The Uniform Progress Reports for HRSA Continuation Training Grants

SUPPORTING STATEMENT

A. Justification

1. Circumstances of Information Collection

This is a request for OMB approval of a revision to the information collection required for performance reporting for the Health Resources and Services Administration (HRSA) Training Grants, under OMB No. 0915-0061, which expires 12/31/2010.

Performance information is collected in the HRSA Performance Report for Grants and Cooperative Agreements (PRGCA). The PRGCA provides HRSA's Bureau of Health Professions (BHPr) with information on grantee activities and performance in meeting approved grant objectives. This report was formerly called the Uniform Progress Report; however, HRSA/BHPr recently changed the name to the Performance Report for Grants and Cooperative Agreements. The report collects program-specific and core performance measures which contributes to data that BHPr uses to report success achieving programmatic and crosscutting goals and in setting new goals for the future. The report also gives program officers information that helps them to provide technical assistance to individual projects as well as to aid them in measuring the progress of grantees in meeting the objectives of their specific grant projects to determine continuing support.

The Affordable Care Act (P.L. 111-148) reauthorized existing programs and created new programs, which provided opportunities to strengthen the Nation's health care workforce. The Affordable Care Act will have an impact across a broad range of health workforce programs by funding scholarships and loan repayment programs already in existence, strengthening infrastructure, and supporting institution and faculty development needs. Section 5303 of the Affordable Care Act creates a new section under Title VII, 748 of the PHSA that authorizes grants to eligible entities for workforce training in general, pediatric, and public health dentistry. Sections 5401, 5402, and 5403 of the Affordable Care Act reauthorized the Title VII diversity programs, including Centers of Excellence, Health Careers Opportunity Program, Area Health Education Centers, and Scholarships for Disadvantaged Students. The Affordable Care Act also updated the primary care training programs under Section 747 of the Public Health Service Act.

Titles VII and VIII of the Public Health Service Act (42 USC 292 et seq.) provided authorization for the training grants which are awarded to educational institutions to increase the supply of primary medical and dental providers, nurses, behavioral and mental health professionals, and public and allied health personnel. Title VII authorized a variety of grants for funds that are used to train health professionals in primary medical and dental care and public health and allied health, and to support the diversity of medical students. Title VIII programs provide funding for basic and advanced nursing education and nursing workforce diversity. This legislation requires that HRSA will develop publish, and implement performance measures and publish guidance for program evaluations.

Legislative Background

The initial legislative purpose of the Title VII, created in 1963, was to increase the general supply of physicians. In successive reauthorizations, the focus of the Program shifted to the education and training of primary care providers, later to addressing geographic distribution problems of healthcare providers and, more recently, to education and training of primary care providers to serve medically and dentally underserved communities. Thus, the legislative intent for Title VII, section 747 has evolved over the years in response to changing healthcare workforce needs and demands.

The initial legislative purpose of the programs was to increase the general supply of physicians and to ensure the financial viability of health professions schools as specified by the 1963 Health Professions Education Assistance Act (Public Law 88-129).

Under the 1968 Health Manpower Act (Public Law 90-490), the Program expanded to fund additional initiatives to strengthen, improve, or expand programs to train health professionals.

The 1971 Comprehensive Health Manpower Training Act (Public Law 92-157) increased support for training primary care medical and dental providers, including for the first time physician assistants, improving the geographic maldistribution of providers, and increasing the number of minorities in health professions. It also provided for start-up and conversion grants, financial distress grants, student loans, health professions scholarships, special projects, health manpower education initiative awards, family medicine training grants, postgraduate training of physicians and dentists, and health professions faculty development.

The 1976 Health Professions Education Assistance Act (Public Law 94-484) represented a major redesign in primary care training funding and was designed to address specialty and geographic distribution problems.

In 1992, the Health Professions Education Extension Amendments (Public Law 102-408) redefined training in primary care to include increasing the number of primary care providers for medically underserved communities (MUCs), increasing the number of students entering family medicine, and exposing students to primary care in ambulatory settings. This Act added to Title VII, section 747 a focus for providing for MUCs and targeting primary care providers to fill this need. It continued training in family medicine pre-doctoral, graduate, departmental, and faculty development programs; general internal medicine and general pediatrics graduate training and faculty development programs; dentistry graduate programs; and physician assistant programs.

