

Program Assistance Letter

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DOCUMENT TITLE: Background and Purpose
of the Performance Measure Implementation
for Health Center Program Grantees

TO: Health Center Program Grantees
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

I. Background

In concert with the quality initiatives occurring within the broader health care community, the Health Resources and Services Administration (HRSA) is incorporating quality-related measures that place greater emphasis on health outcomes and demonstrate the value of care delivered by health centers funded under Health Center Program. A key component of the success of the Health Center Program has been its 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 technological advances and the development of provider incentive programs in the private and public health sector market, have underscored the importance of demonstrating that health centers continue to deliver high quality care to underserved populations. Through the implementation of these new measures HRSA will be able to publicly report on key successes of the Health Center Program in providing quality care to the underserved community, and individual health centers will have additional data to support continued performance and quality improvement.

The Bureau of Primary Health Care (BPHC) recently obtained approval from the Office of Management and Budget to collect data on four new standardized clinical measures, building upon the two existing clinical measures collected through the Uniform Data System (UDS). These new measures will be incorporated in the Calendar Year (CY) 2008 UDS and in the Fiscal Year (FY) 2009 Service Area Competition (SAC) and Budget Period Renewal (BPR) funding opportunities. This alignment across grant application and reporting requirements presents an opportunity for grantees to enhance their focus on performance improvement and for HRSA staff to expand its support to grantees in this area. This document presents: (1) BPHC's rationale for incorporating these quality-related enhancements into the Health Center Program; (2) the plan for rolling out these changes; (3) the processes for collecting these data elements; and (4) BPHC's intended use of these data.

II. RATIONALE FOR THE FOUR NEW CLINICAL MEASURES

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

BPHC selected a subset of four new clinical measures from these HRSA core measures. The four new Health Center Program measures are: 1) appropriate childhood immunizations; 2) cervical cancer screening; 3) blood pressure control; and 4) diabetes control. They include both process and outcome measures: childhood immunization and cervical cancer screening as process measures, and blood pressure and diabetes control as outcome measures. Through the annual UDS, health centers will be asked to report on their overall patient populations for the process measures as well as on the racial and ethnic subgroups within that population for the outcome measures. These new measures augment clinical quality measure reporting already underway in health centers including entry into prenatal care, and birth weight.

The BPHC selected the four new measures because together they provide a balanced and comprehensive representation of health center services, clinically prevalent conditions amongst underserved communities, and the population across life cycles. In addition, the majority of health center grantees have extensive experience working to improve the quality of care in diabetes, hypertension, cancer prevention and childhood immunizations. Finally, these measures are nationally endorsed by the National Quality Forum (NQF), and are commonly used by Medicare and Medicaid and health care insurance/managed care organizations to assess quality performance so many health centers already report these measures to these programs.

To minimize the reporting burden on grantees, and based on feedback from health center grantees, BPHC selected only a small subset of the HRSA-wide measures and pilot tested them with a small group of health centers to determine whether it was feasible for health centers to collect and report on these critical measures. The pilot study confirmed that the health centers were able to collect the data and report on them readily based on chart reviews of a sample of patients or through an electronic health record. The four measures selected were among the small subset that most health centers were able to collect and report.

III. WHY NOW?

The significant growth of the Health Center Program, the focus on quality and performance improvement, and the proliferation of information technology (IT) enhancements within health care systems, including health centers, provided the impetus to evaluate and revise the performance reporting requirements for organizations funded under the Health Center Program. As health centers receive reimbursement and support through multiple funding streams, improved performance reporting serves to align health center reporting on clinical performance measures with requirements of major national quality improvement organizations. Furthermore, enhanced performance reporting results in the ability of the

Health Center Program to make evidence-based statements about the impact of health centers on improving access to cost-effective primary care for the nation's underserved populations. Finally, health centers will have the ability to measure the quality of care delivered to their patient populations. HRSA staff is committed to working collaboratively with health centers to provide HRSA training and technical assistance resources to improve health center performance over time.

IV. HOW WILL THESE MEASURES BE REPORTED IN THE UDS AND USED?

The alignment of the measures across the grant application (SAC and BPR) and grant performance reporting (UDS) provides grantees with the opportunity to establish quality and performance goals for their organization and patient populations, and then assess their progress against these established goals. The alignment will also further HRSA's objectives to collect data in a way that minimizes grantee reporting burden, and to document and demonstrate the value and successes of the Health Center Program.

As mentioned, HRSA's purpose for collecting these data is two-fold: to document the overall value of the Health Center Program, and to provide health centers with an assessment of their performance in these areas so that they can set improvement goals and track their improvement over time. HRSA has also established technical assistance resources at the State and national levels to support health centers in achieving their quality improvement goals. In short, HRSA remains committed to its longstanding history of assisting health center grantees in improving the quality of care delivered to low income, uninsured patients.

