 55 + 56)	(57)	(61)	(37)	(49)
1	Total From Most Recent Medicare Report (Worksheet A; Column 7)										
2	Calendar Year Costs										
3	Reallocation for BPHC Table										
4	Total After Reallocation										
5	Cost after Allocation of Administrative and Facility Costs										
6	Value of in-kind services and donations										
7	Total Cost after Adjustment										

INSTRUCTIONS FOR TABLE 8 PART B: MENTAL HEALTH/SUBSTANCE ABUSE AND ENABLING SERVICES

Table 8 Part B should be completed by all of the five types of BPHC grantees covered by the UDS. The table provides information on the costs of specific services that are important components of BPHC-supported programs, but which are not disaggregated on Table 8 Part A.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES: Include all costs of counseling and/or treatment services rendered by individuals providing mental health/substance abuse services, for whom FTE data were provided on Table 5.

Line 1: *Physicians, Psychologists, Clinical Social Workers:* Include total direct costs for physicians, clinical psychologists and clinical social workers providing mental health and substance abuse services. Include staff and associated direct costs (e.g., equipment, supplies, depreciation, and professional liability insurance). Grantees should provide estimates where costs cannot be disaggregated by type of service.

Line 2: *Other Mental Health/Substance Abuse Staff:* Include total direct costs, other than physicians, psychologists and clinical social workers, for providers of mental health and substance abuse services. Include staff and associated other direct costs (e.g., equipment, supplies, depreciation, and professional liability insurance). Grantees should provide estimates where costs cannot be disaggregated by type of service.

Line 3: *Total Direct Mental Health/Substance Abuse Costs.* Sum costs reported in Lines 1 and 2.

ENABLING SERVICES: The enabling services included in this section are defined in Appendix B. To the extent possible, distribute direct staff and other direct costs associated with enabling services into the listed service categories. Enabling services staff are those for whom FTE data were provided on Table 5.

Lines 4-12: Include total direct costs for each of the listed service types. Include staff and associated other direct costs attributable to the particular type of service (e.g., equipment, supplies, depreciation, and professional liability insurance). Grantees should provide estimates where costs cannot be disaggregated by type of service. If a particular enabling service is not provided, leave the cost line blank for that service.

Line 13: *Total Enabling Services Costs.* Sum the direct staff costs for each of the enabling services included above. The total direct costs for enabling services reported here should equal the total costs for enabling services reported on Table 8 Part A, Line 2.

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TABLE 8 PART B
 MENTAL HEALTH/SUBSTANCE ABUSE AND ENABLING SERVICES

SERVICE	COST
Mental Health/Substance Abuse Services	
1	Physicians, psychologists, clinical social workers
2	Other mental health/substance abuse staff
3	TOTAL MENTAL HEALTH/SUBSTANCE ABUSE SERVICES
Enabling Services	
4	Case Management
5	Transportation
6	Outreach
7	Patient Education
8	Translation/Interpretation
9	Community Education
10	Environmental Health Risk Reduction
11	Other Enabling Services (specify)
12	Other Enabling Services (specify)
13	TOTAL ENABLING SERVICES COST

INSTRUCTIONS FOR TABLE 9 PART A: REVENUES

Table 9 Part A should be completed by all of the five types of BPHC grantees covered by the UDS. It is included only in the Universal Report. This table collects information on revenues received during the reporting period to support the scope of project(s) covered by any of the five BPHC grants.

GRANTS Total BPHC Grants includes all BPHC grants listed on Table 1. These include the five primary care system development programs included in the UDS as well as Ryan White Title III(b); Healthy Schools, Healthy Communities; and any others subsequently provided by BPHC. Non-BPHC grant funds should be reported based on the entity that awards them. For example, funds awarded by the State for maternal and child health services usually include a mixture of federal funds such as Title V and state funds. These should be reported as state grants because they are awarded by the state.

PAYMENTS FOR SERVICES Third party revenues should be reported according to the primary source of payment. For example, if the grantee has a contract with a private HMO to provide services to enrolled Medicaid patients, payments for services to these patients should be reported under Medicaid, not private insurance.

MEDICAID Revenue reported as Medicaid should include federal, state and state-only **Medicaid**-covered services and populations (e.g., include general assistance recipients under a state-only Medicaid program).

OTHER THIRD PARTY PAYORS This refers to sources of reimbursement not listed (e.g., CHAMPUS). It also includes state insurance programs other than Medicaid, where they can be separately identified.

