Supporting Statement A for Request for Clearance:

NATIONAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0234

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Supporting Statement

NCHS National Ambulatory Medical Care Survey

This request is for a revision of an approved data collection (OMB No. 0920-0234: Expiration date 07/31/2012), the ongoing National Ambulatory Medical Care Survey (NAMCS), for the purpose of collecting data for the next three years. NAMCS is a national survey of patient visits to office-based physicians conducted by the National Center for Health Statistics (NCHS), one of the centers of the Centers for Disease Control and Prevention (CDC). Proposed modifications to (1) collected information, (2) instruments, and (3) sampling composition are discussed below. Selected activities below also involve the American Recovery and Reinvestment Act of 2009 (ARRA), which includes the Health Information Technology for Economic and Clinical Health (HITECH) Act, as well as the Patient Protection and Affordable Care Act of 2010 (ACA).

New/modified activities planned for the 2011-2013 survey period:

- Once the President's 2011 budget is passed, increase the sample for NAMCS to 4,700 from the current base of 3,000 office-based physicians
- Remove the current paper-based cervical cancer screening supplement
- Conduct a pretest in Spring 2011 to evaluate the new asthma supplement and new complementary and alternative medicine (CAM) items on the NAMCS-1, retrospective health care data collection on the PRF (lookback module), and the new computerized NAMCS-1 and associated patient record form (PRF)

New activities evaluated in 2011 and planned for the 2012-2013 survey period:

- Introduce a provider-based supplement to assess asthma management by physicians/providers
- Add items to the NAMCS-1 that evaluate a physician's use of complementary and alternative medicine (CAM)
- Computerize data collection activities: NAMCS-1 induction form and PRF
- Add items (beginning in 2012) to the current NAMCS PRF to measure risk factors and medical care provided during the past 12 months (lookback module)

New electronic medical record (EMR)/electronic health record (EHR) workflow supplemental survey planned for the 2011-2013 survey period:

- Beginning in the spring of 2011, we will introduce a provider-supplement to the EMR/EHR mail survey to assess physician workflow before and after EMR/EHR implementation

Continuing data collection activities with no change at the present time:

- Patient visits to office-based NAMCS physicians

- Patient visits to physicians and mid-level providers at community health centers (CHCs)
- EMR/EHR mail survey
- Laboratory values on the Patient Record form (PRF) measuring risk factors for cardiovascular disease and diabetes
- Supplemental sample of 200 oncologists

The continuing EMR/EHR mail survey is one part of an ongoing project that involves the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). The new physician workflow study, a longitudinal follow-up study, expands on the current EMR/EHR mail survey. Both the EMR/EHR and the physician workflow mail surveys help to measure progress towards Health Information Technology for Economic and Clinical Health (HITECH) Act program goals. Additionally, the physician workflow study addresses provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) section 1561 (Public Law 111-148). Section 1561 requires the Department of Health and Human Services (HHS), in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, to develop interoperable and secure standards and protocols that facilitate electronic enrollment to encourage adoption of modern electronic systems. The main purpose of the physician workflow survey is to better understand physician experiences at various levels of EHR adoption and use in order to develop and inform policies that facilitate the adoption of modern electronic systems. The aim of both the HITECH Act and ACA include enhancing efficiency and improving quality in the health care system, expanding access to care, and improving patient health. The EMR/EHR and Workflow surveys will provide important information that will aid in the evaluation and implementation of ARRA and ACA goals.

Typically throughout a survey period, slight modifications to the forms are needed. Therefore, in addition to the requested approval summarized above and herein, we are also requesting the ability to submit non-substantive change packages, as needed, for form modifications occurring throughout the 2011-2013 study period. If less money is approved for a sample size increase in the 2011 budget, OMB will be notified of the exact changes in sample size through a nonsubstantive change request. A three-year clearance is requested.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

NAMCS was conducted from 1973 through 1981, in 1985, and since 1989 has been an annual survey. The breaks in data collection from 1982 through 1984 and 1986 through 1988 were due primarily to budget constraints. The survey is conducted under authority of Section 306 of the Public Health Service Act (42 USC 242k) (**Attachment A**).

Core NAMCS

The core NAMCS refers to (1) the traditional sample of nonfederal office-based physicians, and (2) physicians and mid-level providers sampled in federally funded community health centers (CHCs). The specific purpose of the core NAMCS is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States, and as such, fulfills one of NCHS missions, to monitor the nation's health. Ambulatory services are rendered in a wide variety of settings, including physician offices and hospital outpatient and emergency departments. Since more than 80 percent of all direct ambulatory medical care visits occur in physician offices, NAMCS provides data on the majority of ambulatory medical care services. To complement these data, the National Center for Health Statistics (NCHS) initiated the National Hospital Ambulatory Medical Care Survey (NHAMCS) (OMB No. 0920-0278) in 1992 to provide data on patient visits to hospital outpatient and emergency departments.

In addition to health care provided in physician offices and outpatient and emergency departments, CHCs play an important role in the health care community by providing care to people who might not be able to afford it otherwise. Specifically, CHCs are local, non-profit, community-owned health care providers which serve approximately 13 million individuals throughout the United States. Research has shown that up to 4 percent of all primary care visits and 10 percent of all visits by uninsured patients are made to CHCs. Prior to 2006, visits made to CHCs, although captured in NAMCS, were not purposely included in the sampling plan; at that time, CHCs did not represent a separate NAMCS stratum. In an attempt to obtain a more accurate picture of health care provided in the United States, a sample of 104 CHCs was included in the 2006 NAMCS panel. There has been annual data collection since that time, and these settings will continue to be sampled in 2011-2013.

NAMCS is part of the ambulatory care component of the National Health Care Surveys (NHCS), a family of provider-based surveys that capture health care utilization from a variety of settings, including hospital inpatient and long-term care facilities. NCHS surveys of health care providers, including NAMCS, National Hospital Discharge Survey (OMB No. 0920-0212), National Nursing Home Survey (OMB No. 0920-0353), National Home and Hospice Care Survey (OMB No. 0920-0298), National Survey of Residential Care Facilities (OMB No. 0920-0780) and NHAMCS, have been modified and expanded into this integrated NHCS.

Other justifications for conducting NAMCS include the need for more complete ambulatory medical care data to study (1) the performance of the U.S. health care system, (2) care for the rapidly aging population, (3) changes in services as health insurance coverage change, (4) the introduction of new medical technologies, and (5) the adoption of electronic health records. As a result of these societal changes, there has been considerable diversification in the organization, financing, and technological delivery of ambulatory medical care. This diversification is evidenced by the proliferation of insurance and benefit alternatives for individuals, the development of new forms of

physician group practices and practice arrangements, and growth in the number of alternative sites of care.

