

## Supporting Statement A

### Health Resources and Service Administration Uniform Data System

OMB Control No. 0915-0193

Terms of Clearance: None

#### 1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting OMB approval for the revision of forms used to collect data in the Uniform Data System (UDS). HRSA utilizes the UDS for annual reporting by certain HRSA award recipients, including Health Center Program awardees (those funded under section 330 of the Public Health Service (PHS) Act), Health Center Program look-alikes, and Nurse Education, Practice, Quality and Retention (NEPQR) Program awardees (specifically those funded under the practice priority areas of section 831(b) of the PHS Act). The UDS forms are currently approved under OMB Control No. 0915-0193, and the current expiration date is December 31, 2020.

Growth of the Health Center Program and proliferation of health information technology (HIT) enhancements within health centers along with increased efforts to reduce reporting burden and increase alignment of clinical quality measures are significant factors leading to the need to revise the performance reporting requirements of the Health Center Program.

HRSA is proposing the following modifications to the UDS:

1. *Quality of Care Measures Alignment with the Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs)*

Revise UDS clinical quality measures in accordance with the corresponding CMS eCQMs updates for 2019 calendar year reporting.

2. *Addition of Mental Health and Substance Use Disorder Tables by Provider*

Collect substance use disorder and mental health services by provider specialty to better assess which providers are delivering behavioral health services; support investments in these priority areas; and better describe comprehensive, integrated models of care.

3. *Addition of Column to Capture Virtual Visits in Table 5: Staffing and Utilization*

Collect information on services provided via telemedicine or virtual visits by provider in order to capture the changing healthcare delivery landscape. Health centers have an interest in capturing how the changing healthcare landscape increases access and quality of care.

4. *Removal of Table 5A: Tenure for Health Center Staff*

Retire Table 5A related to the tenure for staff.

5. *Replacement of Coronary Artery Disease Measure With CMS347V2 Statin Therapy for the Prevention and Treatment Of Cardiovascular Disease*

Replace the current non e-specified Coronary Artery Disease measure with an e-specified measure that aligns with the Centers for Disease Control and Prevention and the CMS Million Hearts® clinical quality measures relating to statin therapy.

6. *Revision Of Appendix D: Health Center Electronic Health Record (EHR) Capabilities And Quality Recognition*

Streamline and clarify HIT questions regarding utilization of HIT to include information sharing, patient engagement, quality improvement, and program evaluation and research.

7. *Addition of Appendix F: Workforce*

Collect workforce related information, including workforce satisfaction and health professional training that impacts provider satisfaction, recruitment, and retention.

## **2. Purpose and Use of Information Collection**

HRSA collects UDS data annually to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. The data help to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of medically underserved communities and vulnerable populations. UDS data are compared with national health-related data, including the National Health Interview Survey and National Health and Nutrition Examination Survey to explore potential differences between health center patient populations and the U.S. population at large, and those individuals and families who rely on the health care safety net for primary care. UDS data also inform Health Center Program partners and communities regarding the patients served by health centers. The HRSA Bureau of Health Workforce (BHW) uses the data to determine the impact of healthcare services on patient outcomes. The data also enable BHW to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations. In addition, UDS data are useful to these BHW recipients for performance and operation improvements, patient forecasts, identification of trends/patterns, implication of access barriers, and cost analysis to support long-term sustainability.

## **3. Use of Improved Health Information Technology and Burden Reduction**

Advancements in EHR technology have been proceeding at a rapid pace. To improve quality, safety and efficiency of care, Promoting Interoperability (PI) needs to be implemented to heighten patients' access to health information and reduce the time and cost required of providers to comply with the programs' requirements. EHRs can help health centers achieve larger quality and efficiency goals, and the use of EHRs streamlines and simplifies health center reporting of UDS measures. At present, 99% of health centers have EHRs installed. The integration of these electronic systems decreases the time and effort that would be required to complete paper-based

data extraction and reporting. Additional, optional tools are being offered to health centers in an effort to reduce burden. These tools include an Excel template (attached) and an offline HTML template (attached) that mimics the reporting environment in the Electronic Handbooks (EHBs) where health centers submit their UDS report. Piloting health centers reported an 88% reduction in time it took to upload data into the EHBs.

#### **4. Efforts to Identify Duplication and Use of Similar Information**

The information collected by these forms is unique to the Health Center Program due to differences in coverage and definitions. Information is not captured in the same form and format elsewhere. There are no other existing sources that could be used for monitoring and administration of the Health Center Program.

#### **5. Impact on Small Businesses or Other Small Entities**

This activity does not have a substantial impact on small entities or small businesses.