Line 1: Enter the total amount received during the reporting period for all BPHC grant programs. See Table 1 for a listing of included BPHC grant programs.

Line 2-4: Specify the amount and source of any other federal grant revenue received during the reporting period which falls within the scope of the project(s).

LINE 5: Total lines 2-4.

Line 6-8: For each source listed, enter the amount received during the reporting period that falls within the scope of the project(s).

- Line 9:** Enter the total of Lines 6-8.
- Line 10:** Enter the amount received during the reporting period through patient collections.
- Line 11-14:** For each source listed, enter the amount received during the reporting period as payment for services rendered within the scope of the project(s). Include revenue from both prepaid and non-prepaid arrangements under the appropriate payment source.
- Line 15:** Enter the total of lines 11-14.
- Line 16:** For sources other than those listed previously in the table, enter the total amount as and source of any payments received during the reporting period for activities within the scope of the project(s).
- Line 17:** Enter the total of Lines 1, 5, 9, 10, 15, and 16.

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**TABLE 9 PART A
REVENUES**

SOURCE		AMOUNT
GRANTS		
1	Total BPHC Grants	
2	Other Federal Grants (specify)	
3	Other Federal Grants (specify)	
4	Other Federal Grants (specify)	
5	Total Other Federal Grants	
6	State Government Grants or Contracts	
7	Local Government Grants or Contracts	
8	Foundation /Private Grants or Contracts	
9	Total Non-Federal Grants or Contracts	
PAYMENTS FOR SERVICES		
10	Patient Collections	
	Third Party Payors	
11	Medicaid (Title XIX)	
12	Medicare (Title XVIII)	
13	Private Insurance	
14	Other (e.g., CHAMPUS, State Programs) (specify)	
15	Total Third Party	
Other Revenue		
16	Other Revenue	
17	TOTAL REVENUE	

INSTRUCTIONS FOR TABLE 9 PART B: COST REIMBURSEMENT

Table 9 Part B should be completed only by UDS covered grantees with a cost-based rate under FQHC or RHC. It collects information on costs of reimbursable visits, payment rates, number of billable visits, and substantial retroactive settlements with Medicare and Medicaid.

Line 1: Indicate the most recent completed fiscal year period used for reporting to Medicare and/or Medicaid. All subsequent information reported in this table should be for this same fiscal year time period.

Line 2: Enter total cost per visit for reimbursable services *before* application of screens or limits on reimbursement.

PAYMENT RATES

Line 3: All grantees with a Medicare FQHC/RHC rate and/or an "all-inclusive" Medicaid rate should report the rate(s) in effect for the time period covered by the most recent Medicare/Medicaid fiscal year period(s).

Line 4-7: Grantees with separate service-specific Medicaid FQHC rates for Medical, Dental and/or Other services should report relevant payment rates here. Under "Other," provide rates for the two services, other than medical and dental, that account for the highest proportion of Medicaid billable visits.

NUMBER OF BILLABLE VISITS

Line 8: Enter the total number of billable visits reported to Medicare for the appropriate fiscal year. If the grantee has an all-inclusive rate for Medicaid reimbursement, enter the total number of visits billed to Medicaid.

Lines 9-12: If the grantee does not have an all-inclusive reimbursement rate for Medicaid reimbursement, enter the number of visits billed to Medicaid for each of the service categories listed. Use the same service categories under "Other" that were used under Payment Rates.

RETROACTIVE SETTLEMENT

This section should be completed by grantees who either received retroactive payments or paid back to Medicaid and/or Medicare an amount totalling at least 10 percent of their Medicare or Medicaid receipts for the applicable fiscal year reporting period.

Line 13: Enter the amount of retroactive payments received from Medicare and Medicaid during the current reporting period that were settlements for cost report(s) from previous reporting period(s).

Line 14: Enter the amount the grantee paid back to Medicare and/or Medicaid as settlement for overpayments made during previous reporting periods.

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TABLE 9 PART B
COST REIMBURSEMENT

		MEDICARE	MEDICAID
1	Applicable Time Period (Dates)		
2	Total Cost for reimbursable services, before screens/limits		
Payment Rates			
3	All Inclusive <i>or</i>		
4	Medical		
5	Dental		
6	Other (specify)		
7	Other (specify)		
Number of Billable Visits			
8	Total <i>or</i>		
9	Medical		
10	Dental		
11	Other (specify)		
12	Other (specify)		
Retroactive Settlements			
13	Receipts (+)		
14	Payback (-)		

INSTRUCTIONS FOR TABLE 9 PART C: MANAGED CARE

Table 9 Part C should be completed by all UDS covered grantees participating in Medicare, Medicaid, private, or other managed care plans. This table collects (1) information on revenue received and expenses for prepaid plans and (2) information on the number of enrollees in different managed care plans. If the grantee has more than one managed care contract of a particular type with either Medicare, Medicaid, private, or other insurers, the information for each category should be added together and reported as a total.

