

Health Resources and Services Administration
SUPPORTING STATEMENT A
Optimizing Virtual Care Grant Program Performance Measures
0906-XXXX NEW

A. Justification

1. Circumstances Making the Collection of Information Necessary.

The Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC) is requesting Office of Management and Budget (OMB) approval to electronically collect data for Optimizing Virtual Care (OVC) grant recipient activities and performance measures over an approximately 14-month period. In February 2022, HRSA awarded nearly \$55 million to 29 HRSA-funded health centers through the OVC grant program to increase health care access and quality for underserved populations through virtual care such as telehealth, remote patient monitoring, digital patient tools, and health information technology platforms. The goal of the OVC grant program is to continue to support innovation that began during the COVID-19 pandemic, when health centers quickly expanded their use of virtual care to maintain access to essential primary care services for underserved communities. HRSA-funded health centers serve special and vulnerable populations facing barriers to virtual care access, such as low digital literacy, low connectivity capabilities, or limited technology access. The 29 grant recipients will serve as a model for how to increase equitable virtual care, generating and refining strategies that can be adapted and scaled across the Health Center Program.

The data on grant recipient activities and performance will help HRSA demonstrate, adapt, assess, and disseminate promising practices, strategies, and novel models of virtual care across the nation’s health centers. The grant recipient activities related to implementation of novel models of virtual care, including aggregate data on patients served and the services they received, will be captured via monthly progress reports. A set of health center performance measures will be captured via a biannual measures report and will provide evidence-informed insight into health equity and virtual care.

The Health Center Program and supplemental awards to health centers are authorized by Section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b). Notably, HRSA is authorized under 42 U.S.C. 254b(d) to make supplemental awards for health centers to “implement evidence-based models for increasing access to high-quality primary care services, which may include models related to... expanding the use of telehealth and technology-enabled collaborative learning and capacity building models.” As per 45 CFR §75.301, HRSA is obligated to collect performance information on its grants “in a way that will help the HHS awarding agency and other non-Federal entities to improve program outcomes, share lessons learned, and spread the adoption of promising practices.”

2. Purpose and Use of Information Collection

The goal of the OVC grant program is to provide HRSA with information to guide future program and policy decisions regarding virtual care. Specifically, the information will support an assessment that yields:

- Increased evidence of how to optimize the use of virtual care in the Health Center Program to enhance access to care and improve clinical quality for underserved communities and special and vulnerable populations.
- Maximized impact of the new OVC grant program, as a model to be adapted, leveraged, and scaled across other HRSA funding opportunities.
- Enhanced evidence base for recommendations to promote and scale virtual care innovations focused on increasing health equity and specific to Health Center Program patients.

The assessment will include descriptive analyses of the data on grant recipient activities and performance, including analyses of trends over time. The analyses will inform recommendations for performance measures that HRSA could scale across the Health Center Program and influence future grant programs like the OVC grant program. HRSA has identified a need for innovative measures that expand on the limited measures currently included in the Uniform Data System (UDS), the standardized reporting system that provides consistent information about health centers and health center look-alikes annually. HRSA is interested in identifying measures best suited for the range of telehealth and virtual care approaches employed by health centers. The OVC grant program is a good mechanism in which to pilot the measures given the range of innovative virtual care activities funded under the program, whereby innovation is defined as “the implementation of new or altered products, services, processes, systems, policies, organizational structures, or business models that aim to improve one or more domains of health care quality or reduce health care disparities.”¹

To support the assessment, HRSA requests OMB approval for two data collection instruments: the monthly progress report template and biannual measures report template. The monthly progress report template focuses on program implementation, including the extent to which the grant recipients are carrying out activities described in their grant applications and data on the primary telehealth services offered.

The biannual measures report template instructs grant recipients to report twelve (12) measures. Given the range of virtual care types and Service Categories that are delivered across the 29 grant recipients, the biannual measures report template provides grant recipients some flexibility to choose measure elements to report in several domains. The evidence-based measures span four (4) key population health and clinical domain areas including access to care and information; quality of care and outcomes; patient experience of care; and promoting health equity.