New/modified activities planned for the 2011-1013 survey period

1. Additional Office-Based Physicians

The NAMCS sample will be supplemented with an additional 1,700 office-based physicians annually for 2011-2013. The proposed sample will include 3,000 physicians for the historical sample size, a continued supplement from 2010 of 200 oncologists, and an additional 1,500 office-based physicians. Five-hundred of the proposed 1,500 additional physicians will be funded by the Patient Protection and Affordable Care Act of 2010, and the other 1,000 from the President's general budget. Finances for the additional 500 physicians have been approved; however, finances for the 1,000 supplemental physicians have not yet been approved. Once the President's 2011 budget is passed, the additional 1,000 physicians will be included in the 3rd and 4th quarters of 2011 data collection year and beyond; however, depending on when the budget is passed, the additional 1,000 physicians may not be added until 2012 because of processing deadlines. The supplemental 500 physicians will be incorporated in the 3rd and 4th quarters of 2011 data collection year. Increasing the NAMCS sample will aid in continuing to monitor disease prevention and health promotion by providing more reliable national estimates of health care utilization in physician offices and community health centers. If less money is approved for a sample size increase in the 2011 President's budget, OMB will be notified of the exact changes in sample size through a nonsubstantive change request.

2. Removal of Cervical Cancer Screening Supplement (CCSS)

Funding for this supplement, supplied by the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), has ended and the supplement will not be fielded in 2011.

3. Spring 2011 pretest

A pretest is planned for spring 2011 to evaluate the new asthma supplement (**Attachment R**), complementary and alternative medicine (CAM) items on the NAMCS-1 (**Attachment S**), retrospective health care data collection items on the patient record form (PRF) (look-back module) (**Attachment T**), and the new computerized NAMCS-1 and associated PRFs. If the pretest is successful, we will add the new items to their respective forms for the 2012 survey. If only minor changes are required, we will submit a nonsubstantive change package for OMB review.

New activities evaluated in 2011 and planned for the 2012-2013 survey period

1. Asthma Supplement

Although the means to control asthma have been widely disseminated by the National Heart, Lung, and Blood Institute's (NHLBI) Guidelines for the Diagnosis and Management of Asthma (the Guidelines) (see http://www.nhlbi.nih.gov/guidelines/asthma/index.htm), uptake of effective management strategies remains suboptimal. Although other national sources have reported data on patient outcomes related to asthma, the following relevant points are still uncertain:

(1) Where do major barriers to implementation of asthma management strategies occur on the pathway from health care delivery to acceptance and practice by patients
(2) What is the overall acceptance of the Guidelines by health care practitioners
(3) To what extent can identification of the implementation and barriers to use of specific asthma management strategies by health care providers inform ongoing strategies in the hope of increasing uptake of the Guidelines

The proposed asthma supplement (**Attachment B**) will be administered to primary care physicians, physicians likely to see asthma patients, and all CHC physicians/providers. The bottom of **Attachment B** also includes proposed screener questions that will be added to the 2012 NAMCS physician induction interview to determine supplement eligibility. The goal of the supplement will be to construct an accurate picture of uptake and implementation of asthma management as specified by the Guidelines. The Guidelines have been available since 1991 and most recently updated in 2007.

2. Complementary and Alternative Medicine (CAM)

Use of many complementary and alternative medicine (CAM) therapies have been increasing in the United States. In 2007, almost 4 out of 10 adults (38.3%) had used some type of CAM in the past 12 months, and total out-of-pocket costs for visits to CAM practitioners and purchases of CAM products total $33.9 billion. Although these practices are not part of conventional medicine, some conventional medical providers do refer their patients and/or use CAM treatments in their practices. The short set of questions (**Attachment C**) is slated for evaluation in the 2011 pretest, and inclusion in the 2012 NAMCS-1 induction form. These items will collect information on the frequency of referrals and use of CAM by conventional providers, which has not been previously collected on a large-scale national survey. Because the majority of providers who use CAM do so in conjunction with conventional medicine, it is important to find out the extent to which conventional providers are integrating CAM into their treatment plans. This short set of questions is sponsored by the National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health. NCCAM's mission is to study the use and effectiveness of CAM therapies and data collected via these questions will be invaluable for shedding light on the integration of conventional and CAM therapies in the United States.

3. Activities to Computerize Data Collection: NAMCS-1 and Patient Record form

Beginning in 2012, the NAMCS-1 induction interview will be conducted through a computer assisted interviewing instrument. The Patient Record forms (PRFs) completed by Census Field Representatives will be entered directly into a computerized form. Both

instruments will be evaluated in a 2011 pretest. A physician sample separate from those used for the core and mail NAMCS will be used for the pretest. Note that when physicians and/or their staffs complete PRFs themselves (approximately 35% of all forms), they will have the option to either enter the data on an electronic device, or follow the original protocol and use paper forms. It is anticipated that the use of a computer assisted interviewing instrument will simplify the data collection activities and also reduce data entry errors and omissions, thus improving data quality. Furthermore, it will reduce the time required for processing the data since individual question editing could now be done at the same time data are collected and not retrospectively. The use of a computer assisted interviewing instrument will also reduce respondent burden by tailoring data questions to the individual sampled case, thus skipping out irrelevant questions.

4. Medical Care Provided in Last 12 Months (lookback module)

The lookback module will collect additional information from the 12 month period prior to the sampled visit on risk factors and clinical management of patients with conditions that put people at high risk for heart disease and stroke. For example, the module would record medications prescribed, changes in medications, family history, and contraindications to certain medications. The intent of the lookback module is to improve the nation's ability to monitor and evaluate the quality of clinical care to prevent heart disease and stroke as health reform proceeds. Since these surveys already collect selected intermediate outcomes, including blood pressure and cholesterol levels, combining currently collected PRF data with the additional lookback items would permit the evaluation and monitoring of appropriateness of clinical management and the relationship to these outcomes. The lookback module is funded from prevention funds from the Patient Protection and Affordable Care Act of 2010.

The utility of the lookback module as an addition to the current NAMCS starting in 2012 will be considerable. For example, these items would greatly improve the nation's ability to monitor and evaluate the effects of increased insurance coverage on the quality of care provided in physicians' offices to prevent heart disease and stroke. Furthermore, information on the clinical management of conditions that put patients at risk could identify shortfalls in the quality of care that in turn could lead to improvements in clinical and public policy to improve prevention.

The questions are currently being developed, and they will be similar to the currently collected items on the PRF except they will be based on an earlier visit time period. When the exact questions are finalized, we will submit a nonsubstantive change request to OMB.

<u>New EMR/EHR Supplemental Survey on Physician Workflow</u>

As part of the American Reinvestment and Rehabilitation Act of 2009 (ARA), the Health Information Technology for Economic and Clinical Health (HITECH) Act set forth a plan for advancing a nationwide health information technology infrastructure in order to improve efficiency and the quality of care in the health care system. Central to the vision of a nationwide electronic health information network is the use of electronic health

records (EHRs). HITECH authorizes the Centers for Medicare & Medicaid Services (CMS) to administer incentives to eligible professionals and hospitals for meaningful use of certified EHR technology. The HITECH Act also authorizes the establishment of several new grant programs that will provide resources to facilitate the adoption and use of EHRs by providing technical assistance, the capacity to exchange health information, and the availability of trained professionals to support these activities.

