



CALIFORNIA
HEALTHCARE
FOUNDATION

EHR Selection Toolkit for Community Health Centers

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I. Background

California's safety-net clinics provide a broad array of services to low-income and medically underserved persons, regardless of a patient's ability to pay. Funding for these community health centers (CHCs) may come from a number of sources such as grants, federal and state contracts, or Medicaid and Medicare. There are many categories of safety-net clinics in the state of California including federally qualified health centers (FQHCs), FQHC look-alikes, public clinics, private not-for-profit clinics, rural health clinics, and free clinics.

Each of these categories has different requirements for federal and state licensure and funding. In addition, the reporting requirements of the state, grant funding organizations, the federal government, and the populations that these clinics serve are unique for practice management (PM) and electronic medical record (EMR) systems, collectively referred to as electronic health records (EHRs).

This toolkit describes the differences between commercial and community health centers. Based on this description, a list of functional criteria (Worksheet A) has been developed to review with vendors of EHR systems to ensure that the unique needs of CHCs are met. In addition, Uniform Data Set (UDS) reporting is a requirement for FQHCs and can present substantial complexity. Current data format and reporting requirements can be found in Worksheet B.

This toolkit is not designed to provide a comprehensive guide to EHR selection, but rather list critical areas in which CHC requirements differ substantially from commercial clinics. Any comprehensive analysis of a vendor would need to evaluate the complete product functionality, vendor services, corporate qualifications, and the technology proposal from the vendor. This toolkit provides a practical list of functional criteria that should be considered when evaluating vendors that sell EHR systems to CHCs.

PM and EMR requirements are documented in separate sections of Worksheet A; however, requirements for CHCs often necessitate the integration of both PM and EMR data. Requirements do not change based on whether a clinic is purchasing only the PM or the EMR. CHCs should consider carefully the same requirements when acquiring a single system or an integrated system. CHCs should make certain that vendors describe how they will integrate their system into the current application environment to meet the requirements discussed below.

II. Key Differentiators

A. Calculation of Fees and Other Billing Considerations

CHCs are required to provide care to anyone who requests it regardless of a patient's ability to pay. To provide care at an equitable cost for patients, CHCs are required to have a method for discounting or adjusting fees based upon the patient's income and family size according to the federal poverty guidelines (commonly referred to as the "sliding-fee scale"). CHCs are also required to ensure that the federal grant resources available to the organizations are used to

address true financial access barriers to the maximum degree possible. In application, this has resulted in the establishment of sliding-fee scales and payment plans at the initial visit (rather than after payment has been received from an insurance company and the patient has been deemed unable to pay the remaining balance) to ease the lump-sum cost of care. These functions as well as family billing are not generally supported in software designed for for-profit health centers.

B. Population Management

The patient population served by CHCs is at greater risk for missing required follow-up, preventive care, and disease management interventions due to a lack of access to health care services and/or health insurance. Furthermore, Federally Qualified Health Centers (FQHCs) must have a system of care that ensures access to primary and preventive services, including cancer screening, immunizations, and cholesterol screenings (among others).¹ Therefore, population management capabilities (including population identification, point-of-care reminders, decision support for clinicians, patient reminders, and patient self-management support) is a critical aspect of a CHC's EMR. To provide appropriate population management, a system must first capture data in a format that can be queried and must have the capability to identify the patients in the population or chronic disease group. Once the population is identified, the system needs to remind patients to come in for planned care (proactive intervention through letters, email, or automated telephone calls) and in reminding clinicians about appropriate care during the encounter (opportunistic intervention). In some implementations, CHCs may already have, or may plan to maintain, a separate chronic disease management system (CDMS). In this case, CHCs should pay special attention to the ability of the EMR and PM to export or interface data to the CDMS and vice versa to provide appropriate data to identify the populations and identify appropriate interventions.

C. Unique Patient Identification Issues

Some patient populations served in CHCs, such as migrant populations, undocumented, and homeless patients, present a unique set of challenges for information systems. These patients may not have a Social Security number, telephone number, or permanent address. Patients may also use a variety of aliases and the variety of ethnicities supported by CHCs may also have different naming conventions (e.g., last name first in Asian cultures). Information systems use unique identifiers, such as those above, to identify individuals. In some cases, the systems employ a matching algorithm to verify that incoming data (demographics, laboratory results, etc.) is mapped to the correct patient. Since some of the key data points used to match patient and data are not available or change often for some populations served by CHCs, systems must have very advanced programming or a sophisticated set of tools to link information appropriately and maintain data integrity.

