January 17, 2025

HRSA Information Collection Clearance Officer
5600 Fishers Lane, Room 14NWH04
Rockville, Maryland 20857

RE: Agency Information Collection Activities: Proposed Collection: Public Comment Request; Health Resources and Services Administration Uniform Data System (UDS), OMB No. 0915-0193—Revision

To Whom It May Concern:

On behalf of The Wright Centers for Community Health (TWCCH) and Graduate Medical Education (TWCGME) (collectively referred to as "The Wright Center"), thank you for your leadership in improving population health through the proposed uniform data system changes. TWCCH is a Federally Qualified Health Center (FQHC) Look-Alike, an Essential Community Provider of safety-net primary health services, an Opioid Use Disorder Center of Excellence, and a Ryan White HIV/AIDS provider. TWCCH serves approximately 40,000 patients, operating thirteen primary care community health centers (CHCs) throughout Northeastern Pennsylvania, inclusive of a school-based health center and a mobile medical and dental unit ("Driving Better Health"). TWCCH serves as the cornerstone ambulatory whole person primary care delivery organizational member of our Teaching Health Center (THC) Graduate Medical Education Safety-Net Consortium (GME-SNC) operated by our affiliated entity, TWCGME, our Sponsoring Institution accredited by the Accreditation Council on Graduate Medical Education.

Together with GME-SNC stakeholders, The Wright Center trains over 250 primary care residents and fellows in a community-based, needs-responsive, interprofessional workforce development model to advance our shared mission to improve the health and welfare of our communities through inclusive and responsive health services and the sustainable renewal of an inspired, competent workforce that is privileged to serve. Our Graduate Medical Education Safety-Net Consortium is community owned and governed, with a fiduciary responsibility for high-integrity stewardship of federal resources, including those from CMS, the Health Resources and Services Administration (HRSA) THC, and Veteran Affairs GME programs, as well as multi-payor clinical revenues.

Table 6A (Selected Diagnoses and Services Rendered) Additions

Tobacco Use Cessation Pharmacotherapies and Medications for Opioid Use Disorder (MOUD): The addition of measures for tobacco use cessation pharmacotherapies and medications for opioid use disorder (MOUD) to the Uniform Data System (UDS) is a significant step forward. To further enhance the value of this data, several improvements could be considered.

First, increasing the granularity of data collection would provide more detailed insights. This could involve adding specific NDC codes for different types of pharmacotherapies and disaggregating MOUD and tobacco cessation data by medication type. The addition of NDC codes may be new for Table 6A, as historically it has only looked at ICD10 and SNOMED codes. The addition of including NDC to capture medications would be favorable to ensure the correct data is meaningfully collected.

Next, collecting patient-level data, such as demographics, poverty level and other health conditions, would allow for further identification of disparities and inform targeted interventions to find collation between social determinants of health (SDOH) factors and substance use.

Finally, developing measures to assess the outcomes of these interventions, including patient-reported outcomes, would help evaluate the effectiveness of treatment. Incentivizing and facilitating data sharing and collaboration between health centers and other stakeholders would promote the dissemination of best practices and support evidence-based decision-making. By implementing these recommendations, the UDS data could become an even more powerful tool for improving the quality of care and addressing the public health challenges of tobacco use and opioid addiction.

Alzheimer's Disease and Related Dementias (ADRD) Screening:
The addition of a measure for tracking Alzheimer's Disease and Related Dementias (ADRD) screening to the UDS is also a welcome step towards addressing the growing need for early detection and intervention. Similar to MOUD and Tobacco Cessation mentioned above, there are several areas where this measure could be further enhanced.

First, it would be beneficial to specify which standardized tools or assessments will be included in the measure. This will ensure consistency in data collection and reporting. Historically, health centers have used Mini Cog and Mini Mental State Exams.

Next, considering the complexity of ADRD diagnosis, it could be beneficial to include a measure for follow-up care, such as referrals to specialists or enrollment in supportive services. This would provide a more comprehensive understanding of the continuum of care for patients with ADRD. Additionally, as mentioned earlier, the collection of patient-level data, such as age, sex, race/ethnicity, and other relevant risk factors, could help identify disparities in screening rates and outcomes. This information could inform targeted interventions and resource allocation.

Finally, exploring the feasibility of linking ADRD screening data to other relevant measures, such as cognitive impairment diagnosis of dementia-related healthcare utilization, could provide valuable insights into the impact of early detection and intervention across the country.

Table 6B (Quality of Care Measures) Addition

Initiation and Engagement of Substance Use Disorder Treatment:
The addition of a measure for the initiation and engagement of substance use disorder (SUD) treatment to the UDS is a significant step forward in addressing the ongoing opioid epidemic.

This measure will provide valuable insights into the effectiveness of health centers in delivering timely and comprehensive care to patients with active substance use disorders.

To further enhance the utility of this measure, several considerations should be explored. First, it would be beneficial to expand the definition of "substance use disorder treatment" to include a wider range of interventions, such as medication-assisted treatment, behavioral therapies, and peer support services. This would provide a more comprehensive picture of the treatment landscape and identify potential gaps in care.

Second, when collecting data on adolescents as it pertains to 42 CFR HIPAA regulations, it can prove to be challenging to get them into treatment while still under the care of a legal guardian. This 13-17 year old population may skew the intentions of what HRSA is trying to track, as it relates to targeted interventions and resource allocation to address these disparities in adolescents.