¹[FY 2022 OVC Notice of Funding Opportunity \(NOFO\)](#)

3. Use of Improved Information Technology and Burden Reduction

OVC grant recipients will enter data for the monthly progress report and biannual measures report into excel templates provided by HRSA, and then upload the populated excel templates into the Electronic Handbook (EHB), the grants and program management system used by HRSA and its grant recipients.

The quality of care and outcomes measures in the biannual measures reports are aligned with CMS electronic clinical quality measures (eCQMs) already built into Electronic Health Records (EHRs), with additional stratification not included in the original measure specifications. Given that nearly all health centers use EHRs, the use of eCQMs will reduce reporting burden. In addition, reporting burden will be reduced because the majority of the OVC quality of care and outcomes measures are aligned with measures reported in UDS, albeit with additional stratification not included in the original UDS measure specifications.

4. Efforts to Identify Duplication and Use of Similar Information

There is no other available data source for the Health Center Program that tracks the extent of implementation of a wide range of virtual care approaches and virtual care's contribution to patients' care.

The OVC grant recipients, like all HRSA-funded health centers, are required to submit annual performance measures via UDS. The OVC grant recipients' monthly progress and biannual measures reports will collect more frequent and detailed data on types of virtual care services than UDS. For example, the monthly progress reports will collect information on virtual care modalities offered, including synchronous/live audio-only, synchronous/live video, asynchronous store and forward, remote monitoring, mobile health (mHealth), or other asynchronous technologies. In contrast, UDS collects annual data on a more limited number of virtual care types offered. Having monthly data will enable HRSA to inform and implement process improvements.

The biannual measures reports will collect information on number of health center patients receiving virtual care by Service Category for each of the virtual care types offered by the grant recipient. The Service Categories include Medical Services, Dental Services, Mental Health Services, Substance Abuse Disorder Services, Vision Services, Enabling Services, and other professional services. For example, under the Medical Service category, grant recipients will report the number of patients served by each of the following virtual care types: synchronous/live audio-only, synchronous/live video, asynchronous store and forward, remote monitoring, mobile health (mHealth), or other asynchronous technologies. UDS collects annual data on the number of virtual visits by Service Category but does not collect information on the number of patients touched by each range of virtual care approaches offered in HRSA-funded health centers.

Most of the quality of care and outcome measures in the biannual reports are based on measures collected via UDS; UDS clinical quality measures combine face-to-face and virtual

care visits and are stratified less often than the OVC measures. The measures for the OVC grant recipients will be collected more frequently than the UDS measures, include breakouts for virtual care types, and will be stratified by either service category, telehealth technology, patient age, health insurance type, race and ethnicity or special populations.

The biannual measures report also includes a version of the Virtual Care Strategic Deployment (VCSD) Self-Assessment Model adapted from the Virtual Care Strategic and Tactical Deployment Maturity Self-Assessment Model.² The adapted version of the model asks OVC grant recipients to assess the maturity of their health center leadership and operations across ten categories, including governance, technology platforms, and health equity. OVC grant recipients indicate which maturity level (basic, foundational, or advanced) best describes their health center's virtual care implementation. Completing the VCSD Self-Assessment Model will allow OVC grant recipients to raise awareness within their health center on potential areas for improvement in virtual care delivery and sustainability. HRSA will use the data collected by the VCSD Self-Assessment Model to identify OVC grant recipients' technical assistance and training needs. Piloting the adapted VCSD Self-Assessment Model as part of the biannual measures report will provide insight into its feasibility and appropriateness as a measure of delivering equitable virtual care for the Health Center Program.

5. Impact on Small Businesses or Other Small Entities

This project does not involve small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

OVC grant recipients will be required to respond to this data collection on a monthly and biannual basis. Through collection and analysis of monthly progress and biannual measures report data, HRSA will gain knowledge about the implementation and effectiveness of virtual care services that can be scaled up across the Health Center Program. If HRSA collects the information less frequently, HRSA and OVC grant recipients will not have up-to-date data to inform and implement process improvements that may result in more equitable virtual care. Through collection and analysis of monthly progress and biannual measures report data, HRSA will gain knowledge about the implementation and effectiveness of virtual care services grantees provide to underserved communities.

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

This project is consistent with the guidelines in 5 CFR 1320.5.

