

Supporting Statement A

Medicare Rural Hospital Flexibility Grant Program Performance Measure Determination

OMB Control No. 0915-XXXX

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA)'s Office of Rural Health Policy (ORHP) is requesting authorization by OMB of a new data collection tool to support the Medicare Rural Hospital Flexibility Grant (Flex) program. This activity will collect information on the grant funded activities by the 45 states receiving support administered under the grant program, as well as information to meet requirements under the Government Performance and Results Act of 1993 (GPRA).

In its authorizing language (SEC. 711. [42 U.S.C. 912]), Congress charged ORHP with "administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas." The mission of the Office of Rural Health Policy (ORHP) is to sustain and improve access to quality health care services for rural communities.

Sec. 1820. [42 U.S.C. 1395i-4] of the Social Security Act, subsection (g) establishes the Secretary can establish grants to States for:

- (A) engaging in activities relating to planning and implementing a rural health care plan;
- (B) engaging in activities relating to planning and implementing rural health networks;
- (C) designating facilities as critical access hospitals; and
- (D) providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking.

These grants to the States provide funds for activities covering a wide range of subject areas representing areas of need in their rural communities. Each grant is held to similar standards allowing cross-cutting measures to be applied to chosen activities implemented under the Flex grant program. The Flex grant program funds activities designed to impact Critical Access Hospitals (CAH) through focusing on Quality Improvement, Financial and Operational Improvement, Health System Development and Community Engagement, and CAH Conversion. The overall intent of the program is to maintain a sustainable and high

quality rural health care access point.

This request for approval is for information to be collected and shared with the grant recipients to provide the greatest impact of federal dollars. Grantees will provide information from their electronic records *only* on those activities for which their project received funds.

The Medicare Rural Hospital Flexibility Grant Program provides funding to state governments to spur quality and performance improvement activities; stabilize rural hospital finance; and integrate emergency medical services (EMS) into their health care systems. Flex funding encourages the development of cooperative systems of care in rural areas -- joining together Critical Access Hospitals (CAHs), EMS providers, clinics, and health practitioners to increase efficiencies and quality of care.

2. Purpose and Use of Information Collection

The purpose of the performance measures is to provide standardized useful information about funded activities, to monitor grantee progress and to demonstrate program impact. ORHP currently collects this information on an annual basis as reported in the grantee progress reports and the data has helped to determine the impact of the programs in rural communities. This report provides data on program users, encounters, effectiveness, and user demographic information. In addition, the report provides aggregated data by state to be used for national trending and correlation.

The measures presented in this document cover key topics of interest to HRSA's ORHP and will provide quantitative information about the grant program performance. The measures include: (a) quality reporting; (b) quality improvement interventions; (c) financial and operational improvement initiatives; and (d) multi-hospital patient safety initiatives. Several measures will be used for this program and will inform the Office's progress toward meeting the goals set in GPRA. Grantees report on measures applicable to their awarded project; all measures will speak to the goals and objectives set forth in the HRSA and ORHP strategic plans.

As required by GPRA, HRSA's ORHP has developed an annual program objective related to performance indicators. The information collected will provide the appropriate data necessary for the objective and indicators associated with the completion of stated activities and will be evaluated for potential use as a GPRA reportable. Below is an example of a program objective and its corresponding indicators.

Objective:

Assist CAHs in identifying potential areas of financial and operational performance improvement

Indicators:

- **Measure:** The number of CAHs undergoing financial and operational performance assessments
- **Measure:** The number of CAHs who implemented changes to process based on the recommendations
- **Measure:** Number of financial and/or operational improvement Networks

- **Measure:** Number of critical access hospitals participating in the network
- **Measure:** Total number of other rural providers in the networks
- **Measure:** The number of CAH staff (including part-time, contractors, and governing board) attending network or user group meetings related to financial and operational performance assessment
- **Measure:** Number of improvement activities based on meetings
- **Measure:** The number of CAHs with identified outcomes derived from the meetings

Grantees will only provide information on the performance measures that are applicable to the activities funded through the grant program for which they are reporting. The measures reported will be directly related to activities identified in their workplans. For measures that do not apply, the reporting mechanism will automatically remove the opportunity to report the measures. The noncompetitive guidance (NCC) (Attachment B) outlines the requirements of the grantees in each of the four Flex Core Areas. The NCC only requires reporting on one Objective with associated activities and one Intervention for Quality Improvement. For the second Core Area, Financial and Operational Improvement, Objective one is required and the grantee is required to select one additional Objective and Intervention. Core Area three only requires the selection of one Objective and Core Area four is only answered when applicable. The measures as they are outlined can be incorporated into the grantee planned activities and collected during and upon completion. These measures are inherently intertwined with the activities of the grantee and are not easily separable.