It is imperative for the tracking of initiation and engagement rates for SUD that case management and certified recovery specialists visits be included in the numerator. These trained professionals are typically the staff that patients will be scheduled with for follow up appointments in between doctor's visits for effective MOUD treatment.

Table 6B (Quality of Care Measures) and Table 7 (Health Outcomes and Disparities)

The alignment of UDS clinical quality measures with CMS electronic-specified clinical quality measures (eCQMs) for performance year 2025 is a significant development that promises to enhance data standardization and quality improvement across the healthcare landscape. By adopting these standardized measures, health centers can streamline their reporting processes, reduce administrative burden, and contribute to a more comprehensive understanding of healthcare quality and performance.

However, it is essential to acknowledge the potential challenges and limitations of this alignment. While standardizing measures can improve data comparability and facilitate national benchmarking, it may not fully capture the unique characteristics and priorities of health centers, particularly those providing care to underserved populations. Some measures may not be directly applicable or may require modifications to accurately reflect the specific services and outcomes of health centers.

To mitigate these challenges, it is crucial to strike a balance between standardization and flexibility. While adhering to national standards is important, health centers should be able to retain the ability to report on measures that are relevant to their local context and priorities. For instance, in the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, we continue to lose credit for patients who are more comfortable taking Red Yeast Rice as an over the counter statin. Red Yeast Rice holds the same therapeutic benefit and pharmaceutical therapies, but the UDS reporting continues to not recognize it.

A second example of this issue is the absence of discrediting health centers who continue to provide care to children whose guardians strongly oppose vaccinations. Health centers are put

in a tight spot when trying to respect the guardian's decision for the child, but then may receive negative consequences from the HRSA reporting perspective. The childhood immunization status measure is discouraging to pediatric providers who continue to see these children and counsel their guardians on the importance of vaccination when all the other health systems have dismissed them. Flexibility of the standard measures mentioned above will ensure that the UDS continues to provide a comprehensive and accurate picture of the quality of care delivered by health centers.

To maximize the benefits of this alignment, several key steps should be taken. First, clear and timely guidance should be provided to health centers on the specific measures that will be included in the UDS and how to report on them accurately. This will help to minimize confusion and ensure consistent data collection. Second, ongoing communication and collaboration between HRSA and CMS is essential to address any issues or concerns that may arise during the implementation process. Regular office hours, along with feedback and input from health centers can help to identify and resolve potential challenges in a timely fashion.

UDS+ Test Submissions for Health Centers

As it pertains to UDS + test submissions, it is important to regularly evaluate the impact of the alignment on health center reporting burden and the quality of data collected. By monitoring the implementation process and collecting feedback from health centers, HRSA can identify areas for improvement and make adjustments as needed. By taking these steps, HRSA can ensure that the UDS continues to be a valuable tool for monitoring and improving the quality of care delivered by health centers.

The advent of UDS+ marks a significant stride in healthcare data collection and analysis. By transitioning from traditional, aggregated data to patient-level information, health centers can now delve deeper into the intricacies of patient health and the effectiveness of their services. It would be remiss of us not to mention that the hours spent collecting accurate data to ensure a health center can properly capture their quality measures require at least two full-time equivalents (FTEs) to effectively coordinate with specialists offices, hospital systems, and community agencies. These individuals cannot be overlooked when researching reporting burden hours, nor can the ongoing lack of interoperability across the country be ignored.

As the National Coordinator for Health Information Technology (ONC) continues to focus its time and attention on the Trusted Exchange Framework and Common Agreement (TEFCA), HRSA should be incentivising FQHCs and Look-Alikes to connect to these large vendors as necessary partners. The 31 million lives served by FQHCs and Look-Alikes cannot be overstated, and FQHCs and Look-Alikes need to be contributing to TEFCA to ensure its continued success in closing loops and reducing healthcare costs nationwide.

Next, it is extremely important that as HRSA polishes and refines the UDS+ reporting that the work of Community Health Workers be incorporated into Table 5 under the enabling services categories. It is imperative to include their patients served on Row 27c on Table 5 as the cumulative total, as the Addressing Social Risk Factors badge is linked directly to the absolute

increase in those who received enabling services, yet their patient population can not be reflected in the table. This lapse in oversight sends a disheartening message to those in Community Health Worker positions that HRSA does not “recognize you as an eligible provider,” which is what we have been told by the BPHC help desk when we have raised this concern. We hold faith that HRSA did not intend to exclude the work of Community Health Workers from this badge and that it was likely an unintentional oversight in the design of the table.

Imagine a future where health centers can pinpoint specific populations at risk, tailor interventions to individual needs, and measure the impact of their programs with unprecedented precision. We believe UDS+ is the key to unlocking this potential. By leveraging the power of Fast Healthcare Interoperability Resources (FHIR) and TEFCA connections, health centers could seamlessly integrate their electronic health records with the UDS+ system, streamlining data submission, authentically receiving CHQR badges and reducing administrative burdens.

However, the road to realizing this future is not without its challenges. Technical hurdles, data quality concerns, and the need for comprehensive training and support are just a few obstacles that must be addressed. Health centers and HRSA must work closely together to ensure a smooth and successful implementation.

HRSA can play a pivotal role by providing clear guidelines, comprehensive technical assistance, and robust data security measures. By working together, health centers and HRSA can overcome these challenges and harness the transformative power of UDS+. The ultimate beneficiaries of this endeavor will be the patients themselves, who will receive more targeted, effective, and equitable care.

Sincerely,

Aimee Wechsler

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The Wright Center for Community Health
The Wright Center for Graduate Medical Education