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

A 60-day Federal Register Notice was published in 87 FR 37874 (06/24/22). HRSA did not receive any public comments for this information collection request during the 60-day public

² Meyers, JF. (2021) Virtual Care Strategic and Tactical Deployment Maturity Self-Assessment Model. Oakland, CA: The California Health Care Safety Net Institute.

comment period.

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts.

10. Assurance of Confidentiality Provided to Respondents

The progress reports will not involve the reporting of information identifiable to individuals; only aggregate data are collected. The OVC grant recipient monthly progress reports and biannual measures reports specify reporting of descriptive information on each OVC grant recipient and its activities, in addition to aggregate data on patients served and the services they received during the reporting period. Therefore, the Privacy Act is not applicable to this activity.

11. Justification for Sensitive Questions

There are no questions of a sensitive nature. All information in the monthly progress and biannual measures reports will be reported in an aggregate format. Individuals cannot be identified based on these aggregate totals. OVC grant recipients are instructed to exclude patient counts fewer than six for all patient-level reporting in the biannual measures report.

12. Estimates of Annualized Hour and Cost Burden

12A. Estimated Annualized Burden Hours

The respondents to the OVC grant recipient monthly progress and biannual measures reports are the 29 health centers that received Optimizing Virtual Care grants (Tables 1A and B). A response rate of 100% is assumed because HRSA will require grant recipients to submit the progress reports after OMB approval. Assuming OMB approval in January 2023, the grant recipients will submit OMB-approved monthly and biannual measures reports in the last 14 months of their two-year period of performance, which started in March 2022 and will end in February 2024. Hence, the grant recipients are assumed to submit a total of 14 OMB-approved monthly progress reports, two during the first year of their period of performance (January 2023-February 2023), and 12 monthly progress reports during the second year in their period of performance (March 2023-February 2024). The grant recipients are assumed to submit three OMB-approved biannual measures reports, one during the first year in their period of performance and two during the second year in their period of performance.

Table 1 provides the maximum estimated annualized burden hours reflecting the second year of the grant's period of performance, which assumes that grant recipients will submit 12 monthly progress reports and two biannual measures reports.

Table 1: Estimated Annualized Burden Hours

Form Name	Number of Respondents	Number of Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
OVC Grant Monthly Progress Report	29	12	348	2	696
OVC Grant Biannual Measures Report	29	2	58	55.9	3,242
Total	29		406		3,938

12B. Burden Estimate for OVC Grant Monthly Progress Report

The monthly progress report burden estimate of 2 hours accounts for the recordkeeping needed for monthly reporting on activities (Table 1), and is anchored in burden estimates from previously approved information collections from HRSA-funded health centers with similar updates on program activities and performance measures that do not require data to be extracted from health center EHRs. At the request of OVC grant recipients on a previous version of the monthly progress report, HRSA moved a table requesting data on the number of full-time equivalent (FTE) health center staff to the biannual measures report (Table 14: Health Center Staffing). OVC grant recipients were concerned about the burden of monthly extraction and reporting of staff FTE data.

12C. Burden Estimate for OVC Grant Biannual Measures Report

OVC grant recipients also provided feedback on the biannual measures report, noting which measures would be more burdensome because they would require significant workflow changes. Subject matter experts at the MITRE Corporation (MITRE) in progress reporting, clinical quality measures and health center workflows factored the grant recipient feedback into development of burden estimates for individual measures.

For most measures in the biannual measures report, the burden estimate associated with an individual measure was informed by the UDS Redesign Project, which was sponsored by HRSA and conducted by MITRE in 2015-2016. The project assessed the change in burden that would result from addition or subtraction of individual measures from UDS annual reporting by considering seven domains: the number and different types of data elements, similarity of data elements across measures, the need for data that is not captured in health centers' EHRs, and the administrative, clinical, or workflow complexity required to organize, plan, implement, and maintain the measure. The burden estimates from the UDS Redesign Report were used as a benchmark for burden estimates for individual measures from the biannual measures report that were comparable across the seven domains.

The total burden of each biannual measures report submission was calculated based on the estimated burden of individual measures as shown in Table 2.