These priority grant programs are the following:

i. Health Information Technology Extension Program (Extension Program) - will establish a collaborative consortium of Health Information Technology Regional Extension Centers facilitated by the national Health Information Technology Research Center (HITRC). The Extension Program aims to reach 100,000 priority primary care providers across the nation within two years by providing technical assistance in the selection, acquisition, implementation, and meaningful use of an EHR to improve health care quality and outcomes.

ii. State Grants to Promote Health Information Technology (State Health Information Exchange Cooperative Agreements Program - to promote health information exchange (HIE) that will advance mechanisms for information sharing across the health care system.

iii. Information Technology Professionals in Health Care (Workforce Program)- to fund the training and development of a workforce that will meet short-term HITECH Act programmatic needs.

Additionally, recommendations from Patient Protection and Affordable Care Act of 2010 (ACA) section 1561 requires the Department of Health and Human Services (HHS), in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, to develop interoperable and secure standards and protocols that facilitate electronic enrollment to encourage adoption of modern electronic systems. The aim of both the HITECH act and ARA includes enhancing efficiency and improve quality in the health care system, expanding access to care, and improve patient health.

The physician workflow supplement of the EMR/EHR mail survey is sponsored by the Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (DHHS). To assist in measuring the progress of meeting the President's goal for most Americans to have access to an interoperable EHR by 2014, ONC has funded NCHS to add a follow up longitudinal supplement to the EMR/EHR mail survey first conducted in 2008 (see **Attachment D** for a copy of the 2011 EMR/EHR mail supplement), the Physician Workflow Supplementary Mail Survey. The sample for the follow up supplement will be drawn from the responding physicians from the 2011 EMR/EHR mail survey, which is separate from the traditional NAMCS sample with a state-based sample of 10,302 physicians in 2011. These physicians will be contacted twice in 2011, once for the EMR/EHR supplement, and once for the physician workflow supplement. Additionally, this cohort will be followed for three years from 2011 to 2013. ONC requires continuous information on the costs, benefits, and barriers associated with the use of EHRs at various levels of adoption. This information helps ONC measure the progress towards HITECH program goals and provides insight into

where scarce resources need to be devoted to help physicians achieve Stage I and Stage II meaningful use of certified EHR technology. The longitudinal nature of this physician workflow study will also provide insight into physician investment behavior, intent to meet HHS' meaningful use criteria, and barriers that physicians face at various stages of EHR adoption. ONC will use this information to inform policy-making around Stage II meaningful use criteria. The meaningful use rule is part of a coordinated set of regulations to help create a private and secure 21st century electronic health information system. ONC's criteria for meaningful use will be implemented in three stages. Stage 1 will begin in 2011; Stage 2 will begin in 2013, and will add more requirements and new reports; and Stage 3 will begin in 2015 and is expected to add more requirements. The information obtained from the new workflow supplement will provide great value to ONC and NHCS. Together with the EMR/EHR supplement, the information obtained will help ONC monitor the effectiveness of federal programs and grants, and inform key policy decisions to develop criteria for successive stages.

See **Attachments E1 and E2** for the proposed Physician Workflow supplementary Mail Surveys. One EMR/EHR Workflow survey is intended for physicians who currently have an electronic health record system (**Attachment E1**), and the second is for physicians without a current electronic health record system (**Attachment E2**). .

Privacy Impact Assessment

The substantive information required for this section is provided in detail in "Overview of Data Collection System" below. The section titled "Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age" includes discussion of the NAMCS website.

Overview of the Core NAMCS Data Collection System

The target universe of the core NAMCS includes visits made in the United States to the offices of nonfederally employed physicians, excluding those in the specialties of anesthesiology, radiology, and pathology, who were classified by the American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care." The target universe also includes visits to physicians (MDs and DOs) and mid-level providers (i.e., nurse practitioners, physician assistants, and nurse mid-wives) practicing at non-office-based community health centers.

For the core NAMCS, each physician/provider in private practice/CHC is asked to complete a NAMCS physician induction form (**Attachment F**) over the telephone and during an initial personal interview. The questions in the first-half of the NAMCS-1, which are completed over the telephone, are used to guide Census Field Representatives (FRs) through the induction process and verify the physician/provider's eligibility. The second-half of the form, which is completed in person, is dedicated to obtaining information concerning selected practice characteristics and determining a sampling strategy to collect Patient Record forms (PRFs) (**Attachment G**). In addition, the newly approved EMR/EHR and diagnostic test items, and the new CAM items (**Attachment C**)

will be added to the second half of the NAMCS-1. Each CHC director is also asked to complete a CHC induction form during a personal interview (**Attachment H**). This form permits the collection of general CHC contact information including type of center, sources of revenue, and identification of sampled providers.

The majority of the data collection occurs with the completion of PRFs by the sampled physician/provider and/or office staff. A PRF is completed for each sampled patient visit and will be the same as the one currently used in 2010 except that there will only be only one form. The proposed 2011 PRF will have cholesterol laboratory values on the reverse side although only selected physicians will be asked to complete the items.

Overview of EMR/EHR Mail Survey

NCHS will continue to field the EMR/EHR mail survey with a supplementary sample of 10,302 physicians. The mail survey is a self-administered paper questionnaire that is sent from NCHS and returned in the mail by the sampled physician.

Items of Information To Be Collected

The current core NAMCS collects information on a range of data on the characteristics of the users and providers of physician office-based and CHC care. Information on the sampled provider concerning selected practice characteristics, such as ownership, utilization of electronic medical records, and practice revenue, is collected.

Expanded data collected on the current patient visits include demographic characteristics, injury/poisoning/adverse effects, reasons for visit, continuity of care, diagnoses, vital signs, diagnostic/screening services, health education, non-medication treatment, medications, providers seen, visit disposition, and time spent with provider. Data from the laboratory values implemented in 2010 will allow researchers to better understand the extent to which ambulatory health care providers identify and control abnormal values of lipoproteins, blood sugar, and glycohemoglobin. The EMR mail survey is conducted to help provide more reliable estimates regarding office-based physician's adoption of EMR/EHR systems. Furthermore, information from the physician workflow survey will help (1) ONC measure the progress towards the Health Information Technology for Economic and Clinical Health Act (HITECH) program goals (i.e., advancing a nationwide health information technology infrastructure to improve efficiency and quality of health care delivery) and (2) provides insight into where scarce resources need to be devoted to help physicians achieve Stage I and Stage II meaningful use of certified EHR technology.

