Supporting Statement
Health Resources and Services Administration: Uniform Data System

A. JUSTIFICATION

1. Circumstances of Information Collection

This is a request for a non-substantive change to the currently OMB approved Uniform Data System (UDS), the annual reporting requirement for health centers funded under Section 330 of the Public Health Service (PHS) Act. The non-substantive change relates to Table 3B – Users by Race and Ethnicity and how grantees are to capture and report those data. The Health Resources and Services Administration (HRSA) has responsibility for the administration of the health center programs. An extension of the UDS was recently approved under OMB No. 0915-0193 and expires on 7/31/2010.

The Bureau of Primary Health Care (BPHC) in HRSA has the responsibility for and oversight of programs designed to provide health services to medically underserved and vulnerable populations. These populations include the poor and near poor, migrant and seasonal farm workers, the homeless, and residents of public housing. The overall mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

Health centers receive funding and support from a variety of sources, and HRSA grant dollars represent approximately 25% of health center revenues. Federally qualified health centers include centers that receive federal grants under Section 330 of the PHS Act and centers that qualify for special payment rates from Medicare and Medicaid because they meet the 330 grant requirements.

The term "health center" refers to a variety of different organizations and programs covered by subsections of Section 330. There is no "model" for health centers, yet all health centers share similar attributes, including the goal of providing primary and preventive health care services to underserved populations, and the delivery of high quality clinical services to those they serve.

Health centers are authorized to provide primary and preventive services to medically underserved and vulnerable populations. These populations face great barriers in accessing and obtaining primary and preventive services. Funded health centers form an integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, and public housing residents. Over14 million people are served annually by health centers that would otherwise lack access to primary care providers.

The UDS is the annual reporting requirement for HRSA grantees that receive funding under the following primary care programs:
- Community Health Center (CHC) Program, Section 330(e) of the Public Health Service Act.
- Migrant Health Center (MHC) Program, Section 330(e) of the Public Health Service Act.
- Health Care for the Homeless Program, Section 330(h) of the Public Health Service Act.
- Other 330 funded Grantees

Annual data are required from these grantees to ensure compliance with legislative mandates, to report to Congress and policy makers on program accomplishments and performance, and to prepare HRSA's annual performance plan and budget. No substantive changes have been made to the current UDS. This request is for a single non-substantive revision to the amended race/ethnicity table, which is detailed in the attachment. Three columns regarding ethnicity to Table 3B (Race/Ethnicity by Users) have been added for Hispanic, Non-Hispanic, or Unreported/Refused to Report and indicate how grantees will report race and ethnicity data.

The UDS provides the ability to better demonstrate the quality and value of the health center program through the use and reporting of well-accepted evidence based measures of quality and other performance measures. A key component of success of the Health Center Program has been the ability to demonstrate to payers and patients the value of care delivered to those receiving health center services. The expansion of the Health Center Program and the resulting growth in the number of health center patients and services, along with provider incentive programs and technological advances, have underscored the importance of demonstrating health centers' high quality care to underserved populations. This long-standing emphasis on demonstrating value is consistent with the Department of Health and Human Services initiatives to increase transparency in health care and promote value-based purchasing; transparency and information technology are essential facilitators of increasing value in health care.

HRSA has adopted a set of 12 nationally-standardized (i.e. HEDIS, AQA, NQF, NCQA) clinical core measures as the basis for an Agency-wide quality improvement initiative to span grantee delivery sites that provide clinical care and/or provide referrals for clinical care. The measures encompass six key areas that cut across multiple bureaus, programs and health service delivery grantees: prenatal care, HIV perinatal care, cancer, immunizations, cardiovascular hypertension and diabetes.

2. Purpose and Use of Information

A core set of data are required annually to administer the grant programs funded under Section 330. The UDS is the tool that is used for monitoring and evaluating health center performance, and for ensuring compliance with legislative mandates. The UDS yields consistent information on patient characteristics and clinical conditions that can be compared with other national and state data. These data are also essential in assuring compliance with legislative mandates, facilitating reports to Congress, confirming accomplishments under the President's Health Center Initiatives, and reporting on the Government Performance Review Assessment (GPRA). The UDS is the mechanism used by HRSA to obtain these standardized data elements from funded health centers.

The type of data requested in the UDS provides program information on the following: the total number of low income and/or uninsured people served; services utilized and diagnoses made; services offered that are distinct from other providers of primary care (e.g., enabling services); and, staffing for major service categories.

