

NCFH Comments Regarding HRSA Proposed 2008 UDS Reporting Manual

The National Center for Farmworker Health (NCFH) provides general and table-specific comments on the proposed changes to the 2008 UDS Reporting Manual.

General Comments

- We believe that it is very important that HRSA be more specific in explaining the rationale behind the proposed changes to the UDS. If the proposed changes are intended to align health center reporting with HEDIS and other industry reporting methods, the PIN should make that intention clear. As the proposed changes stand, policy makers will lose rather than gain meaningful data on health center patients in general, and special populations in particular, because less rather than more meaningful data will be collected on special populations.

Response: The program data and the clinical measures proposed in the UDS are used to track health center performance and monitor use of grant funds. They also will result in HRSA's ability to make stronger statements about the Health Center Program through performance measurement, as well as, provide trend statistics related to underserved populations served within the Health Center setting.

With respect to the clinical measures, these measures support HRSA's effort to improve the program's ability to demonstrate its impact and effectiveness for patients, payers, and the American public, as well as provide guidance for program improvement.

The measures are aligned with national quality standards for ambulatory care programs, i.e., those of the Ambulatory Quality Alliance (AQA), the National Quality Forum (NQF), and the National Committee for Quality Assurance (NCQA). They represent clinical care across the patient life cycle (i.e., newborn, childhood, and adult life cycles); and are indicative of the most prevalent conditions and preventive services addressed within the health center patient population.

Finally, it is noted that many grantees and partners sought to retain data tables and elements that were proposed to be reduced, and several of these were retained.

- HRSA has collected program specific UDS data on farmworkers and other special populations for just two years. Policy makers require trend data to monitor program impact over time and to fine-tune modifications when these are required to improve program performance. NCFH asks that modifications to the UDS be delayed until 2010 to allow for at least five years of program specific trend data and to allow for adequate time to retool health center MIS data systems.

Response: See response to Table 6 below.

- NCFH encourages HRSA to bring together health centers and others from the broader research community to provide collective input into the direction for modifications before changes are made to the UDS. HRSA should solicit input and analysis from a coalition of health, program and performance measurement specialists, including, for example, the government and independent sources recommended for use by health centers in HRSA's Need for Assistance worksheet guidance.

Response: HRSA has vetted proposed changes widely with grantees and partners, and has responded by accepting many of their recommendations.

- NCFH encourages HRSA to improve public access to the data reported by health centers. If this is not possible, HRSA should at least make customized data reports which exclude confidential data available upon request.

Response: HRSA will make data available in general reports and to the public upon request. (Also see responses to Table Specific Comments and Table 2 below.)

- NCFH commends HRSA for the addition of the childhood lead screening rate to data proposed for reporting in calendar year 2008. The addition of quality indicators to data proposed for reporting is also a strong and positive development.

Table-Specific Comments:

Cover Sheet:

With the removal of most elements of the Center/Grantee Profile from data reported on the UDS cover sheet, we anticipate that retrieving this data, once

archived, may be difficult. It is not clear at what point the grantee profile and data reported through the UDS will be reconciled.

Response: The proposed changes in data collection are intended to increase HRSA/BPHC efficiencies and reduce redundancies in data acquisition and management. Specifically, data equivalent to the grantee profile information currently in the UDS will be collected through grant applications and stored electronically. This information will be made available in periodic reports, as well as to the general public upon request. Also, information required by partner organizations to perform functions under contractual or grant agreements with BPHC will be made available to them.

Table 2:

By eliminating the collection of information about services and delivery methods from grantees, it is not clear how HRSA will be able to assess a health center's compliance with the required panel of comprehensive primary care, mental health and dental services.

Response: The proposed changes in data collection are intended to increase HRSA/BPHC efficiencies and reduce redundancies in data acquisition and management. Data equivalent to the sites and services information currently in the UDS will be collected through grant applications and stored electronically. This information will be made available in periodic reports, as well as to the general public upon request. Also, information required by partner organizations to perform functions under contractual or grant agreements with BPHC will be made available to them.

Table 5:

By eliminating the collection of information about staffing patterns and utilization, including the number of patients per FTE practitioner type and some encounter and provider data, HRSA's ability to assess a health center's productivity and penetration rate may be jeopardized.

In addition, in the absence of reported information, underperformers may go unnoticed contributing to problems with community access to care. Quality of care issues may remain unnoticed in the case of overachievers who place productivity above requirements for comprehensive patient care.

Response: Eliminating the collection of information about staffing patterns and utilization is not proposed.

Table 6:

Eliminating the collection of information about clinical diagnosis and services rendered has serious implications for all groups served by health centers, but especially for special populations such as farmworkers.

- It was not until two years ago that HRSA requested program specific UDS reports and obtained diagnostic data for farmworkers and other special populations. By eliminating the elements of the current Table 6, HRSA will no longer be able to compare the most common diagnoses among special populations against those of the general public.
- Without information about clinical diagnoses, there will be no solid evidence to substantiate the need for developing disease specific prevention and education initiatives.
- The elimination of diagnoses reported in the current Table 6 may make it difficult to advocate for federal, state and local funds to support programs to prevent these health conditions.
- Specifically for farmworkers, the elimination of diagnoses currently reported will prevent determination of the prevalence of health problems attributed to occupational and environmental health hazards.
- The elimination of diagnoses currently reported may jeopardize the ability of health centers to monitor progress in their health care plans.
- Regarding the proposed new Table 6, as the methodology to be used to report quality of care indicators does not address services delivered specifically to farmworkers and special populations, it may be difficult to determine the quality of care rendered to these populations.

Response: In response to these comments, the previous Table 6 will be retained and relabeled Table 6A. The “new” Table 6, Quality of Care Indicators, will be relabeled Table 6B. In an effort to minimize current grantee reporting burden, only primary diagnosis (as is currently requested) will be collected on the Table 6A.