¹ Bureau of Primary Health Care Policy Information Notice: 98-23, August 17, 1998, Health Center Program Expectations, p13.

D. Grant Funding, Special Population Tracking, and Management Reporting

Grants represent a significant source of funding for CHCs. Grants or funded program often have very specific reporting and compliance requirements. These requirements allow funding agencies to demonstrate that the money they provide is directed as required. Special population tracking and other unique management reporting obligations significantly increase the reporting requirements of both the EMR and PM systems. If reporting requires the commingling of financial and clinical status, it is important to consider the effects of purchasing the PM and EMR systems from separate vendors or from a vendor that does not provide these applications on the same database. The commingling of data is often a requirement of special population tracking when clinical and financial information is combined to define a particular population. CHCs should carefully consider the history of the applications and obtain reference sites that have demonstrated that the reporting requirements can be met with the applications that are being considering.

E. Dental Documentation

Many CHCs provide dental services and therefore require dental billing and documentation tools in addition to medical systems. Most medical systems are not able to incorporate dental billing codes and work flows (or dental EMR capabilities), and very few vendors have experience in developing or maintaining interfaces from dental information systems to medical systems so that billing processes can be consolidated. Furthermore, it can be difficult for PM systems to manage multiple sliding-fee schedules and to distinguish between dental and medical sliding-fee schedules.

F. Uniform Data Set Reporting

Uniform Data Set (UDS) reporting is a requirement for Federally Qualified Health Centers. The UDS is being updated for 2008 and includes substantial increases in reporting complexity, including the addition of clinical measures. Current data format and reporting requirements can be found in Worksheet B. Updated UDS measures are expected to be released by the Health Resources and Services Administration in the fall of 2007.²

III. Conclusion

CHCs are similar to commercial practices in many aspects but depart significantly in others; therefore, CHCs must be prepared to spend significant effort in selecting EHR and PM systems to ensure that commercially available systems meet their unique needs. Many EHR and PM vendors are not sophisticated in their understanding of the unique requirements of CHCs because they have not focused on this market segment in the past. Special attention should be paid to the attached requirements as well as detailed reference checks with similar organizations.

² <http://bphc.hrsa.gov/draftsforcomment/manual/default.htm>

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Each item should be scored as follows:

Yes = Criteria met in current system. Please indicate version below.

Future = Criteria met in system planned for a future release. Please indicate version and release date below.

No = Criteria not met by current system version and not planned for next version.

C = Available via custom development.

O = Configuration option (may affect other criteria). Please describe impact.

Criteria		Response	Version	Comment
1	Practice Management System Functionality			
1.1	Registration/MPI			
1.1.1	The system can support a unique patient identifier (account number) to identify the patient across medical and dental clinics.			
1.1.2	System captures patient demographics (name, address or place or type of residence, migrant status, homeless status, primary language, date of birth, gender, etc.).			
1.1.3	The system allows users to register individuals by family.			
1.1.4	Patients associated with a family or guarantor can have surnames and addresses that differ from the head of household or guarantor.			
1.1.5	The system is able to differentiate between patients and guarantors (patients or non-patients who agree to pay the patient's bill if no one else does).			
1.1.6	At registration, the system will establish a patient account status indicator or code that reflects the payment status of the patient's account. This account status indicator or code will change automatically as the account status changes. Users will have the ability to change this account status indicator or code. An account status indicator value or code will be reserved to indicate that no bill should be sent out.			
1.1.7	The system allows a patient to have more than one guarantor without requiring the patient to have more than one account.			
1.1.8	The system supports recording both a permanent and local or temporary address for the patient.			
1.1.9	At registration, the user is able to identify other programs in which the patient is enrolled for federal reporting.			
1.1.10	The system records a patient's housing status and ethnicity using values in a user-defined table.			

