Supporting Statement A

Health Resources and Service Administration Uniform Data System

OMB Control No. 0915-0193

Revision

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 Uniform Data System (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 Bureau of Health Workforce primary care clinic 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 March 31, 2022.

Increased focus on the provision of comprehensive, integrated care, responding to public health epidemics, using health information technology (HIT) within health centers to reduce reporting burden and increased 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. *Alignment of Quality of Care Measures Alignment with the Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs)*

   Update and align UDS clinical quality measures in accordance with the corresponding CMS eCQMs updates for 2020 calendar year reporting. These include the following:

   1. Childhood Immunization Status CMS117v8.
   2. Cervical Cancer Screening CMS124v8.
   3. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents CMS155v8.
   4. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan CMS69v8.
   5. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention CMS138v8.
   6. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease CMS347v3.
   7. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet CMS164v7 (not updated for 2020).
   8. Colorectal Cancer Screening CMS130v8.

9. Preventive Care and Screening: Screening for Depression and Follow-Up Plan CMS2v9.
10. Controlling High Blood Pressure CMS165v8.
11. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) CMS122v8.
12. Dental Sealants for Children between 6 to 9 Years (CMS277v0).

2. *Addition of Preventive Care and Chronic Conditions eCQMs*
   a. *CMS159v8 Depression Remission at Twelve Months;*
   b. *CMS125v8 Breast Cancer Screening;*
   c. *CMS349v2 HIV Screening; and*
   d. *Pre-Exposure Prophylaxis (PrEP) prescription Current Procedures Terminology (CPT) codes*

The collection of additional mental health, preventative care, and treatment of chronic conditions measures will allow HRSA to better assess the services delivered by health centers and respond to changes in primary health care and public health epidemics.

a. The addition of the depression remission measure at 12 months will collect outcome data on how health centers are helping patients reach remission. Improvement in the symptoms of depression and an ongoing assessment of the current treatment plan is crucial to the reduction of symptoms and psychosocial well-being of patients.

b. The addition of the breast cancer screening measure would complement the other preventative care screening measures included in the UDS. Breast cancer is the most common cancer in women and the fourth leading cause of cancer death in the US.[1] There is substantial geographic and demographic variation in breast cancer death rates suggesting that there are social and structural factors that affect breast cancer mortality. Preventative screening through timely access to mammograms can lead to early detection, better treatment prognosis, and has the potential to reduce health disparities.

c and d. HRSA is one of the lead agencies in the 'Ending the HIV Epidemic' Initiative and is building upon the following key strategies: diagnosing, treating, protecting, and responding.[2] Approximately 1.1 million people are living with HIV in the US; 15% of them are unaware that they are infected.[2] The addition of the HIV screening measure will collect data on the detection of HIV in health center patients. Adding pre-exposure prophylaxis (PrEP) prescriptions via Current Procedures Terminology (CPT) codes will allow for the collection of this important preventative data in health centers. The Centers for Disease Control and Prevention (CDC) reports that daily PrEP reduces the risk of contracting HIV from sex by more than 90% and from injection by more than 70%.[3]

3. *Addition of Prescription Drug Monitoring Program (PDMPs) use to Appendix D: Health*

Center Health Information Technology (HIT) Capabilities

PDMPs are effective tools for reducing prescription drug abuse and diversion. Improving provider utilization and access to real-time data have demonstrated meaningful results in reducing over-prescribing of medication. Currently, 49 states, the District of Columbia and Guam have created and are operating PDMPs that collect information from dispensers and report information to authorized users.

4. *Retiring Use of Appropriate Medication for Asthma (CMS126v5)*

   This measure is no longer being updated when new asthma medications are approved for use. Additionally, this measure was retired from the Healthcare Effectiveness Data and Information Set (HEDIS) and lost National Quality Forum (NQF) endorsement. As this measure is outdated and there is no other eCQM for asthma, this will be removed from the UDS for 2020 reporting.

2. Purpose and Use of Information Collection

HRSA collects the 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, geographically isolated, and vulnerable populations and communities. The UDS data are compared with national health-related data, including the National Health Interview Survey (NHIS) and National Health and Nutrition Examination Survey (NHANES) 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. The 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 and to train future providers of care. In addition, UDS data are useful to these BHW award 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 electronic health record (EHR) technology have been proceeding at a rapid pace. EHRs can help health centers achieve 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 reporting tools are being offered to health centers in an effort to reduce burden. These tools include an Excel file and an offline Hyper-Text Markup Language (HTML) file that mimics the reporting environment in the HRSA provided Electronic Handbooks (EHBs) where health centers submit their UDS report. Both of these files are supported by an Excel mapping document that can be used by HIT professionals to

develop software scripts that can automate and populate the reporting of UDS data elements from EHRs and other HIT platforms. Piloting health centers reported an 88% reduction in time it took to upload data into the EHBs, significantly reducing their reporting burden. These optional tools are being improved based upon customer feedback.