Table 2: Biannual Measures Report Burden Estimates for Individual Measure

Measure(s)	Burden Per Measure	Number of Measures	Burden for Indicated Measure(s)
Tables 1 and 2: Patient Utilization of Countable Virtual Care Types, Table 3: Availability of Countable Care Types by Service Category, Table 14: Health Center Staffing	Combined burden of 6.75 hours	3	6.75 hours
Tables 4-9: The Patient Utilization of All Virtual Care Types	10.5 hours	1	10.5 x 1=10.5 hours
Table 10: Preventive Care and Screening (Select Screenings)	2.5 hours	1	2.65 x 1= 2.65 hours
Table 11: Health Outcome Achievement (Select Outcomes)	1 hours	1	1 x 1= 1 hour
Table 15: Virtual Care Training, Table 16: Changes in Virtual Care Claims Reimbursement	0.25 hours	2	0.25 x 2= 0.5 hours
Tables 17 and 18: Service Reimbursement	30 hours	1	30 x 1= 30 hours
Tables 19 and 20: Median Appointment Wait Time	3 hours	1	3.5 x 1= 3.5 hours
Table 21: Virtual Care Strategic Deployment Self-Assessment Model	1 hour	1	1 x 1= 1 hour
Total for the Biannual Measures			55.9 hours

The rationale for burden estimate for individual measures included in the biannual measures

report is as follows:

- The Patient Utilization of Countable Virtual Care Types, Availability of Countable Care Types by Service Category, and Health Center Staffing measures request data also collected in UDS Table 5 with minor changes such as increased reporting frequency and reporting by Service Category rather than individual personnel categories. Compared to UDS Table 5³, these measures include 27 additional line items. The UDS Redesign Project estimated the health center workload for each line item as 0.25 hours.⁴ Therefore, the combined burden estimate for these measures is 6.75 hours. (27 line items x 0.25 hours per line item).
- The Patient Utilization of All Virtual Care Types Measure requests data also collected in UDS Tables 3A, 3B, and 4B⁵ with minor changes such as increased reporting frequency, consolidation of patient age categories, and additional reporting on virtual care type. Compared to UDS Tables 3A, 3B, and 4B, this measure includes 42 additional line items. The UDS Redesign Project estimated the health center workload for each line item as 0.25 hours.⁶ Therefore, the burden estimate for this measure is 10.5 hours. (42 line items x 0.25 hours per line item).
- The Preventive Care and Screening measure asks OVC grant recipients to select and report on at least three indicated CMS eQMs that are also included in UDS Table 6B⁷, with additional stratification by virtual care type. OVC grant recipients also have the option to report on alternative quality measures not included in the biannual measures report template. Given the similarity in the processes for collecting and reporting eQMs in UDS, all existing UDS Table 6B eCQM measures are estimated to require similar burden to input virtual care stratifications. Assuming a baseline of 53 minutes of burden per selected eCQM established by the UDS Redesign Project⁸, the burden estimate for this measure is approximately 2.65 hours. (3 eQMs x 53 minutes per eCQM = 2.65 hours).
- The Health Outcome Achievement measure asks OVC grant recipients to select at least one indicated CMS eQMs that are also included in UDS Table 7⁹, with additional stratification by virtual care type. OVC grant recipients also have the option to report on at least one health outcome or health center-specific process measures as an alternative to reporting on the indicated eCQM. Given the similarity

3 HRSA Bureau of Primary Health Care. Uniform Data System 2022 Manual: Health Center Data Reporting Requirements. Available here: <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf>

4 CMS Alliance to Modernize Healthcare, Federally Funded Research and Development Center, Data Quality and Use Improvement to Support BPHC Decision Making, Task Order No. HSH250201600008U, “Impact Analysis of Recommended Changes to Health Center Program Data Collection”, Version 0.1, September 7, 2017.

5 HRSA Bureau of Primary Health Care. Uniform Data System 2022 Manual: Health Center Data Reporting Requirements. Available here: <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf>

6 CMS Alliance to Modernize Healthcare, Federally Funded Research and Development Center, Data Quality and Use Improvement to Support BPHC Decision Making, Task Order No. HSH250201600008U, “Impact Analysis of Recommended Changes to Health Center Program Data Collection”, Version 0.1, September 7, 2017.