Information in Identifiable Form (IIF)

The core NAMCS and related supplements provide numerous and varied national estimates on provider, visit, and practice characteristics. Although a majority of the data collected are not considered personally identifiable, some fit the definition of information in identifiable form (IIF). A list of all IIF data items is highlighted below, and all were

approved in past packages by OMB to be collected on survey forms. None of these data are released to the public or become part of public-use files.

Information in Identifiable Form Categories:

- Physician/CHC provider name
- Physician/CHC provider mailing address
- Physician/CHC provider telephone number
- Physician/CHC provider Federal Tax ID
- CHC executive director name
- CHC mailing address
- CHC contact person
- Physician office/CHC staff name
- Patient date of birth

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The ambulatory health care data website dedicated to NAMCS and NHAMCS (http://www.cdc.gov/nchs/ahcd.htm) describes the survey, answers questions physicians may have on why they should participate, describes how the Privacy Rule permits data collection for NAMCS, and provides a link (http://www.cdc.gov/nchs/ahcd/namcs_participant.htm) to our participant website. There are no websites directed at children under 13 years of age.

2. Purpose and Use of Information Collected

The general purpose of this study is to collect information about physician practices, community health centers (CHCs), ambulatory patients, their problems, and the resources used for their care. The resulting published statistics and data sets help the profession plan for more effective health services, improve medical education, and assist the public health community in understanding the patterns of diseases and health conditions. In addition, policy makers use NAMCS data to identify (1) quality of care issues, (2) medical resource utilization, and (3) changes in health care over time.

If NAMCS data were not collected, there would be no national estimates on health care issues faced by office-based physicians and CHC providers. The physician/provider and patient visit data of the 2011-2013 NAMCS will be used in basically the same manner as data from prior surveys. The additional supplements and items on the NAMCS-1 will allow research to focus on the following: (1) measurement of EMR/EHR system adoption and associated system characteristics, (2) ability to perform diagnostic tests at specific in-scope physician practice locations, (3) integration of complementary and alternative medicine in physician treatment plans, (4) clinical management and patient risk factors during the 12 months before a sampled visit associated with heart disease and stroke, and (5) management of asthma by physicians/providers.

Privacy Impact Assessment Information

The following sections highlight the numerous components of the 2011-2013 NAMCS, and in doing so, fulfill the Office of Management and Budget's privacy impact assessment requirement. Specifically, the requirement is met by describing why NAMCS information is being collected, and the usefulness of collecting the data.

Core NAMCS

Each year, the core NAMCS provides a range of baseline data on the characteristics of the users and providers of physician office-based and CHC care. Data collected include the demographic characteristics of patients, reasons for visit, diagnoses, diagnostic services, medications, and disposition. These annual data, together with trend data, may be used to monitor the effects of change in the health care system; provide new insights into ambulatory medical care; and stimulate further research on the utilization, organization, and delivery of ambulatory care.

The data obtained from the core NAMCS are useful to managers of health care delivery system, and others concerned with planning, monitoring, and managing health care resources. The data are valuable to those who develop and evaluate new and modified health care systems and arrangements. The continuing nature of the survey permits observation and measurement over time of different modes (e.g., examinations, imaging, procedures) for managing and treating patient problems. In addition, it provides general information on the patterns of selected conditions. The core NAMCS also provides valuable information about the speed and effectiveness with which certain advances in medical practice are adopted, and about the effectiveness of educational programs among office-based physician practices.

Users of NAMCS include numerous governmental agencies, state and local governments, medical schools, schools of public health, colleges and universities, private businesses, non-profit foundations, corporations, and professional associations, as well as individual practitioners, researchers, administrators and health policymakers. Uses vary from the inclusion of a few selected statistics in a large research effort, to an in-depth analysis of the entire NAMCS data set covering multiple years.

The examples listed below illustrate selected users and uses of core NAMCS data, and an extensive list can be found at http://www.cdc.gov/nchs/data/ahcd/publist9-10-10.pdf.

- Researchers within and outside NCHS have published work in scholarly journals using NAMCS data:
  - Mojtabai R, Olfson M. National trends in psychotropic medication polypharmacy in office-based psychiatry. *Arch Gen Psychiatry*. 2010 Jan;67(1):26-36.
  - Decker SL, Burt CW, Sisk JE. Trends in diabetes treatment patterns among primary care providers. *J Ambul Care Manage*. 2009 Oct-Dec;32(4):333-341.

- Staff from the Ambulatory and Hospital Care Statistics Branch presented core NAMCS data on trends in visit rates for skin and soft tissue infections typical of *Staphylococcus aureus* at the 136th Annual Meeting of the American Public Health Association in 2008.

- The Department of Health and Human Services is currently using core NAMCS data to evaluate certain Healthy People 2010 and 2020 objectives. These objectives are designed to serve as a road map for improving the health of all people in the United States by the year 2010, and NAMCS data support efforts to quantify national improvement.

- The results of the core 2003 NAMCS bioterrorism questions have been presented by Ambulatory and Hospital Care Statistics Branch staff to outside partners, such as the Association of American Medical Colleges, and decision-making components of the Department of Health and Human Services charged with bioterrorism preparedness. Combined results from the 2003 and 2004 core NAMCS bioterrorism questions have been recently published in peer-reviewed journals in the primary medical care literature and as NCHS annual reports.

- The Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency, is required by law to make recommendations to Congress on payment updates to Medicare providers. MedPAC uses core NAMCS data in its analysis of physician services. In particular, core NAMCS data provide MedPAC with information on trends in physician willingness to serve Medicare beneficiaries. MedPAC presents this indicator yearly in its public meetings and in its official reports to the Congress to help determine payment updates for Medicare services.

The addition of CHCs to the traditional physician-only NAMCS sample (now considered the "core NAMCS") has produced a better overall picture of the ambulatory care provided in the United States. The core NAMCS now allows us to compare the delivery of health services at CHCs and non-CHC settings to understand utilization differences across ambulatory care settings. Also, a separate stratum of CHCs allows NCHS not only to improve our estimates of health care for the uninsured, but also to make separate estimates for providers and visits at CHCs.

EMR/EHR Mail Survey

The EMR/EHR mail survey will continue to assist in measuring the progress of meeting the goal for most Americans to have access to an interoperable EHR by 2014. The items for both the mail survey and the NAMCS-1 induction interview will help guide the policymaking process surrounding Stage II meaningful use. The meaningful use rule is part of a coordinated set of regulations to help create a private and secure 21st century electronic health information system. The information obtained from these questions (checking insurance eligibility electronically, questions related to information exchange,

and the new EHR functionality questions) will provide great value to the Office of the National Coordinator for Health Information Technology (ONC) and NHCS.

Having data that identify an office's ability to perform a particular diagnostic test will allow for identifying the adoption of new medical technologies across various physician and practice characteristics (e.g., specialty, office type, and ownership) over time.

Estimates from 2009 and 2010 EMR/EHR data have recently been published by NCHS staff and show that medical record system adoption varies considerably as a function of practice location and type of EMR/EHR system. The highlighted report below can be of great utility for ONC in measuring physician's access to interoperable HER adoption by 2014.

