Supporting Statement
Health Resources and Services Administration: Uniform Data System

A. JUSTIFICATION

1. Circumstances of Information Collection

This is a request for a revision of OMB approval to collect a revised Uniform Data System (UDS), the annual reporting requirement for health centers funded under Section 330 of the Public Health Service (PHS) Act. The Health Resources and Services Administration (HRSA) has responsibility for the administration of the health center programs under Section 330. HRSA also is responsible for administering the FQHC Look-Alike Program, which is comprised of health centers that meet the requirements of the Health Center Program but which do not receive a grant. The UDS was approved under OMB No. 0915-0193 and expires on 1/31/2014.

The significant growth of the Health Center Program, the advent of incentive-based payment for performance initiatives, and the proliferation of information technology (IT) enhancements within health centers are major factors which have heightened the need to evaluate and revise the performance reporting requirements of the Health Center Program. As health centers receive reimbursement and support through multiple funding streams, improving performance reporting can also reduce the reporting burden of the Health Center Program grantees by aligning health center reporting requirements on clinical performance measures with those of major national quality improvement organizations. Furthermore, enhanced performance reporting will result in the ability to make evidence-based statements about the impact of the Health Center Program on improving access to cost-effective primary care to the nation's underserved populations.

Four modifications to the UDS are proposed for 2012: new clinical measures, a table with staff tenure information for key personnel, reporting health conditions with all (vs. primary diagnoses), and additional questions regarding Electronic Health Record (EHR) reporting capabilities and national quality recognition.

1. New Clinical 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 ten nationally standardized clinical performance measures in the UDS which serve 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. These measures encompass ten

key areas which cut across multiple bureaus, programs and health service delivery grantees. From 2008 through 2010, the following clinical measures have been reported: prenatal access to care, low birth weight babies, Pap test cancer screening, childhood immunizations, hypertension blood pressure control, and diabetes HbA1c levels. In 2011, in response to emerging high department priorities, measures were added for weight assessment and counseling for children and adolescents, adult weight screening and follow up, tobacco use assessment and counseling, and asthma pharmacologic therapy.

The clinical quality measures span the life cycle, represent clinically important conditions and services to program populations, and are used to assess program impact. For the three years of data reporting of these measures to date (2008 through 2010), grantees have provided information that is valuable to them for continuous quality improvement and to HRSA for benchmarking and performance monitoring. All ten of the current performance measures are proposed to be retained in the UDS going forward. Three new clinical measures are proposed for the calendar year (CY) 2012 UDS.

Proposed New Measures:

The following three new clinical measures are proposed for grantee data collection in 2012.

Coronary Artery Disease (CAD): Lipid Therapy
Drug Therapy for Lowering LDL Cholesterol: Percentage of patients 18 years and older with a diagnosis of CAD prescribed a lipid lowering therapy (Based on current ACC/AHA guidelines)

Ischemic Vascular Disease (IVD): Aspirin Therapy
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD) and who had documentation of use of aspirin or another antithrombotic during the measurement year

Colorectal Cancer Screening
Percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer (Includes colonoscopy <=10years, flexible sigmoidoscopy <=5 years, or fecal occult blood test (annual)

Rationale:

- The proposed new clinical measures were selected because they are highly relevant to patients served by health centers.
- The proposed new measures are Meaningful Use measures that eligible providers will report on starting in 2012. These measures are described in the Medicare and Medicaid EHR Incentive Program Final Rule dated

- The modifications to the UDS will result in 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. While collection and reporting of the new measures increases the burden of UDS reporting, the benefits to grantees and the agency are considered to outweigh this additional burden. The program is submitting a revised UDS for review and approval, in order to provide sufficient notification to health centers for this calendar year system.

2. Staff Tenure Information

Currently, staffing information in the UDS is that collected in Table 5, Staffing and Utilization. Table 5 displays types of personnel by major service category, the number of FTE's for each personnel type, and for services providers, the numbers of clinic visits and patients. These data are useful for reporting health center staffing, services provided by type, and for calculations of staffing productivity. However, Table 5 only provides cumulative numbers of FTE's for staff and providers; and they do not capture the length of time (i.e., the tenure) that key personnel work at the health center, a measure of staff retention. These data are essential for addressing the extent to which health centers have a relatively stable work environment that provides continuity of care to their patients.