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Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
1.1.11	The registration module records geographical information associated with the patient's and guarantor's residence (e.g., homeless, neighborhood, or census track).			
1.1.12	The system provides a free text comment field associated with the patient's registration record.			
1.1.13	The system can display special instructions on screen based on appointment type, clinic, etc. For example, "bring immunization records with you" or "minimum payment due today."			
1.1.14	The system provides multiple text fields that can be used to categorize the patient for reporting. These fields are accessible via the report-writing tool.			
1.1.15	Poverty level and sliding fees can be updated with changes in poverty guidelines annually.			
1.1.16	A patient can be identified by his or her prior name (e.g., maiden name) or alternate name (e.g., alias) previously entered into the system.			
1.2	Charge Entry			
1.2.1	The system has the ability to identify all procedures which are covered by FQHC rates including those that are date-sensitive.			
1.2.2	The system supports splitting global fees into user-defined components.			
1.2.3	The system prevents users from entering procedures to incorrect sites, departments, or providers (e.g., dental codes cannot be entered in the Department of Pediatrics).			
1.2.4	The system provides the ability to establish and have bills adjust to a center-specific sliding fee scale policy including:			
1.2.4.1	Minimum fee by procedure code.			
1.2.4.2	Minimum fee by visit.			
1.2.4.3	Minimum fee by department.			
1.2.4.4	Combination of above.			
1.2.4.5	Sliding fee by percentage of full charge.			
1.2.4.6	Ability to identify procedures ineligible for slide.			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
1.3	Patient Accounting			
1.3.1	The system shall have the ability to split family members and reassign to appropriate accounts (mandatory with family billing).			
1.3.2	The system can bill secondary payors on a fee-for-service basis, then bill the state on an FQHC basis, and offset all payments received for services related to the FQHC visit.			
1.3.3	Each family can have an unlimited number of insurance policies covering members of the family.			
1.3.4	The user is able to specify which members in the family are covered by each insurance policy.			
1.3.5	The system provides the ability to automatically replicate data for family members during the registration function that is the same (e.g., home telephone number address, payor source, etc.).			
1.3.6	The user can assign the patient to a sliding fee scale and record an associated date for recertifying the patient's sliding fee scale eligibility.			
1.3.7	The system provides fields that can be used to categorize the patient for reporting. These fields are accessible via the report-writing tool.			
1.3.8	The system has the ability to compute a sliding scale and percentage of poverty based on family size plus income data.			
1.3.9	The system sends alerts after every set period/year to ask the patient for proof of document for sliding scale.			
1.3.10	The system retains past fee guidelines and schedules for sliding scales.			
1.3.11	The system tracks the status of each outstanding guarantor and third-party insurer balance by the age of the balance (in intervals of 30 days up to 180 days) and by whether a minimum payment (percentage basis), a full payment, or no payment has been made against the outstanding balance.			
1.3.12	The system supports the development of budget plans and bills guarantors according to the budget plan agreement.			
1.3.13	Special group accounts are available to handle the situation in which services provided to a large group of patients are billed to a single third-party payor and should not or cannot be billed to the patient's guarantor.			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
1.3.14	The system can be configured to ignore sliding fee scale on patients with certain insurances.			
1.4	Payment Posting			
1.4.1	The system has the ability to generate reminder notices to patients with expired sliding fee review dates.			
1.4.2	The system maintains a history of statements mailed to patients (required to file for Medicaid bad debts). The history records the date and type of statement sent.			
1.4.3	The collections module allows the user to flag accounts for follow-up and to add special collection accounts.			
1.4.4	The system has the ability to change the sliding fee type of patients with expired sliding fee coverage (temporary category).			
1.4.5	The system has the ability to slide patient balance after insurance payment is received.			
1.5	Statement Generation			
1.5.1	The system has HIPAA-compliant electronic claims interfaces with the following entities:			
1.5.1.1	Labor and Industries.			
1.5.1.2	Medicaid.			
1.5.1.3	Medicare.			
1.5.2	The system is capable of printing a bill at the time of checkout (on demand).			
1.5.3	The system uses claims clearinghouses to submit electronic claims to all entities listed below.			
1.5.3.1	Labor and Industries.			
1.5.3.2	Medicaid.			
1.5.3.3	Medicare.			
1.5.4	If the patient has been identified as eligible for a certain discount percentage, the bills will automatically include the credit adjustment for the discount and the reversing debit adjustment for the discount.			
1.5.5	If a fixed (minimum) co-payment is specified for the system as a whole or for particular accounts (Medicaid indigents), the bill will reflect the associated adjustments.			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