#### **6. Consequences of Collecting the Information Less Frequently**

UDS data are required annually in order to effectively monitor program performance and administer program funds. For look-alikes, UDS data are used to monitor program performance and for designation and recertification decisions.

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

The request fully complies with the regulation.

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

A Federal Register notice was published on June 26, 2018 (83 FR 29800). No comments were received.

In 2018, HRSA consulted with several health centers and health center networks. Overall, these outside consultants noted that the information requested should be readily available to the health center; an annual collection of this information is appropriate, and the manual instructions are clear. Some provided suggestions regarding updates to UDS reporting requirements specifically regarding EHRs and telehealth. HRSA will continue to assess and monitor measures to align with measurement bodies, such as CMS e-specifications, Healthy People 2020, and the National Quality Forum (NQF). HRSA used feedback from these outside consultants to estimate the burden hours required for completing annual UDS reporting.

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### **9. Explanation of any Payment/Gift to Respondents**

Respondents will not receive any payments or gifts.

### **10. Assurance of Confidentiality Provided to Respondents**

No patient/user level information is reported. Only aggregate data are collected. The UDS does not involve the reporting of personally identifiable information (PII) about individuals. The UDS specifies the reporting of aggregate data on patients and the services they receive, in addition to descriptive information about each health center and its operations and financial systems.

### **11. Justification for Sensitive Questions**

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.

### **12. Estimates of Annualized Hour and Cost Burden**

Estimated Annualized Burden Hours:

<b>Form name</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Total Responses</b>	<b>Average Burden per Response (in hours)</b>	<b>Total Burden Hours</b>
Universal Report	1,469	1	1,469	223	327,587
Grant Report	574	1	574	30	17,220
Total	2043		2043		344,807

The burden estimates for completing the UDS have been determined based on the experience of HRSA, factoring in minor modifications proposed by commenters and feedback received from outside consultation described in section 8. Individual health center burden is estimated to be 223 hours per respondent for completing the Universal Report and 30 hours for completing the Grant Report. HRSA estimates that there will be approximately 2043 respondents annually and notes that the Universal Report is completed by all Health Center Program award recipients and look-alikes, and the Grant Report is completed by a subset of award recipients who receive multiple

HRSA Health Center Program awards.

Estimated Annualized Burden Costs:

<b>Form Name</b>	<b>Type of Respondent</b>	<b>Total Burden Hours</b>	<b>Hourly Wage Rate</b>	<b>Total Respondent Costs</b>
Universal report	Medical Records/Health IT Technician <sup>1</sup>	327,587	\$20.59	\$6,745,016
Grant report	Medical Records/Health IT Technician	17,220	\$20.59	\$354,560
<b>Total</b>		<b>344,807</b>		<b>\$7,099,576</b>

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

Other than time spent on inputting data, we do not anticipate health centers will incur additional annual operation and maintenance costs for programming or re-programming their information technology systems to generate the data in the required format.

**14. Annualized Cost to the Federal Government**

The estimated annual cost to the government for contracts providing technical assistance, training and data reporting support, data processing, editing, and verification is \$1,300,000. Additionally, the estimated annual cost to the government for FTE is \$48,485 (1 GS-13 – approximately 50% time of work) for reviewing and managing the contract. Total estimated annual costs to the government are \$1,348,485.

**15. Explanation for Program Changes or Adjustments**

The estimated increase of 87,095 total burden hours from 257,712 to 344,807 is largely the result of the overall expansion of the Health Center Program. This expansion includes an increase in the number of patients served from 25,860,296 in 2016 to 27,174,372 in 2017, an additional 1.3 million patients to be accounted for in UDS reporting. Additionally, in 2017 the number of grant report respondents, in this case those health centers receiving funding for special populations, increased by 70 health centers resulting in 2,100 additional overall burden hours.

Though overall estimated burden hours increased, HRSA sought areas to decrease burden through better measure alignment and elimination of tables and questions. For example, outside consultants provided feedback that the retirement of Table 5A: Tenure for Health Center Staff and the elimination of Questions 1b-e, 6, 8, and 9 in Appendix D: Health Center Electronic Health Record (EHR) Capabilities and Quality Recognition would result in an estimated reduction of 5 burden hours per respondent, a net overall reduction of 10,215 hours for all respondents.

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<sup>1</sup> Wages for Medical Records and Health Information Technicians are based on Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Employment Statistics*, Medical Records and Health Information Technicians, at <https://www.bls.gov/oes/current/oes292071.htm>.

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

Respondents submit their information within 90 days after the end of the calendar year. At this time, no statistical analysis will be conducted with the information collected. Summary descriptive reports of the information collected will be prepared and published within 9 months after the end of the calendar year.

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

The OMB number and expiration date will be displayed on every page of every form/instrument.

## **18. Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.