The use of the measures introduced here are intended to provide internal program monitoring for the grantee as well as to show the federal program objectives and activities that could be applied more broadly or those that should be discontinued.

3. Use of Improved Information Technology and Burden Reduction

This activity is fully electronic. Data will be collected through and maintained in a database in HRSA's Electronic Handbook (EHB). Grantees submit the data electronically via a HRSA managed website at <https://grants.hrsa.gov/webexternal>. This reduces the paper burden on the grantee and on the program staff.

4. Efforts to Identify Duplication and Use of Similar Information

These data will be collected for the purposes of this program and are not available elsewhere. In an effort to reduce the overall burden on grantees and their subcontract recipients, program has utilized publicly reported data to Hospital Compare for Quality Improvement reporting and the financial cost reports submitted to the Centers for Medicare and Medicaid by CAHs. Though Hospital Compare provides the scoring of data submitted, CAHs are not required to submit to Hospital Compare nor does Hospital Compare reflect low number monitoring which could directly impact programs within a CAH. To show maximum impact of Flex-funded activities, a data submission customized to the activity can only be obtained at the time of the activity and with a progress follow-up. The capture of these two data points are

unique to this program and are not reportable elsewhere.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study.

Every effort has been made to ensure the data requested are the minimum necessary to answer basic questions useful in determining whether grantee awarded goals and objectives are being met. Data requested are currently being collected by the projects or can be easily incorporated into normal project procedures. The data collection activities will not have a significant impact on small entities.

6. Consequences of Collecting the Information Less Frequently

Data in response to these performance measures will be collected on an annual basis. Grant dollars for these programs are awarded annually. This information is needed by the programs, ORHP and HRSA in order to measure effective use of grant dollars to report on progress toward strategic goals and objectives.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This project is consistent with the guidelines in 5 CFR 1320.5(d)(2).

8. Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A:

The original notice required in 4 CFR 1320.8(d) was published in the *Federal Register* on December 29, 2012 (Vol. 77, No. 250, page 77079).

The following comments were submitted by one organization, the National Organization of State Offices of Rural Health:

Comment: The necessity and utility of the proposed information collection for the proper performance of the agency's functions

Response: FORHP appreciates this comment and intends to collect data submitted directly to Qnet as well as data submitted to the state level Flex programs. By diversifying our data sources we will be able to capitalize on the efforts of states and the Critical Access Hospitals (CAHs) themselves in gathering a robust data set. FORHP does not have the capacity to gather individual CAHs' information and will depend upon the State level coordinators as well as the research ability of the Flex Monitoring Team to gather and mine the data. The information that will be collected by FORHP will be the process and outcome measures associated with state activities. The responsibility of working directly with the CAHs falls on the states as a condition of their grant awards.

Comment: The accuracy of the estimated burden

Response: FORHP is acutely aware of the potential for grantee burden for this data collection. An estimate of 6 hours will be evaluated before the continuation of this process. FORHP hopes to keep the burden sufficiently low for the *data* collection and would like to point out the grant requirement for a full-time FTE to be assigned for the execution of the award. Data collection and the administration of the award are two separate things and

burden for said collection will be reviewed.

Comment: Ways to enhance the quality, utility, and clarity of the information to be collected

Response: FROHP agrees Flex grantees should be engaged in the design and execution of the collection of the proposed measures. Flex grantees were consulted, as well as technical assistance centers and research personnel. The measures were vetted with Flex personnel on multiple occasions. FORHP intends to continue this activity and will engage the stakeholders directly affected. Regarding Truserve, FORHP recognizes the utility of the database but cannot endorse nor tell our grantees to utilize the resource. The review of the data and the analysis of the measures of the activities is a project that should be funded and executed by NOSORH in its vendor capacity. Interfacing with PIMS is the responsibility of the vendor and FORHP will provide the electronic specifications for interfacing once the updated system has been completed.

Comment: The use of automated collection techniques or other forms of information technology

Response: FORHP is aware of the time burden associated with previous PIMS submissions. In an effort to rectify this issue, FORHP is working to simplify and reduce the reporting time through adjustments in technology. Target for a September 1, 2013 release, an updated PIMS with a more user friendly interface will be introduced. FORHP hopes this will positively impact the reporting of automated data.

The original comments submitted by NOSORH are located in Attachment A.