In 1998, the Title VII, section 747 programs were reauthorized under the Health Professions Education Partnerships Act of 1998 (Public Law 105-392). The 1998 Act made programmatic changes including allowing BHPr additional flexibility in allocating funds among disciplines and in modifying grant programs. In addition, the Advisory Committee on Training in Primary Care Medicine and Dentistry was authorized under section 748 of Title VII.

2. Purpose and Use of Information:

The performance report and progress report monitor the grantee's performance in meeting

program objectives and cross-cutting outcomes developed for the Bureau of Health Professions' Title VII and VIII health professions and nursing education and training programs.

This request is to revise and extend the current progress and performance reports as well as adding two programs new to reporting on the Performance Report for Grants and Cooperative Agreements (PRGCA).

1) The State Primary Care Offices are not required by legislation to report on performance metrics but have proactively proposed performance measures in efforts to help the Offices highlight their success in meeting the medically underserved.
2) The State Health Care Workforce Development (SHCWD) Grant Program is a new program authorized under Section 5102 of the Affordable Care Act (P.L. 111-148). Under the ACA, HRSA administers planning and implementation grants for the purposes of enabling State partnerships (a) to complete comprehensive health care workforce development planning and (b) to implement those plans or carry out activities as defined by the State application in order to address current and projected workforce demands within the State. ACA requires that HRSA review reports on development and implementation of evaluation activities including reporting performance information to the National Health Care Workforce Commission.

The list of new measures (labeled 0061 Proposed Revisions) reported in the PRGCA is provided as an attachment, and a list of programs (labeled 0061 Programs) currently using the PRGCA is also provided. The total burden is related both program-specific and core performance measures, and the new programs under the ACA are also adding program-specific measures.

Program-Specific Measures: Collects information on activities specific to the grant objectives. These data are critical to reporting on the actual outcomes of BHPr programs.

Core Performance Measures (CPM): Collects data on overall project performance related to the BHPr's strategic goals, objectives, outcomes and indicators. The CPM's purpose is to incorporate accountability and measurable outcomes into the BHPr's programs, and projects. CPM also provides a framework for collection of data to measure workforce quality, supply, diversity and distribution of the health professions workforce for BHPR's Titles VII and VIII programs. Data collected as core performance measures support the goals for geographic distribution, supply, racial and ethnic diversity and are included in the Annual Performance Plan for BHPr programs subject to the Core Performance Measures.

Examples of the Core Performance Measures in the PRGCA are listed below, and are arranged by HRSA goals and sub-goals listed in italics:

Goall II: Strengthen the Health Workforce
Sub Goal: Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care

- Number of enrollees, graduates and/or program completers of primary care tracks by discipline
- Number of enrollees, graduates and/or program completers of health professions

programs that may support primary care by discipline

Sub-goal- Assure a diverse workforce

- Number of under-represented minorities serving as faculty
- Number of minority/disadvantaged graduates and/or program completers
- Number of minority/disadvantaged enrollees

Sub-goal - Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.

- Number of graduates entering residencies that serve underserved areas
- Number of graduates and/or program completers who enter practice in underserved areas

The entire PRGCA package contains general instructions and definitions, tables for entering program-specific information and tables for entering core performance measures information. The sections on core performance measures instructions and definitions are exactly the same for all grantees. However, the section on program-specific information contains tables which are unique to each of the grant programs.

To reduce the burden on grantees, BHPr ensures that the electronic system customizes reports to only the reporting requirements of each grant program. For instance, after the system displays the common elements like general instructions, definitions, and general program information, it displays the one or two program-specific tables required for the specific program. The system then displays only the Core Performance Measure tables appropriate for the specific program. Customized program-specific reports greatly reduce time and the grantee cost of inputting and processing the data.

3. Use of Improved Information Technology

The PRGCA is fully automated through an Electronic Data Collection Instrument that enables grantees to obtain, complete and submit reports electronically. The Bureau's goals are to: 1) make the reporting process less burdensome for the grantee; 2) have the data be more consistent, aggregate and responsive to Congress' performance requirements; and 3) make the data collection more cost effective for the Government in managing and improving our programs.

