Health Resources and Services Administration
Health Center Controlled Networks Progress Reports
Responses to Questions from OMB on HCCN ICR

Please provide a justification for 2 identical progress reports per year (one at 6 months, one at 12 months). The explanation provided in supporting statement #6 provides justification for annual reporting requirements, but does not provide the rationale for a 6 month reporting requirement. Does HRSA expect responses to change within 6 months, even for things like health outcomes?

Response: The six-month report covers progress made by the grantee during the first six months of the grant, and is useful as a tool for monitoring grantee progress. The grantee gives us a baseline of issues that they plan to improve, and the six-month report will assist us in monitoring performance and progress made from that baseline. This report will also help us identify grantees that need technical assistance early in the cycle in achieving the aims of their grant funding. HRSA does not expect substantial changes in responses within 6 months; however, the 6 month reporting period is considered important for monitoring grantee progress for these funding initiatives. The information will be used to ensure compliance with conditions of award and will also help to identify potential areas for providing technical assistance.

Please explain how this ICR will interface with the UDS. The UDS is also collecting outcome information about immunization rates and diabetes outcomes. Is this duplicative? Can the information required here be gleaned from the UDS instead?

Response: Although the UDS is collecting information about immunization and diabetes, this activity does not duplicate the UDS collection. The UDS collects information from health centers receiving funding under Section 330 of the Public Health Service Act, obtaining information on the population served specifically by the funded grantee. The HCCN is a *network* that must consist of at least three collaborator organizations, and the population of the network does not match that of the UDS respondents. HCCNs are led by HRSA funded health centers, but often include other public or private non-profit health care providers who come together to form the network. As a result, the information for the HCCNs cannot be gleaned from the UDS.

What type of guidance will HRSA provide respondents on how to measure these outcomes? For example, the NQF requires 2 face-to-face visits for the diabetes measure when using electronic health records. Is this information provided somewhere? And if respondents are able to select 3 additional performance measures of their choosing, how will HRSA determine whether the respondent is measuring this measure reliably and that it is a valid measure of what they are trying to assess?

Response: As the report was being developed, HRSA consulted with grantees in conference calls to discuss the technical requirements of the measures, and also

provided the National Quality Forum specifications as an additional resource. The information on the health outcome measures has been aligned with the NQF specifications. The requirement for 2 face-to-face visits for the diabetes measure has been provided in the NQF National Voluntary Consensus Standards for Adult Diabetes Care, and the immunization measure specifications are provide in the NCQA Specifications of National Voluntary Consensus Standards for Ambulatory Care: Childhood Immunization Status. HRSA will also provide ongoing technical assistance and consultation with funded grantees, and recognizes the importance of assuring that the measure specifications are aligned with the NQF measures.

Regarding the three additional performance measures, we have asked grantees to propose measures that they determine reflect their project goals in their community. The aims for improvement from which they can propose measures are built around the core needs listed in the Institute of Medicine 2001 Report: *Crossing the Quality Chasm: A New Health System for the 21st Century.* The IOM report recommended six specific aims for improvement in health care: that it should be safe, effective, efficient, personalized, timely, and equitable. The grantees have the flexibility to propose measures that are tailored to their network. HRSA recognizes that there are limitations regarding validity of the proposed measures; however, the measures will not be compared across any of the grantees or networks. Reports on these measures will be used to see if progress has been made from the baseline on the measures that the grantee has proposed. Again, the goal was to allow grantees flexibility to propose measures and outcomes most applicable to their network and community.

How will the grantee's reporting of outcome measures (e.g. the immunization and diabetes measures) show HRSA that it is the implementation of health IT that is leading to these results? How will the cause/effect relationship be established?

Response: Health IT is a tool to collect, maintain, and provide information that can then be used to make changes and improvements in practice. HRSA does not expect a clear causal relationship between the implementation of health IT and the proposed outcome measures. There are too many confounding elements to have a clear direct relationship between these two variables. Having said this; however, the implementation of health IT can certainly contribute to improvement in the outcome measures, by improving accuracy and reliability of information, and by providing clinicians with real-time information while they are seeing patients. One IT example is clinical decision support (CDS), which can provide clinicians and patients with clinical information for immediate use during the patient visit. This includes reminders messages that a patient is overdue for their next immunization at the time they are being seen by their clinician, or alerts for drug allergies and interactions at the time a medication is being considered. Information can be provided at the point of care which can be immediately used for decision making. HRSA is not predicting a direct causal relationship between the implementation of health IT and the outcome measures; but health IT is considered an increasingly important element supporting the delivery of quality healthcare.