Starting with CY 2008 UDS, grantees will be submitting reports on-line, making use of a web-based data collection system that is completely integrated with HRSA Electronic Handbooks (EHBs). BPHC grantees will use their EHB user name and password to login to the EHB to complete their UDS submission. BPHC grantees will be able to submit UDS report data using standard web browsers through Section 508 compliant interface. The system will present users with electronic forms that will clearly communicate what is required and will guide the users in completing their reports.

Usability features such as those that pre-fill data from prior year reports will prevent redundant data entry while other features such as calendar controls to enter dates will speed up the data entry process. Grantees will be able to work on the forms in part, save them online, and return to complete them later in a collaborative manner. The approach will also allow grantees to distribute the data entry burden amongst multiple users if desired. Quantitative and qualitative edit checks will also be applied to ensure accurate and consistent data entry.

Grantees will be provided with a summary of what is complete and what is incomplete along with links to appropriate sections to fix the identified incomplete parts. An electronic table of contents for review and printing will be automatically generated making it easy for the grantees to organize their submissions per the requirements.

V. HOW WILL THESE MEASURES BE REPORTED AND USED IN THE SAC AND BPR?

BPHC has redesigned the Health Care and Business Plans presented in the FY 2009 SAC and BPR applications in order to better align the various data requests based on a continuous quality improvement model. In the SAC, grantees will establish long-term project period length performance goals for their organization and patient populations. When possible, applicants should also provide baseline data that directly corresponds to the four new clinical performance measures, as well as the two existing clinical measures. All SAC applicants must also include one behavioral health and one oral health performance measure of their choice in the Health Care Plan. Applicants who have a UDS comparison report which shows their performance as well as State and national data may wish to use these data to assist them in establishing performance goals. Applicants will also be following a similar model for the Business Plan.

Applicants will be expected to track performance against their established goals from the SAC throughout the entire approved project period, and to report interim (annual) progress achieved on those goals in subsequent BPR applications. When submitting their progress reports (BPR application) applicants will report quantitative progress on the related performance measures (including all required measures). Applicants will also be able to report supplementary information that outline qualitative progress such as major contributing or restricting factors impacting the grantee's performance as well as key strategies or objectives undertaken to date that contribute to the achievement of their goals. In addition, project period end goals may be revised if major accelerated progress or barriers have been experienced in the previous budget period. The rationale and comments for any revisions must be provided in the Health Care or Business Plan and/or Program Narrative as applicable.

VI. TRAINING AND TECHNICAL ASSISTANCE ON THESE MEASURES

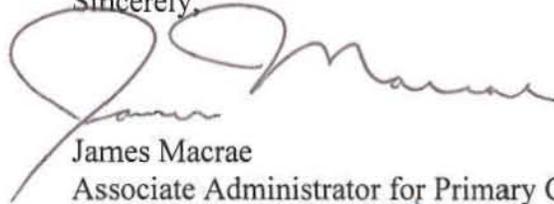
BPHC is embarking on a year-long process to communicate to grantees about these changes and to provide training. BPHC has set aside resources to help grantees understand these changes and respond to these new requirements. Primary Care Associations (PCA) have been trained on these new measures and are prepared to provide technical assistance (TA) to grantees in understanding these measures and how to develop goals and benchmarks for the SAC and BPR Health Care Plans. BPHC has also offered two TA calls on the implementation of the new measures in the SAC opportunity, with replays available until September 2008. The slides and replay information for these calls is available online at: <http://www.hrsa.gov/grants/technicalassistance/sac.htm>. BPHC will also offer TA calls to assist grantees in understanding the new performance requirements in the FY 2009 BPR opportunity, upon its release. To assist grantees in developing baseline and goals for their upcoming SAC and BPR applications, BPHC will also be sending out trend reports to health centers with information from their prior UDS and audit submissions.

For CY 2008, the annual UDS trainings will include additional sessions focused specifically on the four new clinical measures and the sampling and data collection methodology for UDS reporting. More information about the UDS reporting requirements for these measures is available online at: <http://www.bphc.hrsa.gov/uds/2008manual/>. BPHC will also work with its national cooperative agreement partners and all State and regional PCAs throughout the year to continue to communicate these changes and provide training.

VII. CONTACT INFORMATION

For more information and/or questions on the implementation of these new measures, please contact Charles Daly in the Office of Quality and Data at 301-594-0818.

Sincerely,

A handwritten signature in black ink, appearing to read "James Macrae". The signature is fluid and cursive, with a large initial "J" and "M".

James Macrae
Associate Administrator for Primary Care