To better assess workforce needs and improve efforts for workforce development and retention, a new Table 5A, Tenure for Key Staff, is proposed. Table 5A will allow new UDS data collection to:

- Assess numbers of specific primary care providers (e.g., types of physicians, types of nurses)
- Assess approximate degree of retention of staff/providers by determining Average Length of Service (AVL) for each type of staff/provider
- Better assess AVL for health center senior leadership

3. Reporting Health Conditions with All (vs. Primary) Diagnoses

Reporting only primary diagnoses on Table 6A, Selected Diagnoses and Services Rendered, provides a picture of patient health conditions that is less complete than the patient complexity data reported for billing purposes. In order to improve reporting of patient health conditions in the UDS, it is recommended that Table 6A be revised to collect information on patients with multiple diagnoses.

4. Additional EHR and National Quality Recognition Questions

Ensuring that HRSA grantee health centers adopt Electronic Health Records (EHR) is a critical priority, including helping grantees use EHR functionality to obtain Meaningful Use (MU) incentive payments from CMS. At the present time, there are limited data on EHR adoption in health centers. However, the annual UDS report contains data required of all health center grantees, including which centers have adopted EHR systems, what systems they have, and how near they are to meeting the MU requirements. Such data are essential to the provision of necessary and appropriate technical assistance to grantees.

The EHR questions on the 2010 UDS were developed before the MU incentive program (CMS, October 2010) was fully defined in regulations, and represented HRSA's best efforts to capture

information believed necessary to support centers' work to become Meaningful Users of HIT. Over the course of the past year, it has become clear that additional targeted measures are required to properly support the Health Center Program and HRSA objectives for HIT adoption.

The revised UDS EHR questions reflect Stage 1 MU Standards and Measures, and focus more specifically on asking if health center providers are able to meet these requirements and receive incentive payments. In addition, the questions have been modified to more accurately reflect the realities of the HIT vendor environment, and the systems currently in use at and being adopted by health centers.

Two questions are also presented about national quality recognition, an important designation for health centers that distinguishes their quality and coordination of care.

Health Center Program Scope

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 improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.

Health centers receive funding and support from a variety of sources, and HRSA grant dollars represent approximately 20% 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 quality primary and preventive health care services to underserved 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, farm workers, homeless individuals, and public housing residents. Nearly 19 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

- Public Housing Primary Care, Section 330 (i) of the Public Health Service Act

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. Similarly, annual data are required from FQHC Look-Alikes to ensure compliance with legislative mandates and to report to Congress and policy makers on program accomplishments and performance.

2. Purpose and Use of Information

A core set of data are required annually to administer the grant programs funded under Section 330 and FQHC Look Alikes. The UDS is the tool 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 which can be compared with other national and state data. These data are also essential in assuring compliance with legislative mandates, facilitating reports to Congress, reviewing program accomplishments, and reporting on the Government Performance Review Assessment (GPRA). The UDS is the mechanism used by HRSA to obtain these standardized data elements from health centers and FQHC Look Alikes.

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.

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 which 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 will collect a set of clinical measures that emphasize clinical performance and health outcomes. The set of clinical measures relate to:

- Newborn low birth weight
- Childhood immunizations
- Entry into prenatal care
- Cervical cancer screening
- Adult Hypertension (blood pressure levels)
- Adult Diabetes (HbA1c levels)
- Weight Assessment and Counseling for Children and Adolescents
- Adult Weight Screening and Follow Up
- Tobacco Use Assessment and Counseling
- Asthma Pharmacological Therapy
- Coronary Artery Disease Lipid Therapy*
- Ischemic Vascular Disease Aspirin or other Antithrombotic Therapy*

- Colorectal Cancer Screening*

* Proposed new clinical measures for 2012

These measures support BPHC efforts to improve the program's ability to demonstrate its impact and effectiveness for patients, payers, and the American public, as well as to provide guidance for program improvement.

The measures are aligned with national quality standards for ambulatory care programs, e.g., those of 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. They were carefully selected through a deliberative process that included input from HRSA staff and vetting with grantees and partners.