- Hsiao J, Hing E, Socey TC, Cai B. Electronic Medical Record/Electronic Health Record Systems of Office-Based Physicians: United States, 2009 and Preliminary 2010 State Estimates. *NCHS Health E-Stat*. 2010 December. (see http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.htm)

<u>New activities evaluated in 2011 and planned for the 2012-1013 survey period</u>

1. Asthma Supplement

The proposed asthma supplement will be administered to the sample primary care health providers and specialists likely to see asthma patients to assess implementation of guidelines to control asthma. These recommendations are disseminated from the National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma (known as "the Guidelines"). Specifically, a 2-year asthma supplement is proposed for 2012-2013 to obtain a robust sample of physician responses to construct an accurate picture of the identification, uptake, and implementation of asthma management as specified in the Guidelines.

2. Complementary and Alternative Medicine (CAM)

The short set of questions slated for inclusion in the 2012 NAMCS-1 physician induction form will collect information on the frequency of referrals and use of CAM by conventional providers, which has not been previously collected on a large-scale national survey. Because the majority of providers who use CAM do so in conjunction with conventional medicine, it is important to find out the extent to which conventional providers are integrating CAM into their treatment plans.

3. Medical Care Provided in Last 12 Months (lookback module)

The intent of data from the lookback module is to improve the nation's ability to monitor and evaluate the quality of clinical care to prevent heart disease and stroke. To achieve this, NCHS would expand data collected on clinical management and on patients' risk factors during the 12 months before the sampled visit. These items would greatly improve the nation's ability to monitor and evaluate the effects of increased insurance coverage on

the quality of care provided in physicians' offices to prevent heart disease and stroke. Also, these items would allow for monitoring of activities undertaken within the framework of the Patient Protection and Affordable Care Act of 2010 (ACA) section 1561 specifically to improve the use of preventive care. Furthermore, information on the clinical management of conditions that put patients at risk could identify shortfalls in the quality of care that in turn could lead to improvements in clinical and public policy to improve prevention.

New EMR/EHR Supplemental Survey on Physician Workflow

ONC requires continuous information on the costs, benefits, and barriers associated with the use of EHRs at various levels of adoption. This information helps ONC measure the progress towards HITECH program goals and provides insight into where scarce resources need to be devoted to help physicians achieve Stage I and Stage II meaningful use of certified EHR technology. The longitudinal nature of this physician workflow study will also provide insight into physician investment behavior, intent to meet HHS' meaningful use criteria, and barriers that physicians face at various stages of EHR adoption. ONC will use this information to inform policy-making around Stage II meaningful use criteria. The meaningful use rule is part of a coordinated set of regulations to help create a private and secure 21st century electronic health information system. ONCs criteria for meaningful use will be implemented in three stages. Stage 1 will begin in 2011; Stage 2 will begin in 2013, and will add more requirements and new reports; and Stage 3 will begin in 2015 and is expected to add more requirements. The information obtained from the new workflow supplement will provide great value to ONC and NHCS. Together with the EMR/EHR supplement, the information obtained will help ONC monitor the effectiveness of federal programs and grants, and inform key policy decisions to develop criteria for successive stages.

3. Use of Improved Information Technology and Burden Reduction

Information in identifiable form (IIF) is not provided on the public use files or in any reports. No highly sensitive data are collected.

Respondent burden in NAMCS data collection is minimized through sampling procedures, which are discussed in more detail in items A.5 and B.1. In general, improved information technology would significantly reduce the burden for NAMCS respondents when answering NAMCS-1 induction interview questions, and a move to electronic collection is requested. Currently, completing the form requires a Census field representative (FR) to follow the flow of the form from front to back, navigating numerous skip patterns, adding information from complicated lists, and administering flash cards to the respondent. This process can be complicated and lengthy and involve numerous opportunities to enter incorrect data. Using a computer assisted interviewing instrument of the NAMCS-1 will allow FRs to skip unneeded questions, quickly populate write-in fields with drop-down menus, and eliminate the need for paper flash-cards that highlight item choices. In the end, we expect the time a physician/provider spends during the induction interview to be significantly reduced. The burden associated with

completing Patient Record forms (PRFs) for the physician/provider would not be significantly reduced because he/she will still complete only the paper form. However, it is anticipated that the FRs use of a computerized data entry system for PRF data would significantly simplify the data collection activities by reducing data entry errors and omissions, as well as providing on-screen look-up tables for items such as reason for visit, diagnosis, and medications. Overall, using a computerized data entry system should reduce FR and respondent burden, and ultimately improve overall data quality. In addition, collecting the data electronically will speed editing, transmission, and processing, thereby making release of the yearly statistics more timely.

There are no legal obstacles to reducing the burden.

4. Efforts to Identify Duplication and Use of Similar Information

NCHS staff have had extensive contacts regarding survey items with organizations and individuals in both the private and public sectors who are familiar with physician utilization data, e.g., the American Medical Association. Over the 40 years since work on NAMCS began, three sources of similar data have been identified and are discussed below.

The National Health Interview Survey (NHIS. OMB No. 0920-0214) is a population-based survey in which information is obtained through household interviews. In addition to the recall problems that may be associated with household respondents, respondents cannot provide the detailed medical information about diagnoses, diagnostic procedures, medications, or therapeutic procedures that are collected in NAMCS. NHIS can provide only counts of physician visits and general medical information.

The Medical Expenditures Panel Survey (MEPS) (Agency for Healthcare Research and Quality, OMB No. 0937-0187) is a survey of households and their members' health care providers (including physicians in office-based practice), health insurance companies, and employers. As with NHIS, household respondents cannot supply detailed medical information. The medical information collected from physician respondents does not include detailed data on specific diagnostic services, medications, and other therapeutic services. Both NHIS and MEPS also experience an unknown degree of reporting bias since it is likely that respondents may be reluctant to report medical contacts for sensitive problems, such as psychiatric disorders and sexually transmitted diseases.

IMS America, Inc., a private organization, conducts a study titled the National Disease and Therapeutic Index (NDTI) that produces data somewhat similar to those collected in NAMCS. These data are focused on the drug prescribing habits of physicians, and results are sold to drug companies for drug marketing purposes. The data collected are limited to only drug data and the corresponding patient’s age, sex, and diagnosis, whereas NAMCS collects information on expected source of payment, reasons for visit, and other diagnostic and therapeutic services. Although the NDTI data are available for purchase by the government, the cost is prohibitive for most agencies. The data also have limitations that preclude their use for many purposes: data on response rates are proprietary and may be

under 50 percent, and the survey and sampling procedures are of unknown validity. Efforts to obtain such information from IMS America have been unsuccessful.

