Supporting Statement A

Bureau of Primary Health Care Uniform Data System

OMB Control No. 0915-0193 - Revision

Highlighted text is the information changed from the original request.

Terms of Clearance: None

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting a revision to the Bureau of Primary Health Care (BPHC) Uniform Data System (UDS) information collection request, previously approved under OMB Control No.: 0915-0193, Expiration Date: 2/28/2018. The UDS is the annual reporting system for health centers that are entities funded under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, and the Health Center Program look-alikes. In addition, a subset of recipients of the HRSA Bureau of Health Workforce's (BHW) Nurse Education, Practice, Quality and Retention (NEPQR) Program, specifically those recipients that are funded under the practice priority areas listed under Section 831(b) of the PHS Act are also required to complete UDS annual reporting.

The significant growth of the Health Center Program, the proliferation of health information technology (HIT) enhancements within health centers, and the desire to reduce reporting burden and increase alignment of clinical quality measures are major factors that have heightened the need to evaluate and revise the performance reporting requirements of the Health Center Program.

HRSA is proposing six 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)*

   Table 6B and 7 – The UDS clinical quality measures have been revised in accordance with the corresponding CMS eCQMs updates for 2018 calendar year reporting.

   Rationale: To support continued efforts to standardize data collection and reduce reporting burden for health centers.

2. *Diabetes Poor Control Measure Modification*

   Table 7 – The column collecting information on patients with HbA1c levels <8% will be removed.

   Rationale: The CMS eCQM does not include reporting HbA1c <8%. Therefore, HRSA is removing this reporting requirement to be consistent with the Healthy People 2020 national benchmark for diabetes management, the CMS eCQM for diabetes management,

and to reduce health center reporting burden.

3. *Removal of Patient Centered Medical Home Questions in Appendix D*

Appendix D – The two questions on Patient Centered Medical Home (PCMH) recognition and accreditation will be removed.

Rationale: HRSA routinely receives data on PCMH recognition from national quality recognition organizations. Therefore, HRSA is removing this question to reduce reporting burden.

4. *Revision of Telehealth Question in Appendix E*

Appendix E – The question on telehealth that was previously in Appendix D will be moved to Appendix E and will include subparts to allow for more precise information on telehealth use in health centers.

Rationale: Telehealth is increasingly used as a method of health care delivery for the health center patient population, especially hard-to-reach patients living in geographically isolated communities. Based on the uniqueness of telehealth data and its introduction into the UDS system, HRSA is proposing questions that more precisely describe health center efforts in this area.

5. *Revision of the Medication-Assisted Treatment (MAT) Question in Appendix E*

Appendix E – The question on MAT highlighting recipients of the Drug Addiction Treatment Act of 2000 (DATA) waiver that was previously in Appendix D will be moved to Appendix E and will be updated to incorporate nurse practitioners (NPs) and physician assistants (PAs).

Rationale: The current MAT question lists physicians as the only health professionals eligible to receive a DATA waiver to treat opioid use disorder. With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physicians' assistants (PAs). This revision will better align the question with the statute.

6. *Revision of Meaningful Use Attestation Question in Appendix D*

Appendix D – At present, 98.7% of HRSA supported health centers have reported adoption and use of Electronic Health Records (EHRs) at their sites. HRSA is updating the question regarding participation in the CMS EHR Incentive Program, often referred to as Meaningful Use (MU), to capture the extent to which health centers participate in the program.

Rationale: The current MU question lists outdated attestation stage titles. This revision will update the stage titles to align with the EHR Incentive Program Update and ensure accuracy of data reporting.

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. BHW uses the data to determine the impact of healthcare services on patient outcomes. The data also enables 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, EHR incentive programs provide a financial reward to eligible providers practicing in health centers. 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, 98.7% of health centers have EHRs installed.

Respondents utilize a web based data collection system that is integrated fully with HRSA's Electronic Handbooks (EHBs). Once data are extracted from an EHR, they may be readily entered into the EHB, bypassing the need for manual chart reviews and random sampling. The integration of these electronic systems decreases the time and effort that would be required to complete paper-based data extraction and reporting.

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. No other existing sources can be used for grant 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, the UDS data are used to monitor program

performance and for designation and recertification decisions. For BHW, UDS data are used to assess patient outcomes and identify effective services to improve patient health.

HRSA would not be able to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments if the information is not collected.

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

Section 8A:
A Federal Register notice was published on May 5, 2017 (Vol. 82, No. 86, pages 21253-21254). One public comment (Attachment A) was received in response to this notice. We responded to the comment (Attachment B) and have considered the commenter's suggestions, and made appropriate adjustments to the draft instruments.

Section 8B:
In 2017, BPHC 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. BPHC 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 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:

Type of Respondent	Form Name	No. of Respondents	Number of Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
Private Sector (Medical Records/Health IT Technician)	Universal Report	1,471	1	1,471	168	247,128
Private Sector (Medical Records/Health IT Technician	Grant Report	504	1	504	21	10,584
Total		1,975		1,975		257,712

The burden estimates for completing the UDS have been determined based on the experience of BPHC, 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 168 hours per respondent for completing the Universal Report and 21 hours for completing the Grant Report. BPHC estimates that there will be approximately 1,975 respondents annually and notes that Universal Report is completed by all grantees and look-alikes, and the Grant Report is completed by a subset of grantees who receive multiple BPHC grants.

Estimated Annualized Burden Costs:
The estimated annualize burden costs for this request is $5,136,200.

Form Name	Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Universal report	Medical Records/Health IT Technician[1]	247,128	$19.93	$4,925,261

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.

Grant report	Medical Records/Health IT Technician	10,584	$19.93	$210,939
Total				$5,136,200

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 $47,500 (1 GS-13 – approximately 50% time of work) for reviewing and managing the contract. Total estimated annual costs to the government are $1,347,500.

15. Explanation for Program Changes or Adjustments

The proposed revisions will result in a net reduction of two burden hours per respondent with an overall per respondent burden reduction of 3,950 hours. This reduction will be attributable to the collective retirement of the PCMH measure in Appendix D, the reduction of <8% HbA1c reported in the diabetes clinical measure in Table 7, and the modification of the telehealth question in Appendix E.

The overall increase of 25,394 total burden hours from 232,318 to 257,712 is the result of an increase of 673 total respondents. The additional respondents result from the expansion of the Health Center Program and the addition in 2016 of a subset of recipients of the BHW Nurse Education, Practice, Quality and Retention program as respondents.

Although the total number of burden hours has increased due to an expansion of the program, BPHC has reduced the respondent burden through streamlining and alignment of the data collection instrument.

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.