

The following questions describe general reporting requirements for the UDS. Select the correct answer for each of the questions below.

1. Why is the UDS important? (Check all that apply.)
 - a. Data are used by BPHC to demonstrate the 330 program's effectiveness
 - b. Data are used by project officers to monitor program performance
 - c. Data are used by grantees to develop baselines and report progress on SAC and BPR applications
 - d. BPHC uses the data to make funding decisions

2. What kinds of technical assistance and support are available to assist you with preparing your 2009 UDS report (check all that apply).
 - a. Telephone help-line available year round
 - b. E-mail help available year round
 - c. UDS Manual with step-by-step instructions
 - d. Review of your tables by expert consultants
 - e. On-line training modules
 - f. Regional trainings

3. What is the initial due date for your UDS data?
 - a. February 15, 2010
 - b. March 31, 2010
 - c. June 30, 2010

4. Your 2009 UDS Report summarizes your activities for (check all that apply):
 - a. All your organizations activities for your fiscal year
 - b. All in-scope project activities for the period January – December 2009
 - c. All funded activities for the calendar year

5. You can revise your UDS report after March 31, 2010.
 - a. True
 - b. False

The following questions apply to Tables 3A, 3B and 4 which describes the health center's patient population. Select the correct answer for each of the questions

6. What is meant by "unduplicated count" of total patients? (Check all that apply)
 - a. Each patient counts only once regardless of the number of visits they have
 - b. Each patient is counted once each time they are seen by a physician
 - c. Each patient is counted once each time they are seen by a different type of service provider (e.g. medical, dental, mental health, etc.)

7. Patients are characterized by race AND ethnicity on the UDS. Which of the following are acceptable methods for obtaining this information?
 - a. Health center staff can make a best guess of a patient's race if the patient does not provide the information.
 - b. Self reported by patient
 - c. Use census data to proportionally allocate patients to racial and ethnicity categories

8. Patients who do not indicate that they are Hispanic are assumed to be non-Hispanic for purposes of reporting ethnicity on the UDS.
 - a. True
 - b. False

9. What types of information can be used to determine patient income for reporting on the UDS? (check all that apply)
 - a. Patient can self report income on the registration form.
 - b. An eligibility assistance worker can determine a patient's income using approved documentation.
 - c. A patient's insurance can be used as a proxy for income.
 - d. Patient income known for a sample of patients can be used to proportionally allocate the entire population.
 - e. If the patient has not provided income information, the patient must be reported as having unknown income.

10. In reporting patients by primary medical insurance, which of the following are appropriate types of medical insurance to document insurance coverage. (check all that apply)
 - a. Medicaid
 - b. Worker's Compensation
 - c. Medicare
 - d. Aetna
 - e. SCHIP
 - f. Delta Dental
 - g. Breast and Cervical Cancer Control

11. How many member months are reported for a patient who is enrolled in a capitated managed care plan for half the year?
 - a. 1
 - b. 6
 - c. 12

12. Primary care case management is an example of reportable managed care.
 - a. True
 - b. False

13. You must report the number of homeless persons, migrant farmworkers, school-based clinic patients and veterans you serve regardless of whether you receive targeted funding for special populations.
 - a. True
 - b. False

14. Patients reported by age and gender (Table 3A), race and Latino identity (Table 3B), income (Table 4) and medical insurance (Table 4) must be equal.
 - a. True, because you are reporting the same patients by different characteristics
 - b. False, because each table describes the patients differently

The following questions apply to Table 5 which describes the health center's staffing and production. Select the correct answer for each of the questions below.

15. A full-time equivalent (FTE) is defined by dividing paid hours by total full-time hours as defined by the health center.
- True
 - False
16. A full time employee who begins work on July 1, 2009 is counted as:
- 1.0 FTE
 - 0.75 FTE
 - 0.50 FTE
 - Not counted in 2009
 - None of the above
17. The most accurate way to report FTEs is based on:
- Job title
 - Licensure or certification
 - Work performed and credentials / licensure
 - Work performed
18. Which of the following should be included in the staffing reported for the UDS (check all that apply).
- Employee staff
 - Volunteers
 - Contracted staff
 - Residents
 - Locum tenens
 - NHSC providers
 - Employees on temporary unpaid leave
 - Employees on paid maternity leave
19. Which of the following are required for a contact to count as a UDS encounter? (check all that apply)
- Face-to-face with provider
 - Provider must be acting independently
 - Provider must be using professional judgment
 - Encounter must be provided by employee
 - Visit must be documented in the medical record
 - Provider must be appropriately credentialed/licensed, if applicable
 - Encounter must be billable
 - Encounter must be provided on-site at health center

20. Which of the following types of encounters do not count as a UDS encounter? (check all that apply)
- Visit with a volunteer physician
 - Paid referral visit
 - A transportation visit
 - A health education group visit
 - A behavioral health group visit
 - Dental Hygienist visit when the patient was also seen by the dentist
 - A visit with an RN to get a blood pressure check
 - A case management encounter
21. What is the primary difference between the number of patients reported on Table 5 compared with Tables 3A, 3B and 4?
- Tables 3A, 3B and 4 report an unduplicated total patient count whereas Table 5 reports unduplicated patients by service category (e.g. medical, dental, etc.), often resulting in a duplicated patient count.
 - Patients who receive different kinds of services are counted more than once on Tables 3A, 3B and 4, but they are counted only once for each type on Table 5.
 - There is no difference between the patients reported on Tables 3A, 3B, 4 and 5.
22. Special population Grant Table(s) are subsets of the Universal Table. This means:
- You cannot report more patients on a grant table than on the universal table.
 - The grant table and the universal table must be equal.
 - The grant table can report more patients than the universal table.
 - The patients reported on a grant table are not counted on the universal table.