HRSA's Electronic Handbook (EHB) provides an integrated system for grantee reporting, allowing grantees access to reports from previous years, current report status, and editing/correcting administrative information. The system automatically displays for grantees the tables and instructions that are specific to their program and continuation request.

4. Efforts to Identify Duplication

These data are not available elsewhere.

5. Involvement of Small Entities

This project does not have a significant impact on small business or other small entities.

6. Consequences if Information is Collected Less Frequently

Performance reports must be submitted annually as a condition of receiving Federal funding. There is no other basis for compliance to receive benefits. Awards may not be made in any year in which a collection of information does not occur.

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

The collection is conducted in a manner consistent with 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* on June 30, 2010 (75 FR No. 125 37815-37816). No comments were received.

The following grantees were contacted by program staff regarding the format, content of data to be collected, and time to complete the report. There were no problems reported.

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NDHHS - Office of Rural Health
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Direct: (402) 471-0148

9. Remuneration of Respondents

Respondents will not be remunerated.

10. Assurance of Confidentiality

No personal identifiable data will be collected.

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour Burden

The total respondent burden is estimated below:

Annual Number of Respondents	Hours Per Response	Total Hour Annual Burden	Dollar Wage Rate	Total Hour Cost
1,100	8.5 hours	9,350 hours	$20	$187,000

Basis for Estimates:

The number of annual respondents (1,100**)** was based upon committed FY 2009 competing awards that use the PRGCA in FY 2010.

Each grantee listed in the attachment must submit a performance report annually. The average burden estimate for reviewing instructions, compiling necessary information, and completing the performance report includes providing information for the standardized elements, program specific data, and CPMS data. The total response burden for performance reporting per grantee is 8.5 hours, and the total annual response burden is 9,350 (1100 respondents x 8.5 hours per response = 9,350 hours)

Twenty dollars is a generally accepted wage rate for school personnel responsible for completing the PRGCA. The total hour cost to the respondents is $187,000 (9,350 burden hours x $20 per hour = $187,000**).**

13. Estimates of Annualized Cost Burden to Respondents

There are no capital and start-up costs to the respondents. Records used for this data collection will be from the previous academic year and generally are already available.

14. Estimates of Annualized Cost to the Government

Monitoring of the data base system is maintained within the Agency. Staff time is required (program staff and grants management personnel) to review the progress reports. Annual total cost of staff time is $138,448.52 as follows:

Program staff evaluates the grantee's accomplishments on the program's objectives and performance measures. Experience indicates that this effort will require one full-time program staff at a GS 13 level for a total of **$**89,033**.**

Grants management staff evaluates the grantee's accomplishments based on the budget requests of the project. It is estimated that this will require 33% of time for two staff at a GS 12 level for a total of $49,415.52**.**

15. Changes in Burden

There are currently 10,500 total burden hours approved by OMB for this activity. This request is for a total of 9,350, a reduction of 1,150 hours.

Program Decrease:
The current number of respondents has decreased since the previous request. The Bureau has undergone reorganization and many programs were removed or transferred from the Bureau.

Adjustments:
The reduction in total burden hours is also attributed to the following: (1) eliminating multiple race combinations for two or more races has decreased the hours per response. Grantees felt it was too complicated to report on the multiple race combinations. (2) Since grantees are aware of the types of data that are being collected, some have automated their data collection activities and are able to gather information quicker and complete their application faster.

16. Time Schedule, Publication and Analysis Plans

The data will not be published beyond the annual Government Performance and Results Act (GPRA) Report as described below. Descriptive statistics and analyses of missing data will be conducted annually. The results will be published in the HRSA Performance Report as is required by GPRA. Annual performance data related to the previous academic school year or previous project year is included in the Online Performance Report and Budget submitted to Congress in February. The reporting periods are identified for each table using the Electronic Handbooks (EHBs).
17. Exemption for Display of Expiration Date

The expiration date will be displayed.

18. Certification

This information collection fully complies with the guidelines set forth in 5 CFR 1320.9.

Attachments

- List of New Measures
- List of Program