1.5.6	The balance and aging of an account are updated at the time the demand bill is generated and is not delayed until the end of the accounting period.			
1.5.7	The system supports billing by family where all bills associated with members of a family are summarized in a single family account balance.			
1.5.8	The system allows the system manager to modify the format of the patient or family statement/bill without vendor intervention.			
1.5.9	The system automatically determines the sliding fee category based on the family size and income.			
1.5.10	The system has the ability to reprint a day bill on demand.			
1.6	Management Reporting			
1.6.1	Data can be exported, manipulated, and downloaded to Microsoft Access or Excel in the following formats, at minimum: xls, html, xml, and csv.			
1.6.2	The system provides the ability to run all or selected Bureau of Primary Health Care's national goals reports.			
1.6.3	The system provides the ability to run detail data reports to verify the data shown on the Bureau of Primary Health Care's national goals reports.			
1.6.4	The system produces encounters for patients without a third-party coverage report that lists patients' full names, their Social Security numbers, and all encounters and their associated charges within a user-specified date range for patients that show no insurance coverage on their accounts. This report can be used to check eligibility for Medical reimbursement.			
1.6.5	The system is able to provider early intervention program billing and reporting capability.			
1.6.6	The system is able to provide required demographic and statistical reporting capability for the Homeless Persons Health Project.			
1.6.7	The system provides Ryan White reports for HIV patients.			
1.6.8	The system provides dynamic reports that allow the user to view summary information and drill down into detailed information from the report (provider, claim, patient, etc.).			
1.6.9	The system includes a complete set of tools for the development of reports including a library of standard reports used in similar organizations (Crystal Reports, Business Objects, Cognos, etc.).			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
1.7	Remittance Advice Posting			
1.7.1	The system has HIPAA-compliant remittance interfaces to the following payors:			
1.7.1.1	Labor and Industries.			
1.7.1.2	Medicaid.			
1.7.1.3	Medicare.			
1.8	Account Management/Follow-Up			
1.8.1	The system has customizable online work queues to provide follow-up by payor, financial class, balance, etc.			
2	EMR System Functionality			
2.1	General Functionality			
2.1.1	The system has an in-box for managing new information and messages between users.			
2.1.2	The system is CCHIT-certified.			
2.1.3	The system supports industry standard interfaces including HL7, CCR, CCD, CDA and ELINCS at a minimum.			
2.2	Clinical Documentation			
2.2.1	The system supports multiple growth charts based on ethnicity or conditions (Down's Syndrome, premature, etc.).			
2.2.2	The system supports the calculation, display, and printing of patient reminders for health maintenance activities.			
2.2.3	The product offers the flexibility for the client to develop clinic-specific questionnaires, checklists, and flow sheets.			
2.2.4	The system provides the ability to directly capture historical patient data (bubble sheets that can be scanned, waiting room kiosks, patient portal, etc.).			
2.2.5	The system supports the capture of a coded problem list that maps directly to ICD-9 or SNOMED terminology.			
2.2.6	The system captures medical and surgical history in a structured format to allow for use in the calculation of alerts and reminders.			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
2.3	Order Entry			
2.3.1	Health maintenance reminders or interaction alerts can be “turned off” permanently or for definable intervals on a per patient basis once the reason has been documented.			
2.3.2	An interaction alert override history is available for providers to review.			
2.3.3	The provider can be notified if a patient fails to have the test performed at the defined interval.			
2.3.4	The system prioritizes how alerts are shown (e.g., order of severity or order of efficacy of intervention).			
2.4	Population Management and Patient Education			
2.4.1	The system enables the practice to participate in collaboratives for chronic disease management and prevention.			
2.4.2	Providers can create or modify care plans and protocols.			
2.4.3	Tools related to care plans and protocols are updated regularly by the vendor according to evolving care standards.			
2.4.4	The system can suggest interventions at the point of care such as eye exams for diabetics.			
2.4.5	The system can prioritize the interventions mentioned in 2.4.4 in terms of greatest potential benefit.			
2.4.6	The provider can print a patient summary sheet at the conclusion of each visit, providing all recommendations to patients.			
2.4.7	The system provides reference tools for patient education.			
2.4.8	The system allows reference tools to be modified to meet organizational needs.			
2.4.9	The system allows clinical users to use these tools to import educational materials or instructions and modify them for a specific patient.			
2.4.10	Reference tools are available in multiple languages, at lower literacy levels, and in enlarged fonts.			
2.4.11	The system can use diagnoses, medications, lab results, and problem list entries in any combination to identify a population (e.g., two random glucose tests greater than 200 or two fasting glucose tests greater than 126 or any combination within 12 months).			