The low birth weight and prenatal access to care measures have been reported by grantees in the UDS since 1996, and are included in measures recognized under the Children's Health Insurance Program Reauthorization Act (CHIPRA). The measures for childhood immunizations, cervical cancer screening, diabetes control, and blood pressure control have been reported by health centers in the UDS since 2008. These measures are all Meaningful Use measures. The four measures added for 2011 --- Weight Assessment and Counseling for Children and Adolescents, Adult Weight Screening and Follow Up, Tobacco Use Assessment and Counseling, and Asthma Pharmacological Therapy --- also are Meaningful Use measures developed by national standard setting organizations and endorsed by the National Quality Forum in accordance with its protocols for measures approval. As described earlier, the three proposed new measures for 2012 are all Meaningful Use measures.

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

As required by the Government Performance and Results Act (GPRA), BPHC has developed annual program goals and objectives and related performance indicators. Examples of GPRA indicators that the UDS addresses are: services provided to low income individuals, services provided to minority individuals, and percent of low birth weight births to health center patients. The UDS provides data for these and other performance indicators. In addition, the UDS provides information to address the following OMB approved efficiency measure:

- Percent increase in cost per patient served at health centers compared to the national rate.

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 which employ the same formats and definitions as the Universal Report.

Grantees that receive only one BPHC grant are required to complete only the Universal Report. Multiple-award grantees complete a Universal Report for the combined projects and a separate grant report for each Homeless, Migrant or Public Housing program grant. FQHC Look-Alikes are currently only required to submit a Universal Report.

3. Use of Improved Information Technology

Advancements in Electronic Health Record (EHR) technology have been proceeding at a rapid pace. In an effort to improve quality, safety and efficiency of care, EHR incentive programs provide a financial reward to eligible providers practicing in health centers. EHRs can help grantees achieve larger quality and efficiency goals, and the use of EHR can also streamline and simplify health center reporting to UDS measures. Once data are extracted from an EHR, they can be readily entered into the Electronic Handbook (EHB), bypassing the need for manual chart reviews and random sampling. The Electronic Handbook is the mechanism for grantee reporting.

UDS reporting is completed by grantees using a web based data collection system which is completely integrated with HRSA Electronic Handbooks (EHBs). HRSA EHBs provide authentication and authorization services to all HRSA customers, and integration with that system means that the applicants or grantees do 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 are 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 to address questions and provide assistance, including EHB concerns and constraints. The BPHC Help Desk is at bphchelpline@hrsa.gov or 877-974-2742, Monday through Friday (except federal holidays) 8:30 AM to 5:30 PM (ET).

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 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 already collect 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 performance and administer program funds. For FQHC Look Alikes, the UDS data are used to monitor program performance and for designation and recertification decisions.

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 *Federal Register* on June 20, 2011 (Vol. 76, page 35900) and amended on June 30, 2011 (Volume 76, page 38401). No public comments were received in response to this notice. The 30 day notice was published on October 31, 2011 (Volume 76, page 67197).

On October 12, 2011, Program Assistance Letter 2012-01 was published on the BPHC web site and an email about the posting was sent to all health center grantees and partners on October 18, 2011. This email described the proposed new clinical measures and changes to UDS tables for these measures, the proposed staff tenure table, the change in collecting data for all diagnoses for specified conditions, and the proposed EHR and national quality recognition questions; and invited comments on the impact of the changes.

a. Staff Tenure Table

A pilot test of the proposed staff tenure table was conducted with eight grantees from September 14 to October 7, 2011. This pilot test selected grantees based on a mix of geographic location and the following characteristics: large vs. small size, rural vs. urban, and Electronic Health Record at all, some or no sites. Below are the grantees that participated in the pilot test and their characteristics.

Grantee	Location	Large (L) or Small (S)	Rural (R) or Urban (U)	EHR at some or all sites (X)

Thundermist HC	Woonsocket RI	L	R	X
Lifelong Medical Care	Berkeley CA	L	U	
International Community Health Services	Seattle WA	L	U	X
Lawndale Christian HC	Chicago IL	L	U	X
E Central Mississippi Health Care	Sebastopol MS	S	R	X
Manatee County Rural Health Services	Parrish FL	L	R	X
Asher CHC	Fossil OR	S	R	
Green River Medical Center	Green River UT	S	R	X

Pilot participants were asked to complete Table 5A for all categories employees as of August 31, 2011. They were asked to count the number of persons in each staff category (regardless of the amount of time they actually worked) and to report the number of months these employees have worked for the health center. In addition, the participants were asked to complete a brief survey about time needed to complete, source of data, facilitators and obstacles for data collection and reporting. The major results of the pilot are briefly summarized below:

Pilot Results

Results are described by data collection, or the data reported in the completed tables submitted by the participants; and by their survey responses resulting from their experience with collecting and reporting the data.