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 July 26, 2019 (84 FR 36108). Please see attached for the comments and HRSA's response.

In 2019, 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 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:

Form Name	Number of Respondents	Number of Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
Uniform Data System (UDS) Report	1,503	1	1,503	238	357,714
Grant Report for Vulnerable Populations	531	1	531	30	15,930
UTC Tests	100	3	300	80	24,000
Total	2,134		2,334		397,644

The burden estimates for completing the UDS Report have been determined based on the experience of HRSA, factoring in proposed clinical quality measures and feedback received from outside consultation described in section 8. For 2020 UDS reporting HRSA estimates that there will be approximately 1503 respondents annually and notes that the UDS Report is completed by all Health Center Program award recipients, look-alikes and BHW award recipients. Individual health center burden is estimated to be 238hours for completing the UDS report. For this collection, respondents are defined as the health center organization. HRSA is requesting that the organization respond, not an individual person.

The Grant Report for Vulnerable Populations is completed by a subset of award recipients who receive Migrant Health Center, Health Care for the Homeless, and Health Centers for Residents of Public Housing funding. These grant reports are estimated to take 30 hours to complete and those that receive multiple funds are required to report out on the different vulnerable populations they serve.

As part of HRSA's efforts to modernize the UDS reporting structure and ultimately reduce burden a UDS Test Cooperative (UTC) has been established. The UTC will pilot test changes to UDS content or reporting to help HRSA decide how to implement these changes across the Health Center Program. HRSA is planning to conduct between 1 and 3 tests each year as we work to improve our system and reduce reporting burden. The estimated burden for a small sample of health centers, 100, to participate in one test is 80 hours.

Estimated Annualized Burden Costs:

Form Name	**Type of Respondent**	**Total Burden Hours**	**Hourly Wage Rate**	**Total Respondent Costs**
Uniform Data System (UDS) Report	Medical Records/Health IT Technician[1]	357,714	$42.32	$15,138,456.50
Grant Report for Vulnerable Populations	Medical Records/Health IT Technician	15,930	$42.32	$674,157.60
UTC Tests	Medical Records/Health IT Technician	24,000	$42.32	$1,015,680
Total		397,644		$16,828,294.10

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

1 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.

The estimated annual cost to the government for contracts providing technical assistance, training and data reporting support, data processing, editing, and verification is $1,812,175. Additionally, the estimated annual cost to the government for FTE is $58,595 (1 GS-14 – approximately 50% time of work) for reviewing and managing the contract. Total estimated annual costs to the government are $1,870,770.

15. Explanation for Program Changes or Adjustments

The estimated increase of 52,837 total burden hours from 344,807 to 397,644 is largely the result of the overall expansion of the Health Center Program, the addition of clinical quality measures to address HRSA and HHS priority areas, and the creation of the UDS Test Cooperative (UTC) to aid in modernizing and reducing reporting burden over the next 3 to 5 years. The Health Center Program served 1.2 million more patients, from 27,174,372 in 2017 to 28,379,680 in 2018. With more patients 34 more health centers were brought into the program, from 1,469 in 2017 to 1,503 in 2018.

Though overall estimated burden hours increased, HRSA is working to reduce the overall burden through research and development in measure alignment, streamlining of tables and forms, and developing IT systems to support automation of reporting. These efforts are being piloted tested through the formation and operation of the UDS Test Cooperative (UTC). HRSA aims to implement improved IT systems and streamlined reporting to significantly reduce the burden of UDS reporting starting in CY 2023.

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

Respondents submit their information between January 1 and February 15 of the calendar year and report on information from the previous year. For example, 2018 UDS figures are reported January 1 through February 15 of 2019. From February 15 to March 31, UDS reports are reviewed for data quality and consistency. Statistical analysis will be conducted with the information collected, please see Supporting Statement B for more detailed information. Summary descriptive reports of the information collected will be prepared and published by August of the calendar year.

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

The OMB number and expiration date will be displayed on the end cover of the UDS Manual.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

[1] https://seer.cancer.gov/statfacts/html/breast.html
[2] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[3] https://www.cdc.gov/hiv/basics/prep.html