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Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
2.4.12	The system can produce work lists of patients out of compliance with recommended lab values, lab test intervals, or medication management.			
2.4.13	The system has the capability to allow documentation templates to be set up to require the documentation of certain aspects of care in a format allowing the data to be queried or searched on for population management purposes.			
2.4.14	Once the population has been identified, staff can access or create a work queue of the patients in the population that are delinquent for a test (or meet some other criterion for intervention).			
2.4.15	The system allows staff to navigate from the work queue or list to a particular patient's demographics, to the letter module, or to a patient's chart for documentation.			
2.4.16	The system would help users intervene only once for patients in multiple populations, providing all recommendations appropriate for those patients.			
2.4.17	The system flags in which care management is inconsistent with the indicated disease management protocols.			
2.4.18	The system supports disease management tracking keyed to patient registries to allow automatic tracking of care-specific performance measures.			
2.4.19	The system provides tools for defining and developing disease-specific patient registries for tracking disease management information (e.g., clinical outcomes, complications, healthcare utilization, patient satisfaction, patient self-management, adherence to guidelines, percentage of patients using self-monitoring, and other data elements specific to the disease being managed).			
2.4.20	The system supports time-sensitive, system-produced mailers or letters to alert patients of their need for follow-up care.			
3.0	Dental			
3.1	The system manages dental billing on the latest ADA form.			
3.2	The software can list the:			
3.2.1	Tooth numbers.			
3.2.2	Restorative material description.			
3.2.3	Insurance codes.			
3.2.4	Fees and insurance benefits.			
3.3	The system automatically corrects pictorial charts for the patient to			

