



Health Care Access for All

June 6, 2007

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HRSA Reports Clearance Officer
Room 10-33, Parklawn Building
5600 Fishers Lane
Rockville, MD. 20857

**Re: Request for Comments,
Agency Information Collection**

The California Primary Care Association (CPCA) is pleased to have the opportunity to respond to HRSA's 60-day request for comments placed in the Federal Register of Friday, April 13, 2007 at page 18661. We are responding on behalf of the California Primary Care Association (CPCA), the HRSA recognized "Primary Care Association" for the state of California, and on behalf of our 105 HRSA funded Community Health Centers. These centers represent in excess of 10% of all the agencies who will be required to submit the information identified in the Federal Register announcement and, as such, will be required to put forth a substantial portion of the effort and bear a substantial portion of the cost of these changes.

In this submission we will address four separate issues. The first is the lack of completeness in the Federal Register announcement and accompanying reference materials. Items two and three address problems with the quality utility and clarity of information to be submitted: The second is the need of the California Primary Care Association (and others similarly situated) for some of the data which will be eliminated by the proposed changes. The third is the inadequacy of the data to be collected to serve as a surrogate for evaluating either the Community Health Center program as a whole or any of the grantees individually. Finally, the fourth item addresses the agency's estimate of the burden of the proposed data collection and specifically, the level of effort which will be required to perform the analysis required by the data request changes.

This information is based on both our own experience with the UDS *and* the CPCA Data Committee which surveyed their own and other health centers to obtain information about data collection burden and utility of data.

1. Inadequacy of the Announcement.

The appropriately brief announcement indicated that detailed information could be obtained by contacting the HRSA Repots Clearance Officer which we did. We were then directed to a web site maintained by the Bureau of Primary Health Care and a document called the 2008 UDS Manual. The document, however, was *not* the manual. Instead, it was copies of the tables and a statement of which tables would be changed. *No instructions, which normally take up nearly 100 pages in the UDS Manual, were included.* Since the level of burden and the quality, utility and clarity of the information to be collected is totally dependent on these instructions, our comments are, of necessity, tentative.

We formally request that the announcement be reissued with the full information included so that it would be possible to fully evaluate impact, cost, burden, and accuracy.

2. Enhancing the quality, utility, and clarity of the information to be collected:

2.1. CPCA's ongoing need for data identified for elimination.

As a HRSA-BPHC funded Primary Care Association, it is our responsibility to make known the quality and quantity of services rendered to the medically uninsured and underinsured, and to advocate for these populations. To do so, it is critical that we have information about both the CHCs serving the population and their patients. This has traditionally been made available to us through UDS data including information on Tables 2, 6, and 7 which are slated for partial or total elimination.

- **Table 2: Services Provided.** Table 2 provides a listing of some 77 services which are of value to the target population. Each responding health center checks whether or not they provide the service and how it is provided. Our CHC representatives tell us that this table takes less than an hour to complete initially and a fraction of that time to revise annually. No burden is relieved by its elimination.

On the other hand, the information contained in this table permits CPCA to describe the CHCs in California. We proudly point, for example, to the fact that 100% of CHC grantees in California provide or provide for diagnostic lab, diagnostic x-ray, family planning, and HIV testing and counseling. Similarly, 100% provide gynecological care and prenatal care; 99% provide dental care and mental health treatment/counseling, and so on. To lose this valuable tool will only make our job of advocating for CHCs in California that much harder.

- **Table 6: Selected Diagnoses and Services.** Table 6 – a source of information on the patients we serve and the services we provide to them – would be totally eliminated. When we talk about the patients we serve, it is extraordinarily important to be able to say that, for example, in 2005 422,675 patients were served who had a primary diagnosis of diabetes or that 376,602 had a primary diagnosis of hypertension. CHCs do the preventive health care for the community (over 500,000 children received well child care) but they also treat the chronically

ill patients for whom treatment is essential. This tool is similarly valuable and important to our function.

- Table 7: Perinatal Profile. Liens 3 through 8 would be eliminated (among others.) The information showing that health centers delivered 32,416 women in 2005 should be retained and is meaningful. But equally meaningful in telling the story of the health centers is the fact that 17.2% of those mothers were teenagers, and that 280 were less than 15 years old. This detail would be lost. We also would lose the fact that during that year nearly twice as many women (62,190) were provided with perinatal care. We need this information as well.

2.2. Grantees may well be unfairly evaluated with the measures proposed and HRSA inappropriately found to fail.

New data are to be collected in tables numbered 6 and 7 and designed to measure “Quality of Care” and “Health Outcomes and Disparities.” Because the instructions are not provided, we remain unclear about what will be measured, but the potential for misrepresentation and damage is great. (The burden involved will be discussed later.)