Data Collection

- All but one participant reported the aggregate number of persons in each staff category and the total number of months they have worked for the health center. The other participant reported the persons and months worked individually for each person in each category.
- Three participants, including two very small rural grantees, raised concerns about reporting contract, part time, or locum tenens employees. Two of these grantees provided the number of on call staff within each category in a notes column that it added to the form.

Survey Responses

Seven grantees completed the survey. Their responses are summarized below.

- Time to complete: First time <.5 to 7 hours, average 2.6 hours; next year <.5 to 3 hours, average 1.3 hours
- Effort: 85% of participants reported the data collection required not too much or a little effort.
- Facilitators: All participants identified automated human resources systems as the major facilitator.
- Obstacles: Three participants identified the need for more detailed instructions. Three expressed concern about how to report staff with multiple positions. Three expressed concern about whether and how to report locum tenens/part time/contract employees. All of these comments were also reflected in survey responses about how to improve the data collection effort. Instructions with examples were recommended.

Pilot test results

As a result of the pilot test for table 5A, the label to report was changed from full time to full time and part time employees and a column was added for locum tenen, on call and other contract employees. More detailed instructions with examples were also developed.

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 aggregate data on patients 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 burden is as follows:

Type of report	Number of respondents	Responses per respondent	Total Responses	Hours per response	Total burden hours
Universal report	1,287	1	1,287	82	105,534
Grant report	328	1	328	18	5,904
Total	1,615	……	1,615	……	111,438

Basis for the estimates:

The UDS includes two components:

- The **Universal Report** is completed by all grantees and FQHC Look Alikes. 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.

Estimates of burden for the proposed UDS are based on data collection costs for the current UDS, adjusted by an increased burden estimate due primarily to the estimated costs of reporting the three new clinical measures and the proposed new staff tenure table. The table above estimates the additional burden costs. The burden per respondent varies across grantees. Health Centers with multiple funds streams will not be required to submit a report on the new clinical and outcome measures. This burden variation is tied predominantly to the type of data system(s) used by grantees and whether or not the grantee has an Electronic Health Record (EHR). While nearly all grantees use an automated system to generate the required reports, systems vary in their ease of use and flexibility. Some grantees have hierarchically-structured systems requiring time-consuming processes for retrieving data in required formats. Others have relational databases that can easily accommodate the specifications. The majority of grantees, however, are expected to experience a level of burden near the averages cited.

The number of charts selected for chart review will be based upon the patient population of the specific condition. The number of charts sampled and audited for a measure will not exceed 70 charts. To minimize the burden associated with sample size determination and ensure that all grantees are using standard processes, the UDS reporting framework will include an electronic interface that auto-calculates the appropriate sample size for each measure based on the size of the grantee's patient population. For those few grantees that are paper-based, the BPHC will distribute hardcopy reference material that illustrates sample size indexed by patient population. The burden here will differ based on the size of the patient population, the number of grant reports an organization must complete or if the inclusion criteria of the measure relates to the grantee's patient population.

The data reports for Table 3A, 3B, 4, 5, new 5A, 6A, 8, and parts of Tables 7 and 9D and 9E are generated automatically via Practice Management Information Systems, so the work can be performed by a mid-level staff person with an average wage rate of $18 per hour. The data reports for Table 6B and Part of 7 will require a systematic sample chart audit, which can also be performed by a mid-level staff person with an average wage rate of $18 per hour. The additional questions about EHR capabilities and national quality recognition can also be answered by a mid-level staff Information Technology person with an average wage rate of $18 per hour.

13. Estimates of Annualized Cost Burden to Respondents

The proposed 2012 UDS consists of existing tables with updated data elements; in 2012, the proposed three new clinical measures will be added to the ten clinical measures already reported. There are no capital or start up costs for the existing UDS data tables (Tables 3A, 3B, 4, 5, 6A, Part of 7, 8A and 9E). Most grantees currently use their automated data systems to maintain data that are reported in the UDS and for reporting to other funding sources.