7 HRSA Bureau of Primary Health Care. Uniform Data System 2022 Manual: Health Center Data Reporting Requirements. Available here: <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf>

8 CMS Alliance to Modernize Healthcare, Federally Funded Research and Development Center, Data Quality and Use Improvement to Support BPHC Decision Making, Task Order No. HSH250201600008U, “Impact Analysis of Recommended Changes to Health Center Program Data Collection”, Version 0.1, September 7, 2017.

9 HRSA Bureau of Primary Health Care. Uniform Data System 2022 Manual: Health Center Data Reporting Requirements. Table 6B. Available here: <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf>

- in the processes for collecting and reporting eCQMs in UDS, both UDS Table 7 eCQM outcome measures are estimated to require similar burden to input virtual care stratifications. Assuming a baseline of 53 minutes of burden per selected eCQM established by the UDS Redesign Project¹⁰, the burden estimate for this measure is approximately 1 hour. (1 eCQM x 53 minutes per eCQM= approximately 1 hour)
- The Virtual Care Training and Changes in Virtual Care Claims Reimbursement measures are similar to questions included in the practice-level survey for the evaluation of HRSA’s Pediatric Mental Health Care Access Program. Based on the burden estimate included in the proposed Evaluation of the Maternal and Child Health Bureau Pediatric Mental Health Care Access Program and the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program Information Collection Request (ICR) (87 FR 39841 through 39842), the estimated burden for each of these measures is approximately 0.25 hours.
 - OVC grant recipients identified Service Reimbursement and Median Appointment Wait Time as two measures that are not included in annual UDS reporting and therefore not consistently tracked by health centers and will require new workflows (and additional burden) to collect and submit data through the biannual measures report.
 - The Service Reimbursement Measure requests data from OVC grant recipients on virtual care claims reimbursement by patient insurance type and qualifying virtual care types. Collecting this data requires consulting administrative, technical, and operating systems. The capabilities of such systems vary widely in health centers based on system investment and sophistication. Claims systems are typically linked to the EHR, but such linkages are not always present and can require substantial hourly burden until such systems are established that successfully link claims, virtual care, and reimbursement on such claims. Assuming that OVC grant recipients will need to create administrative protocols to collect, summarize, and track virtual visit claims in at least two different systems, and that administrative staff will need to review and synthesize data from each system, the estimated burden for this measure is 30 hours based on expert judgement. The burden hours for specific health centers may vary from this estimate depending on the sophistication and level of connectivity of administrative, operating, and technical systems or as health centers gain more experience in collecting and reporting virtual visits. However, the estimate of 30 hours per instance of reporting represents a reasonable average burden across all 29 health centers.
 - The Median Appointment Wait Time measure requests data from OVC grant recipients that spans different technical and administrative systems to collect and report and compiles 4 data points: date of scheduling appointment, date of future appointment, total number of days between the date of scheduling appointment and date of future appointment, and summaries by service category and relevant virtual care type. The time burden associated with this measure includes administrative and technical burden. Administrative and

10 CMS Alliance to Modernize Healthcare, Federally Funded Research and Development Center, Data Quality and Use Improvement to Support BPHC Decision Making, Task Order No. HSH250201600008U, “Impact Analysis of Recommended Changes to Health Center Program Data Collection”, Version 0.1, September 7, 2017.

scheduling systems likely include the data elements required but new workflows to create and test new software algorithms to collect, calculate and report the measure may need to be developed. In addition, some administrative workflows are likely required to summarize and report the data. The burden estimate, for inputting data for this measure is comparable to the burden estimate identified for eCQMs calculated to assess incremental burden for the UDS Redesign Project.¹¹ After the initial administrative and technical workflows for this measure are established, the estimated burden is approximately 3.5 hours. (4 data points x 53 minutes per data point).

- The developer of the original Virtual Care Strategic and Tactical Deployment Maturity Self-Assessment Model confirmed a burden estimate of 1 hour for completing the adapted VCSD Self-Assessment Model per biannual measure report.