These information sources are not adequate for needs such as those described in A.2 above. NAMCS allows for greater emphasis on analysis of the provision of effective health services, adoption of electronic medical technology, determination of health care workforce requirements, and improvement of medical education. Furthermore, the depth of data collected in NAMCS about ambulatory patients allows for rich analysis regarding the principal reason for patients' visits and the resources used in the provision of their medical care.

Although general information is known about community health centers (CHCs) through the Uniform Data System (a mandatory reporting system of characteristics submitted to the Bureau of Primary Health Care at the Health Resources and Services Administration (HRSA)), the continuation of a CHC sample in NAMCS will provide details of the patient/physician encounter not collected elsewhere. Only federally qualified health centers that are funded under Section 330 of the Public Health Service Act are required to submit information to HRSA.

Advice from consultants, attendance at relevant meetings, and literature reviews have been used to identify other sources that collect practice characteristics similar to those collected by NAMCS; however, there has been no other source found that would be able to provide national estimates.

5. Impact on Small Businesses or Other Small Entities

Many NAMCS respondents are physicians in solo practices. In order to reduce respondent burden for these and all respondents, several data collection methods are used. These methods are designed to be flexible to meet the varied reporting and record keeping situations found in physician offices and community health centers (CHCs). A sample of patient visits is collected within practices and CHCs to minimize data collection workload. The data reported on each patient visit is limited to data already obtained by the physician for the patient's medical record and is further limited to a minimum number of items which adequately describe the utilization of ambulatory medical care. In addition, the impact of NAMCS on office-based physicians is further reduced by (1) design procedures that limit participation to once every three years, and (2) for all providers, requirements that ask for the collection of forms for a designated one-week period. Because of limitations in population size, a small number of CHCs may be included in the survey for successive years. Census field representatives (FRs) monitor reporting, and assist physicians/providers and their staffs in data collection to the extent possible.

6. Consequences of Collecting the Information Less Frequently

The rapidly changing environment of ambulatory care delivery makes it important to have annual data for decision making, describing the public's use of physician services, monitoring the effects of change, and planning possible changes in payment policies. This

information has become even more crucial with the need to track the effects of the health care industry's changing arrangements for delivering care, by having continuous data collection before, during, and after the restructuring. To increase reliability, data from NAMCS are often analyzed by combining data across years, and less frequent collection would limit the study of rare visit characteristics. The current design asks a sampled physician/provider to participate for a 1-week period no more than once every 3 years, and only a small proportion of all physicians/providers are included in the survey each year. There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. Federal Register Notice

This project fully complies with all guidelines of 5 CFR 1320.8(d). The 2011-2013 NAMCS was published for public comment in the Federal Register July 13, 2010, Vol. 75, No. 133, pages 39947-39948 (**Attachment I**).

Four public comments were received in response to the notice and shown in **Attachment U**. The following CDC response, plus additional documents when needed, was forwarded to each of the four individuals providing comments:

> Thank you for your comments concerning the CDC 60 Day Federal Register Notice for OMB No. 60-Day 10-0237, National Health and Nutrition Examination Survey. We have given the concerns you described careful consideration. For further information regarding the unique mission of CDC, please refer to our website at www.cdc.gov.

B. Efforts to Consult Outside the Agency

The core/CHC NAMCS has not changed appreciably from the design and data collection summarized in the last 2010-2012 OMB package. The following consultants both within and outside CDC were instrumental at that point. The Office of the Assistant Secretary for Planning and Evaluation (OASPE) was consulted along with other government agencies, such as the Food and Drug Administration, National Institutes of Health, and Centers for Medicare and Medicaid Services. In addition, representatives from the American Medical Association and other major national medical organizations as well as private and public health services researchers were contacted for their input. We are currently collaborating with Census about the implementation of computerized data collection.

In the summer of 2005, experts from Batelle and the University of California-San Francisco were consulted to review the CCSS questionnaire and provide recommendations concerning items to add, delete, or modify on the supplement. Also during this time, considerable consultation was solicited prior to the introduction of the CHC sampling strata. First, The National Association of Community Health Centers (NACHC) worked closely with NCHS in reviewing and providing comments on all the CHC forms and procedures. A meeting was held with individuals identified as having an interest in data collection from CHCs. A total of 15 people attended whose affiliation ranged from the federal government (NCHS, HRSA, and the Census Bureau) to professional association (NACHC) to academia (The Johns Hopkins Bloomberg School of Public Health). During this meeting, NCHS presented the methodological plan as well as the survey instrument for comment and discussion. Based on comments received during this meeting and those afterwards, changes were made to the CHC survey instruments. Finally, NCHS met with representatives from the Indian Health Service (IHS) to present our plan for including Indian Federally Qualified Health Centers in the CHC sample. During this meeting, NCHS explained our methodological plan and provided all forms for comment. The IHS commented on the forms and agreed to provide their list of health centers locations.

The additional NCHS sample of office-based physicians for the EMR/EHR mail survey was funded by the Office of the National Coordinator for Health Information Technology (ONC), DHHS. Both ONC and NCHS have worked closely on the development of the EMR/EHR questions currently used in the core NAMCS and the mail survey. Consultation has also taken place with experts from the Robert Wood Johnson Foundation, Massachusetts General Hospital, and The George Washington University.

The new physician workflow study continued earlier collaborations with the Office of the National Coordinator for Health Information Technology, and a panel of health information technology experts were consulted in development of the physician workflow surveys (**Attachment E**)

NCHS will continue to work closely with these individuals and agencies as the need for consultation arises. There are no outstanding unresolved issues. A list containing the names of the consultants is provided in **Attachment J**.

9. Explanation of Any Payment or Gift to Respondents

No payments or gifts are proposed for the 2011-2013 survey. OMB will be notified of any plans to offer payment or gifts in the future.

10. Assurance of Confidentiality Provided to Respondents

An assurance of confidentiality is provided to all respondents according to section 308 (d) of the Public Health Service Act (42 USC 242m) which states:

> "No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section...306 (NCHS legislation),...may be used for any purpose

> other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and (1) in the case of information obtained in the course of health statistical or epidemiological activities under section...306, such information may not be published or released in other form if the particular establishment or person supplying the information or described in it is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release in other form,..."

In addition, legislation covering confidentiality is provided according to section 513 of the Confidential Information Protection and Statistical Efficiency Act (PL 107-347) which states:

> "Whoever, being an officer, employee, or agent of an agency acquiring information for exclusively statistical purposes, having taken and subscribed the oath of office, or having sworn to observe the limitations imposed by section 512, comes into possession of such information by reason of his or her being an officer, employee, or agent and, knowing that the disclosure of the specific information is prohibited under the provisions of this title, willfully discloses the information in any manner to a person or agency not entitled to receive it, shall be guilty of a class E felony and imprisoned for not more than 5 years, or fined not more than $250,000, or both."

Privacy Impact Assessment Information

A. This submission has been reviewed by Information Collection Review Office (ICRO), who determined that the Privacy Act does apply. The applicable System of Records Notice is 09-20-0167 Health Resources Utilization Statistics. The NCHS Privacy Act Coordinator and the NCHS Confidentiality Officer have also reviewed this package and have determined that the Privacy Act is applicable.