In addition to program data, the UDS collects a small set of clinical measures that emphasize clinical performance and health outcomes. The set of clinical measures relate to:
- Newborn low birth weight

- Childhood immunization
- Childhood blood lead levels
- Entry into prenatal care
- Cervical cancer screening
- Adult Hypertension (blood pressure levels)
- Adult Diabetes (HbA1c levels)

The UDS provides data for these and other performance indicators. In addition, the UDS provides information to address the following OMB approved efficiency measures, common measures used for certain health systems in the Department of Health and Human Services.

The UDS provides uniformly defined data for HRSA's health center grant programs using standard formats and definitions. In addition, it yields consistent information on patient characteristics and clinical conditions that can be compared with other national and state data.

The UDS consists of two separate components. The first component is the *Universal Report,* which is completed by all grantees and contains nine tables. This report provides data on services, staffing, and financing across the five primary care system development programs included in the UDS.   The second component is the *Grant Report,* which provides information on the characteristics of users whose services fall within the scope of a project funded under a particular grant. Each Grant Report includes three basic tables that employ the same formats and definitions as the Universal Report.

Grantees that receive only one BPHC grant or that receive only CHC and MHC grants are required to complete only the Universal Report. Multiple-award grantees other than C/MHC grantees complete a Universal Report for the combined projects and a separate grant report for each Homeless or Public Housing program grant.

3.   Use of Improved Information Technology

UDS reporting is completed by grantees using a web based data collection system that is completely integrated with HRSA Electronic Handbooks (EHBs). HRSA EHBs already provides authentication and authorization services to all HRSA customers, and integration with that system means that the applicants or grantees will not have to remember multiple usernames and passwords.

Respondents submit UDS data using standard web browsers through a Section 508 compliant user interface. The system provides electronic UDS data tables that clearly communicate what is required and guide the respondents in completing their UDS reporting requirement. Usability features such as those that pre-fill data from prior year grant applications based on business rules prevent redundant data entry while other features such as calendar controls to enter date speed up the data entry process. Respondents will be able to work on the forms in part, save them online and return to complete them later. The approach allows applicants to distribute the data entry burden amongst multiple users if required. Business rules that check for quantitative and qualitative edit checks are applied to ensure that the data submitted meets the legislative and programmatic requirements. Respondents are provided with a summary of what is complete and what is incomplete along with links to jump to the appropriate sections to correct the identified incomplete parts.

In addition, BPHC has a toll free hot line on the BPHC ACCESS Bulletin Board to address questions and provide assistance, including MIS concerns and constraints; submit330uds@bphcdata.net and 1-866-uds-help

4.   Efforts to Identify Duplication

HRSA explored alternative sources for the cost information and found that, because of differences in coverage and definitions, there are no other existing sources that could be used for grant monitoring and administration.

5.   Involvement of Small Entities

Every effort has been made to ensure that the UDS contains the minimum amount of data necessary to meet important legislated monitoring and reporting requirements. Duplicative reporting has been eliminated. The UDS builds on data currently collected and maintained by grantees for internal administrative and clinical needs. As such, the UDS imposes few additional data collection demands on its grantees beyond what they are already collecting for internal purposes.

6.   Consequences if Information Were Collected Less Frequently

Grant dollars are awarded annually; therefore, the UDS data are required annually in order to monitor program compliance and administer program funds.

7.   Consistency with Guidelines in 5 CFR 1320.5(d)(2)

The data are collected in a manner consistent with guidelines contained in 5 CFR 1320.5(d)(2).

8.   Consultation Outside of the Agency

The notice required by 5 CFR 1320.8(d) was published in the <u>Federal Register</u> on April 13, 2007.

Representation from the National Association of Community Health Centers (NACHC), and Health Center grantees were consulted in the review of the UDS tables and instructions.

The following individual from NACHC provided review:

John Ruiz and Freda Mitchum
Health Systems Specialist
National Association of Community Health Centers
202-659-8008

The following Health Centers tested the clinical performance measures and provided comment on the UDS reporting:

Ray Otake   Community Health Center Network

510-769-2288

David Campbell
Community Health Network of West Virginia
304-201-5700

Paul Kaye, MD
Hudson River Health Center
914-734-8747

Dexter Pearce
Community Health Centers Inc. of Utah
801-891-5362

Janice Bacon West, MD

G.A. Carmichael Family Health Center
601-859-5213

Debra Gott
East Tennessee State University Health Center
423-439-4068

Anne Evans, Ph.D and LeTesia Guinn
Bethel Family Clinic
907-543-3773

Carla Flaim
Health Care for the Homeless, Inc.
Baltimore, MD 410-837-5533 x335

Additionally, Arthur Stickgold of Stickgold & Associates and John Snow Inc. Mathematical Statistician will provide technical assistance to grantees and their vendors on their data systems and provided consultation and review of the UDS materials; instructions and definitions. The sources consulted determined that the annual burden estimate was reasonable and the instructions were clear.