It is expected that grantees will experience cost "economies" from reporting the clinical measures as they are consistent with those currently endorsed by national standard setting organizations and are Meaningful Use measures. Furthermore, upon vetting with our grantees and partners, it was found that grantees already collect and report such measures to payors and other organizations. However, since this is the first reporting year for the three new measures, it is anticipated that grantees will require additional processing time to develop their reporting methods. To effectively report on the new measures, grantees are expected to utilize their existing clinical data sources – paper-based charts, patient registries, electronic health records or any combination of data sources. Therefore, during the initial reporting year there will be grantees that will incur costs in the form of additional staff time. It is estimated that the additional costs related to data abstraction from paper charts and/or electronic systems to report the new measures will amount to approximately $173,745 (7.5 hours x 1,287 grantees and FQHC Look Alikes x $18/hour).

The proposed new Table 5A for staff tenure will require start up costs for an analyst to set up an Excel spread sheet to collect limited data on physicians, NPs, PAs, CNMs, Nurses, Dentists, Dental Hygienists, Optometrists, licensed clinical psychologists, licensed clinical social workers, CEOs, CFOs, and CMOs. It will take an estimated 4 hours at $18 per hour (GS-8 step 1 2010) to set up this spreadsheet. The estimated costs of reporting the staff tenure data at the end of the first year are $ 69,498 (3 hours x 1,287 grantees and FQHC Look Alikes X $18/hour). In subsequent years, the time to report these data should be reduced. (Note: In general, the requested data are readily available from existing Human Resources files.)

Minimal additional costs are expected to be incurred for reporting patients and visits for all diagnoses for the conditions included in Table 6A. This is because these data are already routinely collected and reported for billing purposes using Practice Management Systems. The cost of providing visits and patients for all diagnoses is estimated to be $6,950 (.3 hours x 1,287 grantees and FQHC Look Alikes x $18 per hour). In addition, minimal one time costs might be incurred by some grantees to make programming changes to report data for all (versus primary) diagnoses for specified conditions in the UDS.

The costs of answering the additional EHR and national quality recognition questions are estimated to be $4,633 (.2 hours x 1,287 grantees and FQHC Look Alikes x $18/hour).

As grantees and FQHC Look Alikes develop reporting proficiencies and advance from initial start up activities to establishing routine data abstraction methods for the new clinical measures, it is expected that the reporting time and associated costs will decrease by at least 20% each year.

It is estimated that approximately 50 percent of these grantees and FQHC Look Alikes will incur programming or re-programming costs for generating the new clinical measures data in the required format. These costs are estimated to average $700 per center for generating the new clinical measure tables for a total of $455,000 ($700 X 650 grantees and FQHC Look Alikes). Costs will be incurred only during the first year of reporting for those grantees that are new and require programming.

HRSA anticipates reducing the average time to report the UDS data by offering significant technical assistance in the manner of advanced notification, training, toll-free telephone line,

email address box, Webex training sessions and Webcast play back.

If OMB approves the proposed UDS data collection and reporting then HRSA will:

- Officially notify the Section 330 funded organizations and the FQHC Look Alikes of the approval.
- Make the 2012 UDS Reporting Manual available to Health Centers and FQHC Look Alikes via the UDS Web site.
- Introduce the UDS reporting data elements in the 40 trainings to be held at various locations throughout the nation in fall 2011 and winter 2012. These sessions will offer a question and answer period in which grantees can pose specific inquiries.
- Update all training modules posted on the Web to include the UDS reporting data elements.
- Hold a webinar for grantees and FQHC Look Alikes on meaningful use and the new clinical measures during summer 2012.
- Update clinical measures reporting pages for the new clinical measures and implement prior to January, 2013.
- Update EHB Tables with new Table 5A and add EHR questions to EHB prior to January, 2013.
- HRSA will offer a toll-free line 8:30 AM - 5:30 PM, Eastern Standard time to address reporting questions and a voice mail will be available for after hours.

14. Estimated Cost to the Federal Government

One time start up costs will be incurred to create new Table 5A and install it in EHB for grantee reporting. The estimated annual contract cost to the federal government for technical assistance, training and data reporting support, data processing, editing, and verification is $750,000. In addition, costs include one FTE at 50% time at a GS 13 level for $ 50,000. Total estimated annual costs to the government are $800,000.