This report includes enrollment information for the following two types of managed care plans. Revenue and expenditure information is reported only for the **prepaid/capitated** plans.

- **Prepaid/Capitated Managed Care Plans:** a plan under which the grantee receives a fixed payment amount per enrollee. Payment is made in advance, generally on a monthly basis (referred to as “per member per month”) and covers all services included in the plan’s contract with the center. Under capitated arrangements, the grantee is generally at risk, on a full or partial basis, for services in the contract and/or for other services (e.g., referral, inpatient) whose costs are not included in the capitation rate.
- **Fee for Service Managed Care:** a plan under which the grantee receives payment on a fee-for-service basis for enrollees receiving contractually-specified services. Under these arrangements fee schedules are typically discounted and providers may also receive a fixed amount per enrollee per month for managing the care of the enrollees.

SOURCE OF

PAYMENT: Payments should be reported according to the primary source of payment. For example, if a center has a contract with a private HMO to provide services to enrolled Medicaid patients, this would be reported under Medicaid.

- Line 1:** Enter the sum of Lines 2 and 3 under the appropriate source of payment, and the total.
- Line 2:** Enter the amount of revenue received during the reporting period for all enrollees in capitated Medicare, Medicaid, private, and other plans, and the total.
- Line 3:** Enter the amount received during the reporting period from bonuses, patient co-payments, and any other revenue for managed care enrollees under the appropriate source of payment, and the total.
- Line 4:** Enter the total of Lines 5-7 under the appropriate category, and the total.

- Line 5:** Enter the Primary Medical Care expenses incurred during the reporting period for patients enrolled in managed care under the appropriate source of payment, and the total. These services are those included in the plan's contract with the center that are similar to those services funded by BPHC.
- Line 6:** Enter the Specialty Referral expenses incurred during the reporting period for patients enrolled in managed care under the appropriate source of payment, and the total. These are specialty services included in the center's contract for which patients are referred to a physician outside of the center. Funds to pay for these services may or may not be included in the capitated rate. These services may not be included in the scope of project for BPHC grant(s).
- Line 7:** Enter the Inpatient Referral expenses incurred during the reporting period under the appropriate source of payment, and the total. These are services included in the center's contract with the plan for which patient's are referred to a hospital. Funds for inpatient services may or may not be included in the capitated rate. These services may not be included in the scope of project under the BPHC grant.
- Line 8:** Enter the number of member months for each source of payment, and the total
- Line 9:** Enter the number of managed care enrollees as of December 31 for each source of payment, and the total.
- Line 10:** Enter the number of users enrolled in capitated managed care plans as of December 31 for each source of payment, and the total.
- Line 11:** Enter the number of users enrolled in fee for service managed care plans as of December 31 for each source of payment, and the total.
- Line 12:** Enter the number of managed care enrollees who used a service during the reporting period under each source of payment, and the total.
- Line 13:** Enter the total number of managed care enrollees in capitated plans who used a service during the reporting period under each source of payment, and **the** total.
- Lines 14:** Enter the total number of fee for service managed care enrollees who used a service during the reporting period under each source of payment, and the total.

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**TABLE 9 PART C
MANAGED CARE**

		TOTAL	SOURCE OF PAYMENT			
			MEDICARE	MEDICAID	PRIVATE	OTHER
PREPAID/CAPITATED PLANS						
1	Total Revenue					
2	- Capitation					
3	- Other (Bonuses, Co-pays, etc.)					
4	Total Expenses					
5	Primary Medical Care					
6	Specialty Referral					
7	Inpatient Referral					
8	Total Member Months					
MANAGED CARE ENROLLMENT						
9	Number of Enrollees (as of 12/31)					
10	- Capitated Plans					
11	- Fee for Service Managed Care					
12	Enrollees Who Used a Service During the Period					
13	- Capitated Plans					
14	- Fee for Service Managed Care					