**EHR Selection Toolkit for Community Health Centers
Worksheet A: Functional Criteria**

Criteria		Response	Version	Comment
3.4	The system produces a nicely printed chart to for patient education.			
3.5	The system provides automated periodontal charting.			
3.6	The system provides for the integration of extra-oral and intra-oral images.			
3.7	The system has the ability to incorporate digital radiographs.			
3.8	The system supports all ADA-approved treatment and diagnostic codes with associated modifiers particular to the specialty being charted.			
3.9	The system supports on-screen treatment planning.			
3.10	The system provides the ability to generate multiple treatment plans for one patient.			
3.11	The system provides the ability to retain deleted and/or changed treatment plan items and identify them as deleted and/or changed.			
3.12	The system provides the ability to store explanatory notes in association with individual treatment plan items.			
3.13	The system supports the electronic transmittal of treatment plans to third-party carriers for predeterminations.			
3.14	The system automatically calculates insurance benefits and patient financial liability when entering procedures on a treatment plan.			
3.15	The system supports a method to record soft tissue and hard tissue pathology.			
3.16	The system supports sharing of family health history records among family member records.			
3.17	The system provides the ability to calculate DMFT and DMSF from odontogram.			
3.18	The system supports the historical comparisons of clinical observations (e.g., changes in periodontal data over a two-year period).			
3.19	The system provides the ability to store digital diagnostic images for viewing on workstations.			
3.20	The system has the ability to store altered images with time/date stamp and markings denoting them.			
3.21	The system supports full-color chart printing.			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Center/Guarantee Profile Cover Sheet			
Patients by ZIP code, including unknown.			
Table 3A			
Patients by sex and age category:			
Under age 1.			
Age 1.			
Age 2.			
Age 3.			
Age 4.			
Age 5.			
Age 6.			
Age 7.			
Age 8.			
Age 9.			
Age 10.			
Age 11.			
Age 12.			
Age 13.			
Age 14.			
Age 15.			
Age 16.			
Age 17.			
Age 18.			
Age 19.			
Age 20.			
Age 21.			
Age 22.			
Age 23.			
Age 24.			
Ages 25–29.			
Ages 30–34.			
Ages 35–39.			
Ages 40–44.			
Ages 45–49.			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Ages 50–54.			
Ages 55–59.			
Ages 60–64.			
Ages 65–69.			
Ages 70–74.			
Ages 75–79.			
Ages 80–84.			
Ages 85 and over.			
Table 3B			
Number of patients by ethnic category:			
Asian.			
Native Hawaiian.			
Other Pacific Islander.			
Black/African American.			
American Indian/Alaska Native.			
White.			
Hispanic or Latino.			
Unreported/refused to report.			
Number of patient best served in a language other than English.			
Table 4			
Income as a percentage of Federal Poverty Level:			
100% and below.			
101% to 150%.			
151% to 200%.			
Over 200%.			
Unknown.			
Principal third-party insurance source by age groups of: 0–19 years including the following categories:			
Regular Medicaid.			
SCHIP Medicaid.			
Other public insurance non-SCHIP.			
Other public insurance SCHIP.			
Principal third-party insurance source by age groups of: 20 or older, including the following categories:			
Regular Medicaid.			
SCHIP Medicaid.			
Other public insurance non-SCHIP.			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Other public insurance SCHIP.			
Number of patients with the following characteristics:			
Migrant.			
Seasonal.			
Homeless shelter.			
Transitional.			
Doubling up.			
Street.			
Other.			
Unknown.			
Table 5			
Number of encounters with family practitioners.			
Number of encounters with general practitioners.			
Number of encounters with internists.			
Number of encounters with obstetricians/gynecologists.			
Number of encounters with pediatricians.			
Number of encounters with other specialty physicians.			
Number of encounters with nurse practitioners.			
Number of encounters with physician assistants.			
Number of encounters with certified nurse midwives.			
Number of encounters with nurses.			
Number of encounters with dentists.			
Number of encounters with dental hygienists.			
Number of encounters with psychiatrists.			
Number of encounters with other licensed mental health providers.			
Number of encounters with substance abuse services.			
Number of encounters with other professional services.			
Number of encounters with case managers.			
Number of encounters with educational specialists.			
Number of encounters with outreach workers.			
Number of encounters with transportation staff.			
Number of encounters with other enabling services.			
Number of encounters with administrative staff.			
Number of encounters with facility staff.			
Number of encounters with patient services support staff.			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Table 6			
Patients and encounters with a primary diagnosis of symptomatic HIV (ICD-9 042.XX).			
Patients and encounters with a primary diagnosis of asymptomatic HIV (ICD-9 V08).			
Patients and encounters with a primary diagnosis of tuberculosis (ICD-9 010.XX – 018.XX).			
Patients and encounters with a primary diagnosis of syphilis and other sexually transmitted disease (ICD-9 090.XX – 099.XX).			
Patients and encounters with a primary diagnosis of asthma (ICD-9 493.XX).			
Patients and encounters with a primary diagnosis of chronic bronchitis and emphysema (ICD-9 490.XX – 492.XX or 496.XX).			
Patients and encounters with a primary diagnosis of abnormal breast findings (ICD-9 174.XX, 198.81, 233.0X, or 793.8X).			
Patients and encounters with a primary diagnosis of abnormal cervical findings (ICD-9 180.XX, 198.82, 233.1X, or 795.0X).			
Patients and encounters with a primary diagnosis of diabetes mellitus (ICD-9 250.XX, 775.1X, or 790.2).			
Patients and encounters with a primary diagnosis of heart disease (ICD-9 391.XX – 392.0X or 410.XX – 429.XX).			
Patients and encounters with a primary diagnosis of hypertension (ICD-9 401.XX – 405.XX).			
Patients and encounters with a primary diagnosis of contact dermatitis and other eczema (ICD-9 692.XX).			
Patients and encounters with a primary diagnosis of dehydration (ICD-9 276.5X).			
Patients and encounters with a primary diagnosis of exposure to heat or cold (ICD-9 991.XX – 992.XX).			
Patients and encounters with a primary diagnosis of otitis media and eustachian tube disorders (ICD-9 381.XX – 382.XX).			
Patients and encounters with a primary diagnosis of selected perinatal medical conditions (ICD-9 770.XX, 771.XX, 773.XX, 774.XX – 779.XX, excluding 779.3X).			
Patients and encounters with a lack of expected normal physiological development but does not include sexual or mental development or nutritional deficiencies (ICD-9 260.XX – 269.XX, 779.3X, 783.3X – 783.4X).			
Patients and encounters with a primary diagnosis of alcohol-related disorders (ICD-9 291.XX, 303.XX, 305.0X, 357.5X).			
Patients and encounters with a primary diagnosis of other substance-related disorders (excluding tobacco use disorders) (ICD-9 292.1X – 292.8X, 304.XX, 305.2X – 305.9X, 357.6X, 648.3X).			
Patients and encounters with a primary diagnosis of depression and other mood disorders (ICD-9 042.XX).			
Patients and encounters with a primary diagnosis of anxiety disorders, including PTSD (ICD-9 042.XX).			
Patients and encounters with a primary diagnosis of attention deficit and disruptive behavior disorders (ICD-9 042.XX).			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Patients and encounters with a primary diagnosis of other mental disorders, excluding drug or alcohol dependence (ICD-9 042.XX).			
Patients and encounters with the following diagnostic test, screening, or preventative service: HIV test (CPT-4 86689, 86701 – 86703, 87390-87391).			
Patients and encounters with the following diagnostic test, screening, or preventative service: mammogram (CPT-4 86689; 86701– 86703, 87390-87391).			
Patients and encounters with the following diagnostic test, screening, or preventative service: Pap test (CPT-4 86689, 86701 – 86703, 87390-87391).			
Patients and encounters with the following diagnostic test, screening, or preventative service: selected immunizations (CPT-4 86689, 86701 86703, 87390-87391).			
Patients and encounters with the following diagnostic test, screening, or preventative service: contraceptive management (CPT-4 86689; 86701 – 86703, 87390-87391).			
Patients and encounters with the following diagnostic test, screening, or preventative service: health supervision of infant or child (CPT-4 86689; 86701 – 86703, 87390-87391).			
Patients and encounters with the following selected dental services: emergency services (ADA: D9110).			
Patients and encounters with the following selected dental services: oral exams (ADA: D0120, D0140, D0150, D0160, D0170, D0180).			
Patients and encounters with the following selected dental services: prophylaxis – adult or child (ADA: D1110, D1120, D1201, D1205).			
Patients and encounters with the following selected dental services: sealants (ADA: D1351).			
Patients and encounters with the following selected dental services: fluoride treatment – adult or child (ADA: D1201, D1203, D1204, D1205).			
Patients and encounters with the following selected dental services: restorative services (ADA: D21XX, D23XX, D27XX).			
Patients and encounters with the following selected dental services: oral surgery (ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280).			
Patients and encounters with the following selected dental services: rehabilitative services (ADA: D3XXX, D4XXX, D5XXX, D6XXX, D8XXX).			