The following questions apply to Tables 6A, 6B and 7 which describe clinical services and characteristics of care. Select the correct response for each question.

23. Which of the following should be included in the total count of prenatal patients on the UDS? (check all that apply)
- A patient who had a positive pregnancy test and counseling only
 - A pregnant patient who received one or more prenatal visit with your provider
 - A pregnant patient who was transferred to another provider after receiving one or more prenatal visits at the health center
 - A patient who received prenatal care but then miscarries
 - A patient who has an abortion after one or more prenatal visits with your provider
 - A pregnant patient who delivers during the reporting year
 - A pregnant patient who saw your prenatal provider in 2009 but will not deliver until 2010.
24. A patient who has her first prenatal visit *with the health center* in her third trimester but who transferred from another provider where she began care in the first trimester, is considered to have begun prenatal care:
- in the first trimester with another provider
 - in the second trimester with another provider
 - in the third trimester with your health center
 - in the third trimester with another provider

25. It is possible to report significantly more women aged 24-64 in the universe for the pap test than total women reported on Table 3A aged 24-64.
- True
 - False
26. You can use a log of women who received a pap test to identify the universe of women for the pap test clinical performance measure.
- True
 - False
27. Which of the following clinical performance measures do NOT have an exclusion? (check all that apply)
- Childhood immunization
 - Pap test
 - Controlled diabetes
 - Controlled hypertension
28. Self reported clinical information received from the patient (e.g. on vaccines received or date for a Pap test) is sufficient to document compliance?
- True
 - False
29. A patient is considered to be in compliance with the clinical performance measure (e.g., immunization, pap test) if documentation in the record clearly demonstrates that the clinic explained the importance of the service and the patient refused.
- True
 - False
30. The number who deliver should equal the number of women who receive prenatal care.
- True
 - False
31. To accurately report on all patients who meet the criteria for a clinical measure, the data source must meet all but which of the following criteria?
- include patients from all service sites
 - include patients from all funded programs
 - include searchable fields with required clinical measure(s)
 - support reporting of all clinical measures
 - include data for the required time frame (e.g., 3 years)
 - permit identification of patients to be excluded from the universe
32. The number of women who deliver may be different from the number of birth outcomes reported for which of the following reasons? (check all that apply)
- Woman miscarried or had an abortion sometime during her prenatal care
 - Woman had multiple births
 - Woman had a stillbirth
 - Woman was high risk and was transferred to another provider

33. A patient for whom no documented HbA1c or blood pressure is available for the reporting year should be excluded from the universe (sample).
- True
 - False
34. It is possible to report significantly more African American patients with hypertension than total African American patients.
- True
 - False
35. Which of the following are examples of acceptable random samples?
- 10 random charts selected from each of 7 service sites
 - 70 random charts selected from the PECs database which includes patients from the two collaborative sites but not the smaller site not in the collaborative
 - 90 charts pulled from a universe of 1350 patients – 10 for each provider
 - First 70 patients seen for a condition in the reporting year
 - All qualifying patients from one of two service sites
 - None of the above
36. You can use a State Immunization Registry to determine compliance with the childhood immunization clinical performance measure.
- True
 - False

The following questions apply to Tables 8A, 9D and 9E and relate to costs and revenues. Select the correct response for each question.

37. Administrative costs include which of the following? (check all that apply)
- Corporate administrative staff
 - Billing and collections staff
 - Medical records and intake staff
 - Patient registration IT system
 - Accounting and legal expenses
 - Provider continuing education
 - Provider benefits
38. Medical direct costs include the costs of front desk staff and medical records staff.
- True
 - False
39. Which of the following are examples of other professional costs? (check all that apply)
- Family practice
 - Legal services
 - Nutrition
 - Podiatry
 - Cardiologist
 - Contracted Provider
 - Grant Writer

40. Other Program Related costs include which of the following costs?
- Direct personnel and supplies expenses for "pass through" funds
 - Non-health-care services
 - Podiatrist
 - WIC
 - Job training
 - Home-maker chore programs
 - Behavioral health
41. What is the goal in allocating overhead to direct cost centers?
- Maximize costs for medical services which are billable
 - Minimize time and effort in allocating overhead
 - Assign costs to accurately reflect costs to deliver services
42. Total patient service charges should include which of the following? (check all that apply)
- Estimated value of non-billable services such as pharmacy samples and enabling services.
 - Net charges after allowable discount based on a sliding scale.
 - Charges from the fee schedule for all billable services including medical, dental, ancillary, behavioral health, etc.
 - Charges for pharmaceuticals
 - Adjusted (+ or -) charges based on amount payor will reimburse.
43. Total collections include which of the following? (check all that apply)
- Cash payments received for charges incurred in 2009
 - Patient payments from 2008 received in 2009
 - PPS or FQHC reconciliation payments received in 2009
 - Capitation payments received in 2009
44. Allowances equal charges minus collections for:
- All payors.
 - Capitated managed care plans, only.
 - Self-pay, only.
 - Fee-for-service and capitated plans.
45. Sliding discounts equal the difference between patient charges and the amount collected from patients.
- True
 - False
46. Failure to reclassify the patient portion of third party charges to self pay results in which of the following? (check all that apply)
- Third party and self pay collection rates are correctly stated.
 - Third party collections are understated and self pay collections are overstated.
 - Third party collections are overstated and self pay charges are understated.
47. Grants and contracts should be reported using the "last party rule". Select the example below that satisfies the rule.
- Federal dollars received through the state are reported as "state"
 - Federal dollars passed through another health center are reported as "federal"