From:	Katie Noss
To:	HRSA Paperwork
Cc:	Shelley Riser; Andrea Flowers; Eric Kiehl
Subject:	[EXTERNAL] Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193—Revision
Date:	Tuesday, January 21, 2025 8:30:13 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193—Revision - PACHC comments.docx

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Good morning,

I am submitting comments on Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193—Revision on behalf of the Pennsylvania Association of Community Health Centers. Please see comments below and/or attached. Thanks you!

UDS/UDS+ Public Comments to Federal Register OMB No. 0915-0193—Revision

HRSA specifically requests comments on: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We believe in HRSA's UDS modernization efforts in both the data collection and the framework standardization of such. In that perspective it is our belief that this is a true necessity and there are a few ways by which this can be accomplished with a mutually beneficial intended outcome for both HRSA and the health centers by which the data is collected and reflective of the true patients served annually. At the core data accuracy relies on a standardization of framework with collection which includes database fields and the requirement of such without algorithm aggregation. It is our opinion that this is all accomplishable, but there are a few idea/suggestions that we feel can make this a true success.

The first is to address the process in which ONC certified HIT vendors are certified to US CORE and USCDI standards that are behind/out of sync with what is being required by HRSA for this data/framework standardization. Similarly, if you couple this with the Standard Version Advancement Process, (SVAP) where this is par for the software development course, the out of balance sync is then further amplified. In our opinion, vendors at a base are only developing their software and associated modules to what is required by these frameworks and the process of "what's coming" sits on the ideation phase way to long. Only SOME go as far as to develop to the approved SVAP standards and release it in beta forms only to a few clients and not their entire customer base. This creates an ecosystem of data mismatch and health centers reliant on the vendors are beholden to this complexity with the consequence of data capture errors. The success of this proposed modernization strongly relies on the right required fields

being available in the softwares by which the data is captured.

The second opinion to which this process can be ratified even further is to address with the US Census the race and ethnicity options for all especially in the minority populations. The current options of selection do not accurately represent the aforementioned and therefore health centers are unable to capture this data with stronger accuracy because patients will choose "other" rather than something that is identifiable to them which then further complicates the data. Couple this with what has been suggested in the first opinion then we get years behind in accurately understanding the data of the patients and where a true reflection of their classifications outside of the "other" fields in the capture because we typically capture this information yearly.

With the aforementioned, it seems to be primed and ready for the opportunities to implement machine learning, (ML) and artificial intelligence, (AI) to solve/remedy the complexity of the requirements and we agree. The maturity of both ML/AI can be implemented thoughtfully but this adds costs and a burden that if not addressed will have an adverse reaction of unintended consequences. The costs are including but not limited to research, demos, acquiring, installing, configuring, support, staffing, skill development, maintaining, etc. In our opinion this is all doable and a next step advancement worthy of further financial investment by HRSA to 330 grant recipients and health center program look-alikes as we navigate and deal with the necessary maturity of Information Technology in health centers to continue to position us all in the next age of what makes health centers great in delivering quality outcomes worthy of the previous 51 years of bi-partisan financial investment.

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