EHR Selection Toolkit for Community Health Centers
Worksheet B: Uniform Data Set Reporting Requirements for Federally Qualified Health Centers

Reporting Requirement	Number of Patients ¹	Number of Encounters ^{1, 2}	Application Supports Reporting Requirement
Table 7			
Total patients known to be HIV+ pregnant women.			
Demographic characteristics of prenatal care patients by age group: less than 15 years, ages 15–19, ages 20–24, ages 25–44, ages 45 and over.			
Number of prenatal patients by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Prenatal care patients who delivered during the year by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Deliveries performed by grantee provider by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Births less than 1,500 grams (very low) by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Births 1,500 to 2,499 grams (low) by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Births 2,500 grams or more (normal) by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Prenatal care patients who received post-partum care within 8 weeks of delivery by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Infants delivered who received newborn visit within 4 weeks of birth by ethnic category: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, Hispanic or Latino, unreported/refused to report.			
Enrollment of prenatal care patients in WIC.			
Enrollment of infants of prenatal care patients in WIC.			
Enrollment of postpartum care patients in WIC.			

1. Encounter definitions are needed both to determine who is counted as a patient (Tables 3A, 3B, 4, and 6) and to report total encounters by type of provider staff (Table 5). Encounters are defined to include a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. To be included as an encounter, services rendered must be documented. Encounters which are provided by contractors, and paid for by the grantee, such as Migrant Voucher encounters or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be encounters to be counted on the UDS to the extent that they meet all other criteria.

2. Areas in grey do not require a response.