B. The survey is designed so that NCHS receives no identifiable patient information, such as patient names, Social Security numbers, or health identification numbers. The top section of each Patient Record form (PRF), which contains the patient's name and record number, is separated from the bottom section by a perforation running across the page. The top section remains attached to the bottom until the entire PRF is completed. To ensure confidentiality, before collecting the completed PRF, the top section is detached and given to the physician/provider or his/her staff. The field representative instructs the provider to keep this portion for a period of four weeks, in case it is necessary to retrieve missing information or clarify information that had been recorded. Hard copies of the survey forms will be stored in a locked file cabinet in a secure building at NCHS.

Prior to 2003, NAMCS was exempted from IRB review because physician practices were not considered to be human subjects, the medical record data already existed, and no patient identifiers were collected. However, with the implementation of the Privacy Rule

mandated by the Health Insurance Portability and Accountability Act (HIPAA) in April, 2003, a full review of NAMCS protocol was required by the IRB.

The NAMCS data collection plan has been approved by CDC's Research Ethics Review Board (IRB) (Protocol #2010-02) based on 45 CFR 46. In addition, the Board has granted (1) a waiver of the requirement to obtain informed consent from the patient, (2) a waiver of the documentation of informed consent by physicians, and (3) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation (45 CFR 164.512), a waiver of patient authorization for release of patient medical record data by health care providers.

The Research Ethics Review Board's letter granting approval for continuation of Protocol #2010-02 NAMCS for the maximum allowable period of one year is presented in **Attachment K**.

In this survey, as in others, NAMCS will include a routine set of measures to safeguard confidentiality, including the following: all staff who have access to confidential information are given instruction by NCHS staff on the requirement to protect confidentiality, and are required to sign a pledge to maintain confidentiality; only such authorized personnel are allowed access to confidential records, and only when their work requires it; when confidential materials are moved between locations, records are maintained to ensure that there is no loss in transit, and personally identifiable information is shipped separately from providers' contact information; and when confidential information is not in use, it is stored in secure conditions.

In keeping with NCHS policy, NAMCS data are made available via public-use data files to the public. Confidential data are never released to the public. All personal identifiers such as physician/provider name, address, patient date of birth, and any other specific information are removed from the public release files. All data releases are reviewed by the NCHS Disclosure Review Board to avoid data breaches, such as release of detailed geographic information that may allow anyone to identify practices or individuals in the general population.

C. The Research Ethics Review Board granted a waiver of the requirement to obtain informed consent from the patient.

D. In the introductory letter from the NCHS director, it states that participation in the NAMCS is voluntary. There is no effect on the respondent for not participating. NAMCS data are used to monitor office-based and CHC ambulatory health care utilization. The information is not shared with anyone, although public-use data files are available on the NAMCS website once individually identifiable information is removed. The legal authority for NAMCS data collection is Section 306 of the Public Health Service Act (42 U.S.C. 242k).

11. Justification for Sensitive Questions

No new sensitive data items are being proposed.

It is necessary for NAMCS to collect some protected and approved health information, such as date of visit, birth date, and ZIP code. These data are used internally to create certain composite variables, such as patient age, which contains 6 mutually exclusive groups. Also, in cases when the Census Bureau abstracts the data from the medical record, the patient's name or address may be viewed in the process of collecting the survey data. Strict procedures are utilized to prevent disclosure of identified NAMCS data. Individual patient names or other identifying information are not collected. At no time are the patients contacted to obtain information. After the data have been collected from the physicians/providers and processed, a file of the sample visits will be sent to NCHS. The only identifiable elements on the file are date of visit, ZIP code, and birth date. For the public use files, date of visit is converted to month and day of week, birth date is converted to patient's age, and ZIP code is deleted. Patient's ZIP code is used within NCHS to match the visit data to characteristics of the patient's residential area, such as median household income or percent of the population who are high school graduates.

In general, no sensitive data, except tax ID is collected or shared. The tax ID is used to identify ownership of office-based physician practices, as it is important to ensure that each office is not administratively connected to a hospital or outpatient department.

12. Estimates of Annualized Burden Hours and Costs

A. Burden Hours

This submission requests OMB approval for three years of NAMCS data collection. The burdens for one complete survey cycle and the proposed pretest are summarized in the tables below. The estimated annualized burden hours were based on previous years' experience in administering the survey, and final data from multiple components of the 2006 NAMCS. The table represents an average for one year of data collection. The average annual burden is 12,179 hours. If 75% of the budget is passed to increase the number of physicians, the sample will include 4,762 office-based core NAMCS physicians filling out a NAMCS-1 and 969 filling out PRFs; this will reduce the total average annual burden to 11,798 hours. If 50% of the budget is passed, the sample will include 4,512 respondents filling out the NAMCS-1 and 922 filling out PRFs; this will reduce the total average annual burden to 11,423 hours. NCHS will notify OMB of the outcome via a nonsubstantive change submission.

Table of Estimated Annualized Burden Hours

Type of Form	Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Hours per Response	Total Burden (Hours)
Core NAMCS Forms	Office-based physicians/CHC providers	Physician Induction Interview (NAMCS-1)	5,012	1	28/60	2,339
	Community Health Center Directors	Community Health Center Induction Interview (NAMCS-201)	104	1	20/60	35
	Office-based physicians/CHC providers/staff	Patient Record form (NAMCS-30)	1,017	30	11/60	5,594
	Office/CHC staff	Pulling, re-filing Patient Record form (NAMCS-30)	893	30	1/60	447
	Office-based physicians/CHC providers/staff	Asthma Supplement	669	1	15/60	167
EMR/EHR Mail Survey	Office-based physicians	EMR/EHR Mail Survey	5,460	1	20/60	1,820
Follow up EMR/EHR Mail Survey	Office-based physicians	Physician Workflow Survey	2,982	1	20/60	994
Pretest NAMCS Forms	Office-based physicians	Physician Induction Interview (NAMCS-1)	100	1	35/60	58
	Office-based physicians	Asthma Supplement	100	1	15/60	25
	Office-based physicians/staff	Patient Record form (NAMCS-30)	100	30	14/60	700
	Total					12,179

Core NAMCS and EMR/EHR Mail Survey

For the core NAMCS, each physician/provider in private practice/CHC is asked to complete an induction form (NAMCS-1) (**Attachment F**), while each Community Health Center director is also asked to complete a CHC induction form (NAMCS-201) (**Attachment H**) (4,700 core physicians, 312 CHC providers, 104 CHCs).

Of the 5,012 physicians/providers originally sampled in the NAMCS (4,700 core physicians + 312 CHC physician/providers) an estimated 1,175 core physicians are anticipated to be found ineligible (all CHC physician/providers are considered eligible).