The total burden of the biannual measures report per grant recipient is 67.15 hours (Table 2). The subset of questions from the CAHPS Clinical & Group Survey Visit 4.0 (beta) (CG-CAHPS 4.0) in the biannual measures report is not included in the burden estimate. The Agency for Health Care Research and Quality developed CG-CAHPS 4.0 in response to the rapid adoption of telehealth during the COVID-19 pandemic. CG-CAHPS 4.0 has not been field tested or formally approved as a CAHPS survey.¹² HRSA does not require OVC grant recipients to administer any CAHPS survey to health center patients and completing the corresponding tables in the biannual measures report is optional. Based on OVC awardee responses to a monthly progress report question on what patient experience surveys they were using, the majority of OVC grant recipients are not collecting patient experience using a standardized instrument, including CAHPS-CG 4.0. Further, none of the standardized patient experience surveys will be used by more than nine OVC grant recipients (i.e., respondents).

12D. Estimated Annualized Burden Costs

Based on the estimated total number of burden hours, that the annualized cost to respondents is approximately \$271,666. The burden cost for the monthly progress report result was obtained by multiplying the number of burden hours by the mean hourly wage rate for Medical or Health Services Manager who would be able to provide the necessary detail on project staffing and activities. The burden cost for the biannual measures report was obtained by multiplying the number of burden hours by the mean hourly wage rate of a Health IT Technologist/Medical Registrar who would have the sufficient skills to pull and submit the necessary data from the grant recipients' EHRs.

Table 3: Estimated Annualized Burden Costs

Form Name	Type of	Total Burden	Adjusted	Total Respondent
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11 CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, Data Quality and Use Improvement to Support BPHC Decision Making, Task Order No. HSH250201600008U, "Impact Analysis of Recommended Changes to Health Center Program Data Collection", Version 0.1, September 7, 2017.

12 CAHPS Clinician & Group Survey. Content last reviewed July 2022. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html>

	Respondent	Hours	Mean Hourly Wage Rate ^{i, ii}	Costs
Monthly Progress Report	Medical and Health Services Managers	696	\$115.22	\$80,193
Biannual Measures Report	Health Information Technologists and Medical Registrars	3,242	\$59.06	\$191,473
Total		3,938		\$271,666

ⁱ Source: Occupational Employment and Wage Statistics Home Page (bls.gov), May 2021, occupation series 11-9111 and 29-9021

ⁱⁱ The adjusted hourly wage rates account for fringe benefits and overhead costs by multiplying the BLS unadjusted hourly wage rates by a 2.0 multiplier.

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

Because the biannual measures reports include stratification and more frequent reporting of clinical quality measures previously reported via UDS, the grant recipients may incur additional annual operation and maintenance costs for programming or re-programming their information technology systems to generate the data with the required level of stratification. The monthly progress will require grant recipients’ information technology systems to capture more granular information on virtual care types (e.g., synchronous/live audio only, synchronous/live video, asynchronous store and forward, remote monitoring, mobile health, or other asynchronous technologies.) The virtual care types and definitions selected for this project align with established HRSA and HHS definitions to minimize grant recipient burden.

14. Annualized Cost to Federal Government

HRSA Program Officers provide guidance and support on submission of monthly progress and biannual measures reports via the Electronic Handbook, and review and approve the reports after receipt. The estimated annual cost of those activities is \$69,705. This assumes 1,000 hours per year at an hourly rate of \$40.70 for a GS-11 Step 5 employed in Washington DC-Baltimore metro area and 500 hours per year at the hourly rate of \$58.01 for a GS-13 Step 5 employed in the Washington DC-Baltimore metro area.¹³

15. Explanation for Program Changes or Adjustments

Not applicable as this is a new information collection request.

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

¹³ [Pay & Leave: Salaries & Wages - OPM.gov, effective January 2022](#)

HRSA contracted with MITRE to develop four biannual assessment briefs that will document the progress of grant recipients and their performance. Key assessment findings will be distributed cross the Health Center Program via a virtual care implementation toolkit to be completed no later than July 2024. The toolkit will primarily include curated and enduring resources like the set of 12 (twelve) measures, key information from biannual assessment briefs, and resources to address key challenges and lessons learned.

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

The expiration date will be displayed on the monthly progress and biannual measures report templates.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.