APPENDIX A
LISTING OF PERSONNEL

APPENDIX A

LISTING OF PERSONNEL

Personnel by Major Service Category	Provider	Non-provider
MEDICAL CARE SERVICES		
PHYSICIANS		
Family Practitioners	X	
General Practitioners	X	
Internists	X	
Obstetrician/Gynecologists	X	
Pediatrician	X	
Psychiatrists	X	
OTHER SPECIALIST PHYSICIANS		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Ophthalmologists	X	
Other specialists and sub-specialists	X	
NURSE PRACTITIONERS/PHYSICIANS ASSISTANTS	X	
CERTIFIED NURSE MIDWIVES	X	
NURSES		
Clinical Nurse Specialists	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurse	X	
Licensed Practical Nurse	X	

APPENDIX A (continued)

Personnel by Major Service Category	Provider	Non-provider
LABORATORY PERSONNEL		
Pathologists		X
Medical Technologists		X
Laboratory Technicians		X
Laboratory Assistants		X
Phlebotomists		X
X-RAY PERSONNEL		
Radiologists		X
X-ray Technologists		X
X-ray Technician		X
OTHER MEDICAL PERSONNEL		
Nurse Aide/Assistant (Certified and Uncertified)		X
Clinic Aide/Medical Assistant (Certified and Uncertified)		X
OTHER PROFESSIONAL SERVICES		
DENTISTS		
General Practitioners	X	
Oral Surgeons	X	
Periodontists	X	
Pedodontists	X	
OTHER DENTAL		
Dental Hygienists	X	
Dental Assistant		X
Dental Technician		X
Dental Aide		X
MENTAL HEALTH AND SUBSTANCE ABUSE SPECIALISTS		
Psychologists	X	
Social Workers — Clinical and Psychiatric	X	
Nurses — Psychiatric and Mental Health	X	
Alcohol and Drug Abuse Counselors	X	
Nurse Counselor	X	

APPENDIX A (continued)

Personnel by Major Service Category	Provider	Non-provider
ALL OTHER PROFESSIONAL PERSONNEL		
Audiologists	X	
Occupational Therapists	X	
Optometrists	X	
Podiatrists	X	
Pharmacist		X
Pharmacist Assistant		X
Physical Therapists	X	
Respiratory Therapists	X	
Speech Pathologists	X	
Nutritionists/Dietitians	X	
ENABLING SERVICES		
CASE MANAGERS		
Patient Advocates/Ombudsmen	X	
Social Workers	X	
Public Health Nurses	X	
Home Health Nurses	X	
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses	X	
EDUCATION SPECIALISTS		
Family Planning	X	
Health Educators	X	
Social Workers	X	1
Public Health Nurses	X	
Home Health Nurses	X	1
Visiting Nurses	X	
Registered Nurses	X	
Licensed Practical Nurses	X	
HOMEMAKER/PERSONAL CARE ASSISTANTS/HOME HEALTH AIDE	X	

APPENDIX A (continued)

Personnel by Major Service Category	Provider	Non-provider
OUTREACH WORKERS		X
PERSONNEL PERFORMING OTHER ENABLING SERVICES		
Child Care Workers		X
Eligibility Assistance Workers		X
Interpreters/Translators		X
ADMINISTRATION AND FACILITY		
ADMINISTRATION		
Project Director		X
Administrator		X
Finance Director		X
Accountant		X
Bookkeeper		X
Secretary		X
Director of Planning and Evaluation		X
Clerk Typist		X
Billing Clerk		X
Cashier		X
Director of Data Processing		X
Key Punch Operator		X
Personnel Director		X
Registration Clerk		X
Receptionist		X
Director of Marketing		X
Marketing Representative		X
Enrollment/Service Representative		X
FACILITY		
Janitor/Custodian		X
Security Guard		X
Groundskeeper		X
Equipment Maintenance Personnel		X

APPENDIX A (continued)

Personnel by Major Service Category	Provider	Non-provider
Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF		
Medical and Dental		
Medical and Dental Team Clerks		X
Medical and Dental Team Secretaries		X
Medical and Dental Appointment Clerks		X
Medical and Dental Patient Records Clerks		X
Patient Transportation		
Patient Transportation Coordinator		X
Driver		X
Patient Records		
Patient Records Supervisor		X
Patient Records Technician		X
Patient Records Clerk		X
Patient Transcriptionist		X
Appointments Clerk		X