- Table 6: Childhood Immunization Rate. Table 2 asks as seemingly simple question: What proportion of the children served by the CHC were fully immunized on their second birthday? But the devil lies in the details which are omitted from the Federal Register notice and the accompanying materials. California’s CHCs provide ongoing care for hundreds of thousands of children, including roughly 50,000 who would have turned two in 2005. Many, if not most, are our regular patients. But a large (though unknown) number may have come in once for an acute illness because they could not get to their regular doctor, and then never again. Another 40,000 were seen in their first year and never again.

One group of six clinics responded in detail as follows:

“Our consortia recently wrote a federal grant in which we were asked to include the immunization data for 2-year-olds in the same format as the new UDS reports. It was impossible for any of our six clinic members to get accurate data on this, with the significant exception of one of our clinics who participated in the Statewide Immunization Registry. One of our clinics did pull charts in order to figure out her vaccine rate and found that only 2 out of 38 2-year-olds APPEARED to be up to date on their vaccines. The problem is that parents bring their child to the local pediatric group for well-child visits, maybe go to the Dept. of Public Health once in a while for a vaccine, and end up going to the clinic when their child is sick for a single or two appointments in the span of a year. So, even though the child is counted as a clinic patient, the child is really getting their immunizations at another location. So, clinic records are either incomplete in terms of vaccinations, or are missing altogether (because the kid came in for poison oak or an ear infection, and vaccine information wasn’t collected and/or documented.) Thus, it generates artificially low vaccination rates for our clinic patients.”

California CHCs would limit this variable to those children who were seen during the reporting year and who had been seen at least three times in the two years prior to their second birthday. If this is not done, the CHCs and HRSA will appear negligent.

- Table 6: Childhood Lead Test. A second question is asked about lead testing: What proportion of children served by the CHC received testing for elevated lead levels by the age of three. This question no doubt seems reasonable to people in Washington D.C. where the old lead paint in apartments where the indigent live often provides a source of lead poisoning to children. This is so much not the case in the west that, at least in California, our clinicians rarely conduct lead screening tests. Instead a risk assessment is routinely done and, if exposure is indicated, then, and only then, is a test ordered.

But even if the language were changed to risk assessment or testing, we are still facing the problem of who we would look at. In California, a quarter of a million children were under the age of three at some point in 2005. Of these, tens of thousands were never in the practice long enough to be tested and many – probably in excess of 50,000, had not been seen for over a year.

California CHCs would limit this variable to those children who were seen during the reporting year, who had been seen at least three times in a period of not less than six months nor more than two years, and would count *in compliance* children who had a risk assessment as well as those who had a blood test. If this is not done, the CHCs and HRSA will appear negligent.

4. Burden statement.

The current UDS carries with it a stated burden of 24 hours. The Federal Register suggests it would increase to 30 hours or an additional six hours. Removal of Table 2 would not have reduced the burden at all, but removal of table 6 and part of 7 would have removed some portion. Grantees suggest that, compared to the financial tables, the amount would have been minimal. Most have practice management systems which provide the numbers which are then just copied into the form. It would appear that, at most, the estimated burden of adding the clinical tables is one person day or eight hours.

Grantees representing roughly 10% of CPCA's BPHC funded members responded to a request to estimate the burden involved in responding to the clinical items. The four which were most clearly quantified are summarized here. We assume that the five new measures will each require 70 charts to be pulled, or a total of 350 charts:

- Agency #1. Immunization data are available from a registry. The time to collect was thought to be relatively minimal. To collect data for lead test screening and Pap tests would take 15 hours each. To collect hypertension and A1c data would take 23 hours each or a total of 76 additional hours.
- Agency #2. Chart reviews would take approximately 20 minutes per chart for each of the variables or a total of $(350 * 20 / 60)$ 116 additional hours.
- Agency #3. Chart reviews would take an average of 17 minutes per chart, however the time they felt it would take to find and replace the charts was

probably excessive. Cutting this time in half brings us to 10 minutes per chart or $(350 * 10 / 60)$ 58 hours.

- Agency #4. Chart reviews took as much as 20 minutes at first, but settled down to 10 minutes per chart. Using 10 minutes we again get 58 hours.

What is most remarkable is the relative consistency of the estimates, with three of them in the 58 to 76 hour range and one at 116. What is most notable is that none of them come even close to what we would consider to be the roughly eight hour HRSA estimate of added burden. The burden statement seems to be off by an order of magnitude or more! The overall burden would appear to increased by as much as 300% with the addition of these elements. We understand that a pretest was done to assess the burden but that it was completed after the April 6 drafting of the Federal Register notice.

Sincerely,

Amanda Stangis
Director of Programs
California Primary Care Association