If OMB approves the revised race and ethnicity collection (Table 3B) then HRSA will:
- Officially notify the 330 funded organizations in the January of 2009.
- Make the 2009 UDS Reporting Manual available in the Summer of 09 to Health Centers via the UDS Web site.
- Introduce the revised Table 3B at the National Association of Community Health Centers in March 2009.
- HRSA will start the trainings for the 2009 UDS reporting late summer/early fall of 2009. In addition to the field training there will be 3 Webex trainings with Web Cast replay. These additional web-based trainings will allow alternate training opportunities to Health Centers staff unable to attend the field trainings.
- HRSA will offer a toll-free line 8:00am - 5:30 pm, Eastern Standard time to address reporting questions and a voice mail will be available for after hours.

9.   Remuneration of Respondents

Respondents will not be remunerated.

10.   Assurance of Confidentiality

No patient/user level information is reported. Only aggregate data are collected. The UDS does not involve the reporting of personally identifiable information about individuals. The UDS specifies the reporting of <u>aggregate</u> data on users and the services they receive, in addition to descriptive information about each funded grantee and its operations and financial systems.

11.   Questions of a Sensitive Nature

There are no questions of a sensitive nature. All information is reported in an aggregate format. Individuals cannot be identified based on these aggregate totals. Grantees leave blank any cells where the total is less than five.

12. Estimates of Annualized Hour Burden

The **revised** burden to modify the table collecting race and ethnicity is shown in the separate row below:

Type of Report	Number of Respondents	Hours per Response	Total Burden Hours	Wage Rate	Total Hour Cost
Universal Report	1,076	59.68	64,212	$18	$1,155,816
Grant Report	150	18	2,700	$18	$48,600
Revised race/ethnicity	1,076	1	1,076	$18	$19,368
Total	1,076		67,998		$1,223,784

Basis for the estimates:

The UDS includes two components:
- The **Universal Report** is completed by all grantees. It consists of all 9 tables captured in UDS reporting. This report provides data on services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.
- The **Grant Reports** are completed by a sub-set of grantees **who receive multiple BPHC grants**. It consists of Tables 3A, 3B, 4, 5, 6A. These reports cover all or part of the elements of five of the Universal Report tables. They provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant.**   Separate Grant Reports are required for the Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees _unless _ a grantee is funded under one and only one of these programs. No Grant Report is submitted for the portion of multi-funded grantee's activities supported by the Community Health Center grant.

13.   Estimates of Annualized Cost Burden to Respondents

There are no capital or start up costs associate with revising the UDS race/ethnicity data tables. Most grantees currently use their automated data systems to capture and maintain data that are reported in the UDS and for reporting to other funding sources. Cost burden is expected to be minimal and is covered in the original estimates of costs for the currently approved UDS.

Furthermore, upon vetting the new format with our grantees and partners, of Table 3B- Users by race/ethnicity, it was found that most grantees already collect and report such race data to payors and other organizations.

14. Estimated Cost to the Federal Government

There will be no additional cost to the Federal Government.

15. Changes in Burden

The current approved OMB Inventory contains 66,912 burden hours for this activity.   This request is a program change for an increase of 1,076 hours, an additional one hour per respondent. The change is due to the following: 1) a one hour increase per grantee due to revised reporting of race and ethnicity data for the Universal Report.

16. Time Schedule, Publication and Analysis Plans

The grantees are required to submit the reports 61 days after the end of the calendar year. No statistical analyses are planned; only summary descriptive reports from the tables will be prepared.

17. Exemption for Display of Expiration Date

The expiration date will be displayed.

18. Certifications

This project fully complies with CFR 1320.9. The certifications are included in this package.

Appendix A: Modifications to the 2008 UDS (New Data Elements to be collected starting with Calendar Year 2009 Reporting.

Table 3B – Patients by Race/Ethnicity/Language

Add 3 columns to the Patients by Race Table; Hispanic, Not Hispanic and Unreported/Refused to Report (See Attached)