APPENDIX B

SERVICE DEFINITIONS
BPHC UNIVERSAL REPORTS

APPENDIX B
SERVICE DEFINITIONS
BPHC UNIVERSAL REPORTS

Service Category	Definitions
PRIMARY MEDICAL CARE SERVICES	
Diagnostic Laboratory (technical component)	Technical component of laboratory procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures,,
X-Ray Procedures (technical component)	Technical component of diagnostic X-ray procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures,,
Diagnostic Tests/Screenings (professional component)	Professional services to order and analyze/interpret results from diagnostic tests and screenings.
Urgent Medical Care	Medical care provided on a non-scheduled basis to treat emergency conditions.
24-Hour Coverage	The availability of emergency services and medical backup on a 24-hour basis.
Family Planning Services (Contraceptive Management)	Provision of contraceptive/birth control or infertility treatment. Counseling and education by providers are included here; when provided by other staff include under enabling services.
HIV Testing	Testing for HIV. Counseling and education by providers included here; when provided by other staff include under enabling services
Immunizations Selected immunizations (Table 6): Diphtheria, Tetanus, Pertussis Poliovirus Measles, Mumps, Rubella Hemophilus influenza B Hepatitis B Influenza virus	Provision of preventive vaccines. Provision of specific vaccines listed. For user totals, include any individual who received at least one immunization during the reporting period.
Following hospitalized patients	Contacts with health center patients during hospitalizations.

Appendix B (*continued*)

Service Category	Definitions
Gynecological Care	Gynecological services provided by a nurse, nurse practitioner, nurse midwife or physician, including annual pelvic exams and pap smears, follow-up of abnormal findings, and diagnosis and treatment of sexually transmitted diseases. This category does not include family planning services.
Obstetrical Care Prenatal care Antepartum fetal assessment Ultrasound Genetic counseling and testing Amniocentesis Labor and delivery professional care Postpartum care	Provision of listed services related to pregnancy, delivery and postpartum care.
Specialty Medical Care	Directly observed TB therapy: Delivery of therapeutic TB medication under direct observation of center staff. Other specialty care: Services provided by medical professionals trained in any of the following specialty areas listed below: Allergy; Dermatology; Gastroenterology; General Surgery; Neurology; Optometry/Ophthalmology; Otolaryngology; Pediatric Specialties; Radiology; Psychiatry; Anesthesiology
OTHER PROFESSIONAL SERVICES	
Dental Care Preventive Restorative Emergency	Provision by a dentist or dental hygienist of the listed services. Preventive dental care includes cleaning, prophylaxis, sealants, and fluoride treatments.
Environmental Health Risk Reduction	Includes the detection and alleviation of unhealthful conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health (e.g., lead paint testing and abatement and pesticide management).

Appendix B (continued)

Service Category	Definitions
Mental Health Treatment/ Counseling 24-hour Crisis Intervention/ Counseling Other Mental Health Services	Mental health therapy, counseling, or other treatment provided by a mental health professional.
Substance Abuse Treatment/ Counseling	Includes treatment for abuse of alcohol and/or other drugs. Counseling and other medical and/or psychosocial treatment services provided to individuals with substance abuse problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services, and aftercare.
Occupational or Vocational Therapy	Therapy designed to improve or maintain an individual's employment/career skills and involvement.
Physical Therapy	Assistance designed to improve or maintain an individual's physical capabilities.
Pharmacy	Dispensing of prescription drugs and other pharmaceutical products.
ENABLING SERVICES	
Case management	Client-centered service that links clients with health care and psychosocial services to insure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Key activities include: 1) assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary. Includes risk assessment, eligibility assistance, coordination and referral, follow-up and tracking, and documentation.
Child Care	Assistance in caring for a user's young children during medical and other health care visits.
Discharge Planning	Case management-type services related to an individual's discharge from the hospital.

Appendix B (continued)

Service Category	Definitions
Eligibility Assistance	Assistance in securing access to available health, social service and other assistance programs, including Medicaid, WIC, SSI, Food stamps, AFDC, and related assistance programs. Includes outstationed eligibility workers.
Employment/Educational Counseling	Counseling services to assist an individual in defining career/employment/ educational interests, and in identifying employment opportunities and/or education options.
Food Bank/Delivered Meals	Provision of actual food or meals/not finances to purchase food or meals.
Health Education	Personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition! and others.
Homemaker/Aide	Non-medical, non-nursing assistance with household chores and/or activities of daily living.
Housing Assistance	Assistance in locating and obtaining suitable shelter, either temporary or permanent. May include locating costs, moving costs, and/or rent subsidies.
nterpretation/Translation Services	Services to assist individuals with language/communication barriers in obtaining and understanding needed services.
Nursing Home and Assisted-living Placement	Assistance in locating and obtaining nursing home and assisted-living placements.
Outreach	Case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
Transportation	Transportation provided by the grantee for users.