Of those eligible, a majority of participants will complete Patient Record forms (NAMCS-30) (**Attachment G**) themselves (N=1,017), while 893 will rely on Census abstractors to complete the forms. In cases abstracted by Census FRs, staff will only pull and re-file the medical records (N=893) (**Attachment L**). The Patient Record form contains the items on the lookback module being pretested. Approximately 30 forms are expected from each sample physician's practice.

We estimate that approximately 669 physicians and CHC providers will be asked to complete the asthma supplement (**Attachment B**).

In 2009, 1,054 out of 2,000 (53%) sampled physicians completed the EMR/EHR mail survey (**Attachment D**), and this participation rate is used as a proxy for the anticipated survey cycle of 10,302 physicians in 2011. Therefore, we expect that approximately 53% of physicians should complete the mail survey each year, extrapolating to 5,460 physicians in 2011-2013.

The above burden table assumes a fully-funded core NAMCS sample of 4,700 office-based physicians in addition to the mail survey. If the President's 2011 fiscal year general budget does not pass in a timely manner, we will be unable to include the additional 1,000 NAMCS physicians in 2011. If this scenario takes place, we will submit a non-substantive change package highlighting the sample modification.

Automation/New Items/Supplement Pretest

For the automation/new items/supplement pretest, we present an average for one year of data collection, which means that the above estimates are based on 100 physicians (300 total physicians in pretest) who will complete the pretest Physician Induction Interview, PRFs, and asthma supplement.

B. Burden Cost

The cost to providers for each data collection cycle is estimated to be $750,348. The hourly wage estimates for completing the forms mentioned above in burden hours table along with pulling and re-filing PRFs are based on information from the Bureau of Labor Statistics web site (http://www.bls.gov). Specifically, we used the "May 2007 National Occupational Employment and Wage Estimates" for (1) health care practitioners and technical occupations, and (2) office administrative and support administrative support occupations. Data were gathered on mean hourly wage in 2007 for (1) physicians, mid-level providers (e.g., registered nurses), and other professionals involved in managing a private office-based practice (e.g., nurses, receptionists, etc.) as well as for (2) physicians and mid-level providers at CHCs who will complete the forms (i.e., physician assistants, nurse practitioners, and nurse midwives). The total cost estimate for office-based physicians/providers includes estimates for completing the Physician Induction Interview (NAMCS-1), PRF, asthma supplement, pretest, and EMR/EHR mail survey. The average hourly wage for these respondents is weighted based on who typically completes each applicable form. For example, the estimate of $56.10 (office-based physicians/staff) is

somewhat lower than the average physician salaries presented in the 2007 National Occupational Employment and Wage Estimates (NOEWE) because the wages of various office workers was averaged with the hourly salary of a physician. In addition, the salaries in the table below were approximated based on an average starting salary using the 2007 NOEWE figure, adding an approximate cost of living increase, and averaging the estimates from 2009-2012. The following table shows the breakdown of the total annual respondent cost.

Table of Annualized Respondent Cost

Type of Respondent	Response Burden (in hours)	Average Hourly Wage	Total Cost
Office-based physicians/CHC providers (completing NAMCS-1s)	2,339	$64.34	$150,491
Office-based physicians/CHC providers/staff (completing PRFs)	5,594	$51.24	$286,637
Office-based physicians, mail survey	1,820	$87.17	$158,649
Office-based physicians, workflow survey	994	$87.17	$86,647
Office/CHC staff (pulling & re-filing PRFs)	447	$25.03	$11,188
Community Health Center Directors	35	$59.00	$2,065
Office-based physicians/staff (completing pretest NAMCS-1, PRFs, & asthma supplement)	783	$56.10	$43,926
Office-based physicians/CHC providers (asthma supplement)	167	$64.34	$10,745
Total			$750,348

13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers

For this project there will be no annual capital or maintenance costs to the respondent resulting from the collection of information.

14. Annualized Cost to the Government

The estimate of average annual (one-data cycle) cost to the government for the 2011-2013 survey is as follows:

$3,422,247 Interagency Agreement for data collection with the Bureau of the Census
$ 401,711 Overhead
$ 23,528 Printing
$ 867,316 Contract costs for conducting the EMR/EHR mail survey and coding/keying data
$ 671,168 Staff salaries, data processing, printing, overhead, etc.

$ 5,385,970 Total cost for 12 months

15. Explanation for Program Changes or Adjustments

Adding physicians to the core NAMCS, both EMR mail samples, the proposed asthma supplement, and the pretest will increase the requested burden by 4,807 hours from the

7,372 total hours reported in the most previously approved package. The total NAMCS burden will now equal 12,179 hours.

16. Plans for Tabulation and Publication and Project Time Schedule

Revisions for the EMR/EHR mail survey

2/2011	Begin data collection for 2011 EMR/EHR mail survey
5/2011	End data collection
7/2011	Begin data analysis
11/2011	Publish Health E-stat

Revisions for the Physician Workflow mail survey (Follow up EMR/EHR mail survey)

3/2011	Begin data collection for 2011 Physician Workflow mail survey
7/2011	End data collection
8/2011	Begin data analysis
12/2011	Publish Health E-stat

The duration of activities for the core/CHC survey will span 36 months. The timetable for key activities for the 2011 survey is as follows:

12/2010	Begin data collection for 2011 survey
6/2011	Begin scheduled NAMCS pretest
8/2011	End scheduled NAMCS pretest
12/2011	Formally end reporting period
4/2012	Close out field work
3/2013	End data processing
4/2013	Begin data analysis
6/2013	Publish National Health Statistics Report
7/2013	Public use data available on Internet
3/2014	Publish additional reports

Plans for types of data analyses will parallel the analyses completed for the NHAMCS because a majority of the data items from NAMCS and the outpatient department are the same. For example, data will be presented in the following tables: patient visits by age, sex, and race; expected source(s) of payment; principal reason for visit; primary diagnosis; diagnostic service; disposition; and provider type seen. NCHS plans to publish the data on the Web and in various data briefs. The most recent NAMCS data brief, titled "Population Aging and the Use of Office-based Physician Services" can be found on-line at http://www.cdc.gov/nchs/data/databriefs/db41.pdf. In addition, a report comparing data from NAMCS and NHAMCS and combining data from both surveys has recently been published. The link for an on-line copy of the 2006 combined NAMCS and NHAMCS summary is http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf. Finally, NCHS reports examining (1) characteristics of office-based physicians and their practices (on-line copy: http://www.cdc.gov/nchs/data/series/sr_13/sr13_166.pdf) and (2) electronic medical

record use by office-based physicians and their practices (on-line copy: http://www.cdc.gov/nchs/data/ad/ad393.pdf) have also been released.

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

An exception for displaying the expiration date is not requested.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

The data encompassed by this project will fully comply with all guidelines of 5 CFR 1320.9, and no exception is requested to certification for Paperwork Reduction Act Submission.