January 21, 2025

HRSA Information Collection Clearance Officer
Health Resources and Services Administration
Room 14NWH04
5600 Fishers Lane
Rockville, Maryland 20857

RE: Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193—Revision.

To Whom it May Concern,

The Alabama Primary Health Care Association (APHCA) is a nonprofit statewide primary care association representing community health centers operating across 19 organizations at over 200 locations serving over 336,000 patients. For 40 years, APHCA has been a catalyst for high performance and operational excellence across its integrated community health center network. Services, training, and technical assistance programs are rooted in organizational values of servant leadership, excellence, and performance. APHCA appreciates the opportunity to comment on the proposed changes to the Health Resources and Services Administration Uniform Data System.

Tobacco Use Cessation Pharmacotherapies A new measure is being added to line 26c2 to identify the number of visits where patients received tobacco cessation pharmacotherapies as an intervention and the number of patients who received this pharmacologic treatment. While the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention electronic-specified clinical quality measures (CMS138v12) (Table 6B, Line 14a) that is currently reported in the UDS assesses for cessation, it lacks the capacity to disaggregate and report a distinct percentage for patients receiving counseling or recommendation to cessation pharmacotherapies. Adding a line for reporting tobacco use cessation pharmacotherapies will promote a greater understanding of the breadth of tobacco cessation interventions provided at health centers, specifically allowing HRSA to see differences in tobacco use cessation approaches.

- Pharmacologic therapies may be indicated in some cases, but the underserved, uninsured populations served by the FQHCs don't often have the luxury of paying for medications. There are programs (like QuitNow, Quit Assist, and SmokeFree.gov) that have proven behavioral and peer support models, often along with nicotine patches/lozenges as part of their program. These are cost-effective and often utilized in FQHCs to allow uninsured and underinsured patients more than a prescription – but a program for sustained cessation. By requiring data on the prescriptions written, providers will feel more compelled to write prescriptions, and patients will unfortunately feel they can't quit because they cannot afford what is recommended. A more accurate measure for overall patient care would

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perhaps involve measuring how many patients are offered or connected with a long-lasting cessation method (beyond education at the visit, which "checks" the box in the preventative care visit measure.

- This will only add a reporting requirement. The bulk of tobacco cessation therapies are available to patients OTC. Nicotine replacement therapies are safe for most, and patches, gum, and lozenges are all available OTC. Varenicline is available by prescription only. It is also unsafe for many with depressive disorder. The unintended consequence of this rule is going to push more prescriptions of a less safe drug because it's easier to track and prove intervention. This is a mistake in every way. Please go back to the drawing board.

Medications for Opioid Use Disorder (MOUD)

A new measure for MOUD services will be reported on line 26c3 for the number of visits where MOUD was administered and the number of patients who received this medication-based intervention. This new measure will enhance the existing MOUD related measures that health centers currently report on in Appendix E: Other Data Elements (*e.g.,* number of providers who treat opioid use disorder with MOUD). The inclusion of this measure is critical for supporting public health efforts to address the ongoing opioid epidemic. A greater understanding of the use of MOUD in health centers is necessary to understand existing services and identify remaining healthcare gaps.

- Providers initiating and engaging in the conversation and allowing care to actively involve the patient in the decision-making process should be monitored and rewarded – regardless of a prescription being written.
- APHCA applauds the focus on increasing MOUD prescriptions. There are times when the correct answer is no. The appropriate metric here would be MOUD prescription considered in patients with opiate addiction. Just knowing a raw number will miss the real question.

Alzheimer's Disease and Related Dementias (ADRD) Screening

A new measure is being added to line 26f to capture the number of visits where patients received ADRD screenings and the number of patients who received the screenings. This measure will encompass assessments representing standardized tools used for the evaluation of cognition and mental status of older adults. The addition of a measure to capture screening of ADRD will be valuable in understanding the level of need and resources required to continue to support the growing aging population served by the Health Center Program and will foster early detection for those at risk for ADRD.

- In an effort to provide holistic care, identifying cognitive decline (as well as other disease processes) is imperative. Still, the ongoing addition of screening tool after screening tool will inevitably lead to "checking a box" to meet a measure but no practice change. Each year, more screen tool requirements are added. The list is longer. The patient intake process becomes more burdensome for the patient, and whether they refuse to participate or decide to give the easiest answers to get through the questions, the result will be that the screening tools will not have the intended effect of identifying the challenge. Patients who dread going to their provider will simply not go. If we are using screening tools that are long or intricate, more time is added to the visit and the provider/staff burden – especially for something that has no significant impact on the course of the disease.
- Alzheimer's is a devastating diagnosis for which we have no great therapeutic options. We all want to identify it earlier but are not great at altering the course of the disease, even with currently available medications. These screening tools that have proliferated within HRSA's

desire for more accountable medicine are extremely time and labor-consuming. The unintended consequence of this is the contraction of the number of patients who can be seen. Most good clinicians can diagnose Alzheimer's, depression, opiate use, tobacco readiness to quit, attention deficit, SDOH, and a myriad of other conditions without screening tools. What none of them can do is fulfill their duty to the population while waiting for a litany of screening tools to be completed at every visit. The burden of paperwork is hurting patient access, a key component of the iron cross of quality.

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Table 6B (Quality of Care Measures) Addition

Initiation and Engagement of Substance Use Disorder Treatment

A new measure with two distinct rates is being added to Lines 23a and b to capture the initiation and engagement of substance use disorder treatment, in alignment with electronic-specified clinical quality measure CMS137v13. This measure will report on the percentage of patients 13 years and older with a new substance use disorder episode who received treatment, including (a) those who initiated treatment within 14 days and (b) those who engaged in ongoing treatment within 34 days. By incorporating this measure, HRSA strengthens its alignment with national performance standards and gains greater insight into how effectively health centers are initiating and engaging patients in substance use disorder treatment.

- The measure is inherently complicated on the face and, therefore, will be quite burdensome to understand or meet. The requirement for it being "new" disorder is another challenge – both from data and documentation standpoint and also from trying to also reengage patients in treatment that may have had SUD for years. If they are NOW ready, they would have the same intervention options. The initial and ongoing treatment options outlined also assume that the patient can get the treatment in the health center -if they cannot and a referral is made (to AA or NA, for example) then there is no way for the center to meet the ongoing measure because they will not have any referral closure opportunities to then document that the patient remained in care. The requirements to meet this measure (in both parts) are exceedingly complex when evaluated in the context of centers that do not have vast service offerings or are rural. They may not be able to provide their own SUD treatment or ongoing substance use provider support for the patients and, therefore, refer them out. If they receive referral information from their SUD partners back, then it will be the staff who have to analyze and input into the EHR for reporting – the value of that data input seems minimal.
- This is stated as if there is one path or even a very limited number of paths for the treatment of "new" substance use disorders. The better investigatory group would be "Any" person with a substance use disorder. This would allow for regression to the mean of what you are going to be able to measure for intervention. In many of these cases, we are going to refer a patient to Alcoholics Anonymous or another 12-Step program. Please realize that these, by definition, in their name do not close the referral gap.

APHCA appreciates your consideration of these comments but are asking you to please consider the potential burden in your interventions. In each of these cases, you are adding more burden than improvement. Let's demand and get better quality in patient care. Let's get there by demanding and getting better quality in our quality improvement mandates.

Sincerely,

Mary Hayes Finch, JD, MBA, CHC
President and CEO
Alabama Primary Health Care Association