Section 8B:

In order to create a final set of performance measures after the revisions that are useful for all program grantees, a large set of measures was vetted through research, evaluation, grantee and federal resources. The initial measure development occurred in calendar year 2011 and was vetted through early 2012. Through webinars and field reviews, the measures were pared down and streamlined to maintain a reduced burden load. The following organizations participated in the final vetting process:

Organization/Contact
Hospital State Division (10 project officers), Office of Rural Health Policy, 301-594-4438
Eric Shell, Principal, Stroudwater Associates, eshell@stroudwater.com
Jeff Johnson, CPA, Partner, Wipfli LLP, jjohnson@wipfli.com
Dr. Mark Holmes, Assistant Professor of Health Policy and Management and Dr. George Pink, Humana Distinguished Professor, Cecil G. Sheps Center for Health Services Research, University of North Carolina- Chapel Hill, gpink@email.unc.edu , mark_holmes@unc.edu
Dr. Ira Moscovice, Professor, Director and Principal Investigator, Minnesota Rural Health Research Center, Flex Monitoring Team, mosco001@umn.edu
Corinne Chavez, Project Coordinator for State Office of Rural Health, California Primary & Rural Health Division , California Department of Health Care Services, (916) 449-5152

Debra Robbins, Rural Programs Manager, Alabama Office of Rural Health , 334-206-5441
Kevin Driesen, Flex Program Director, Arizona Center for Rural Health , Mel & Enid Zuckerman College of Public Health, University of Arizona, 520-626-5837
David Palm, Flex Program Director, Nebraska Office of Rural Health , Nebraska Department of Health and Human Services, 402-471-0146

The following chart reflects the personnel who responded when contacted to assist in providing the burden requirements associated with the proposed measures.

Organization/Contact
David Palm, Flex Program Director, Nebraska Office of Rural Health , Nebraska Department of Health and Human Services, 402-471-0146
Michelle Mills, Director, Colorado Rural Health Center , 303-407-0410, mm@coruralhealth.org
Larry Baronner, Critical Access Hospital Coordinator, Pennsylvania Office of Rural Health Pennsylvania State University, 814-863-8214, ldb10@psu.edu

9. Explanation of any Payment/Gift to Respondents

Respondents will not be remunerated.

10. Assurance of Confidentiality Provided to Respondents

The data system does not involve the reporting of information about identifiable individuals; therefore, the Privacy Act is not applicable to this activity. The proposed performance measures will be used only in aggregate data form for program activities.

11. Justification for Sensitive Questions

There are no sensitive questions.

12. Estimates of Annualized Hour and Cost Burden

The annualized burden was determined by reaching out to six current grantees of the Flex program. The grantees were provided a list of measures (Attachment B) associated with the most recent non-competing continuation progress report (Attachment C) for the program, along with a definition of burden as defined by the 60-day FRN, and the expectations of program regarding data collection to enable the attainment of program goals. The measures expected to be gathered and reported are limited to what each grantee lists as an intended activity in their submissions. The measures that do not apply will not be required to be completed. Of the six grantees contacted, four responded with estimates that ranged from 181

hours to 280 hours for preparation, gathering, and submission of data. The variance in preparation, collection, and submission can be attributed to the number of activities initiated, the number of personnel within each State Offices of Rural Health, and the time required for analysis and submission. With the variance in office personnel assigned to the program, ORHP determined the use of an average would be appropriate as the grant program provides support for a minimum of one FTE. An average of 216 hours was determined, with an expected programmatic burden of 9,720 hours per year for the 45 state grantees.

12A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Flex Program Coordinators	Flex PIMS Report	45	1	216	9,720

12B.

Burden as it pertains to the Flex grantees will vary depending upon the size and capacity of the office. To enter information, some grantees have mid-level staff to enter the data, whereas others may have their project director enter the data. To determine the average hourly rate and total respondent costs, five geographically diverse grantees were selected and used to calculate the rates and total cost. All program grantees currently use the HRSA EHB to submit requested information annual as a measure of work progress.

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs

Flex Program Coordinator	9,720	\$26.62	\$258,746.40
Total	9,720	\$26.62	\$258,746.40

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

There is no capital or start-up cost component for this collection.

14. Annualized Cost to Federal Government

Data collection for the Flex grant program is expected to be carried out at an annualized cost to the Federal Government of \$30,000. ORHP has invested in annualized maintenance of a database contained with the HRSA EHB for facilitated reporting of performance measures for grantees. Staff at ORHP monitor and provide guidance to grantee project staff at a cost of \$3,412.80 per year (80 hours per year at \$42.66 per hour at a GS-13 salary level). The total annualized cost to the government for this project is \$34,412.66.

ORHP will provide access to data submitted to CMS for specific measures reported in Hospital Compare that aligns with program goals. ORHP has entered into a four-year contract with Telligen totaling \$178,113, with an annualized cost of \$44,528.25.

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation, Publication, and Project Time Schedule

At this time, there are no plans to publish the data. This information will be collected through census to comply with GPRA requirements. The data may be used on an aggregate program level to document the impact and success of rural health, state-based grant programs. The information will be accessible to the state-based grantees for data manipulation as the data relates to them and may be used for comparisons of National and/or regional benchmarks.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

No expiration exemption is requested.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.