15. Changes in Burden

The current OMB Inventory contains 89,755 burden hours for this activity. This request is for 111,438 hours, for an increase of 21,683 hours. The change is due to a revision in the burden estimate for the Universal report, increasing the burden from 71 to 82 hours per response. The increased burden is attributable to three factors: three new clinical measures, the new Staff Tenure Table 5A , and the addition of questions about EHR capabilities and National Quality Recognition. Reporting of UDS data by FQHC Look Alikes increases the number of respondents for the Universal report from 1,181 to 1,287.

1. New Clinical Measures (increase burden by 7.5 hours per response)

   The proposed new clinical performance measures are particularly beneficial to grantees and the government. The clinical measures were chosen carefully to reflect key health indicators for health center patients across the life cycle, including preventative screenings, perinatal care, and chronic conditions. Health centers will benefit from improved information and feedback to respond to changing conditions in the health care market. Since the measures are aligned with those of national standard setting organizations and are Meaningful Use measures, many grantees already or soon will

report these measures to demonstrate quality and value to payors, state agencies, and the general public. In order to promote continuous quality improvement, the data resulting from this effort will be utilized by BPHC to provide better and more effective technical assistance, as well as, identify best practices within health centers. Overall health center program effectiveness can also be better demonstrated to responsible federal government agencies using improved outcomes measures.

2. New Table 5A, Key Staff Tenure (increase burden by up to 3 hours per response in first year)

   Currently, staffing information in the UDS is that collected in Table 5, Staffing and Utilization. Table 5 displays types of personnel by major service category, the number of FTE's for each personnel type, and for services providers, the numbers of clinic visits and patients. These data are useful for reporting health center staffing, services provided by type, and for calculations of staffing productivity. However, Table 5 only provides cumulative numbers of staff and providers; and they do not capture the length of time (i.e., the tenure) that key personnel work at the health center, a measure of staff retention. These data are essential for addressing the extent to which health centers have a relatively stable work environment that provides continuity of care to their patients.

   To better assess workforce needs and improve efforts for workforce development and retention, a new Table 5A, Tenure for Key Staff, is proposed. Table 5A will allow new UDS data collection to:

   a. Assess numbers of specific primary care providers (e.g. types of physicians, types of nurses)
   b. Assess approximate degree of retention of staff/providers by determining Average Length of Service (AVL) for each type of staff/provider
   c. Better assess AVL for senior leadership of CHC's

   In general, the costs of new data collection are minimal because the requested data are readily available from Human Resources files.

3. Reporting Health Conditions with All (vs. Primary) Diagnoses (increase burden by 18 minutes per response)

   Reporting only primary diagnoses for visits and patients on Table 6A, Selected Diagnoses and Services Rendered, provides a picture of patient health conditions that is less complete than the patient complexity data reported for billing purposes. In order to improve reporting of patient health conditions in the UDS, it is recommended that Table 6A be revised to collect information by all diagnoses on patients with multiple diagnoses. These data are readily available in Practice Management Systems and used for billing records. Reporting these data in the UDS will create minimal additional reporting burden.

4. Electronic Health Record and National Quality Recognition Questions (increase burden by 12 minutes per response)

   Ensuring that HRSA grantee health centers adopt Electronic Health Records (EHR) is a critical priority for BPHC and OQD, including helping grantees use EHR functionality to obtain Meaningful Use (MU) incentive payments from CMS. At the present time, there are limited data on EHR adoption in health centers. However, the annual UDS report contains data required of all health center grantees, including which centers have adopted EHR systems, what systems they have, and how near they are to meeting the MU

requirements. Such data are essential to the provision of necessary and appropriate technical assistance to grantees.

The EHR questions on the 2010 UDS were developed before the MU incentive program (CMS, October 2010) was fully defined in regulations, and represented HRSA's best efforts to capture information believed necessary to support centers' work to become Meaningful Users of HIT. Over the course of the past year, it has become clear that additional targeted measures are required to properly support the Health Center Program and HRSA objectives for HIT adoption.

The revised UDS EHR questions reflect Stage 1 MU Standards and Measures, and focus more specifically on asking if health center providers are able to meet these requirements and receive incentive payments. In addition, the questions have been modified to more accurately reflect the realities of the HIT vendor environment, and the systems currently in use at and being adopted by health centers.

National quality recognition, either through accreditation or designation as a primary care medical home, increasingly is important to distinguish high quality health centers. Responses to questions regarding national quality recognition, and if so, by what 3rd party organization, provide essential Health center Program information.

16. Time Schedule, Publication and Analysis Plans

The grantees are required to submit the reports within 90 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.