Supporting Statement A for Request for Clearance:

NATIONAL ELECTRONIC HEALTH RECORDS SURVEY

OMB No. 0920-1015
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Supporting Statement

NCHS National Electronic Health Records Survey

- Goal of the study: To collect information on physicians' electronic health record (EHR) systems and other physician and practice characteristics. The survey content has expanded to include more detailed questions on health information exchange, unintended consequences of using EHRs, and advanced payment models associated with using EHRs.
- Intended use of the resulting data: To help provide more information about the use and adoption of EHRs by office-based physicians both nationally and by state. Data from the National Electronic Health Records Survey (NEHRS) have been used by researchers in such reports as Health United States, Healthy People 2020, and various other reports and research from all over the Federal, Public, and international communities.
- Methods to be used to collect data: Data will be collected directly from a sample of office-based physician respondents through a self-administered web questionnaire, self-administered paper questionnaire or telephone interview.
- Subpopulation to be studied: Non-federally employed office-based physicians.
- How data will be analyzed: Data will be weighted to provide state and national estimates.

The National Center for Health Statistics (NCHS) requests approval to collect data for the National Electronic Health Records Survey (NEHRS) (OMB No. 0920-1015: Exp. Date 04/30/2017). NEHRS was originally designed as a mail supplement to the National Ambulatory Medical Care Survey (NAMCS) (OMB No. 0920-0234, Exp. Date 03/31/2019) and was known as the Electronic Medical Records Supplement. NEHRS has been conducted annually since 2008 and was expanded to make state-based estimates since 2010. This submission represents a revision request package for the National Electronic Health Records Survey (NEHRS) for a period of 3 years.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

NEHRS is a national survey of office-based physicians conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). The NEHRS is sponsored by the Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (DHHS). The continuing NEHRS is partially funded by the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5), 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). NEHRS is one source of data that HHS uses to measure progress towards the program goals of the HITECH Act. NEHRS is intended to serve the particular goal of measuring progress in EHR adoption and meaningful use. The aim of both the HITECH Act and ACA include the overarching goals of enhancing efficiency and improving quality in the health care system, increasing the adoption rate of electronic health records (EHR), expanding access to care, and improving patient health. NEHRS will provide important information that will aid in the evaluation and implementation of EHR provisions laid out in ARRA and ACA.

We are requesting approval to:

- Collect data on the 2017, 2018, and 2019 NEHRS cohorts using the updated instrument,
- Collect additional data on the 2017 cohort using the NEHRS supplemental instrument for 1 year and,
- Change the title of this information collection from the National Ambulatory Medical Care Survey (NAMCS) National Electronic Health Records Survey (NEHRS) to the National Electronic Health Records Survey (NEHRS).

A three-year clearance is requested. 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 2017-2019 study period.

Due to contractual obligation with ONC, NCHS has fiduciary responsibility to collect timely NEHRS data annually. A contractor was not selected to oversee the data collection for the 2016 NEHRS due to a new contracting process. Therefore, with ONC agreement, data collection for the 2016 NEHRS, now called the 2017 NEHRS, is expected to be conducted in the third quarter

of 2017. Moreover, NCHS was able to secure additional funding in 2017, allowing for the collection of additional information on physician attitudes and experiences with EHR systems about EHR-related impacts (e.g., administrative burden, financial benefits, patient care, and data security) that ONC values as necessary using a supplementary survey following the 2017 NEHRS. The NEHRS supplement will be administered to the same sample as used for the 2017 NEHRS and is expected to be conducted in the first quarter of 2018. At this time, the NEHRS supplement is only going to be administered on the 2017 NEHRS sampled physicians. Note, the NEHRS supplement would have been the annual survey conducted in 2017 (i.e., 2017 NEHRS) if the current 2017 NEHRS, which was the 2016 NEHRS, were conducted in 2016 as expected in a typical NEHRS data collection cycle. Any potential future changes to this approach will be submitted to OMB as a nonsubstantive change request. The 2017 NEHRS questionnaire (formerly the 2016 NEHRS) has been approved by OMB (OMB No. 0920-1015) and IRB (Protocol # 2016-07) and is shown in **Attachment C.** A listing of the proposed changes to the previously approved questionnaire are captured in **Attachment D,** with **Attachment E** representing the clean version of the 2017 NEHRS questionnaire**.** Meanwhile, the proposed supplemental questionnaire of 2017 NEHRS is represented by **Attachments F1, F2, and F3**.

2. Purpose and Use of Information Collected

The general purpose of this study is to collect information about EHR adoption in physician offices. The resulting published statistics and data sets help policymakers track EHR adoption and associated system characteristics over time as well as progress towards the HITECH Act program goals measurement. If NEHRS data were not collected, there would be no known national and state-level estimates on EHR adoption in physician offices outside of the PII form from the traditional NAMCS, which produces national estimates. However, NEHRS allows for more detailed and more timely estimates on EHR adoption than is feasible with the traditional NAMCS. We would not be able to produce the estimates needed to track adoption of EHRs in physicians' offices and measure progress towards HITECH program goals. Complementary attitudinal data on physician experiences with EHRs will help us understand how physicians' care has been affected since implementing EHR systems. Specifically, the purpose of the 2017 NEHRS supplement is to understand the context surrounding the relatively low levels of interoperability (defined as sending, receiving, integrating, and searching for patient health information) and assess providers' use of health IT for the purpose of delivery system reform. Deeper examination of these topics will help inform the implementation of the Interoperability Roadmap, the report to Congress on progress related to interoperability for the Medicare CHIP Reauthorization Act (MACRA), and initiatives that can improve physicians' use of health IT for delivery system reform.

Several modifications in the approved questions are proposed for the first 2017 NEHRS questionnaire; **Attachment D** highlights the changes from the approved survey to 2017 in red. The modifications on the 2017 NEHRS are designed to be responsive to decisions made in the context of the Stage III meaningful use rule promulgated in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program — Stage 3, 42 CFR §§ 412-413-495 (2015). The suite of meaningful use rules are designed to guide the creation of a private and secure 21st century electronic health information system. Meaningful use is being implemented in three stages. Stage 1 established a baseline in 2011, while Stage 2 and Stage 3 (2014 and

2018, respectively) add additional requirements and new reports. The survey instrument will continue to evolve as the requirements for functionality evolve. NCHS proposes to modify the currently approved 2017 NEHRS by deleting several questions relating to computerized capabilities, as these topics were no longer a priority for ONC. Meanwhile other items were modified in order to capture data on the sending, receiving, searching, and integrating of patient health information within health information exchanges. The proposed new questions will not increase the survey burden for physicians; that is, for each question that will be added, we have removed or modified an existing question in order to keep the survey length constant.

Some questions change on a periodic basis to collect new and/or updated information as needed. That is, most of the content in the supplemental survey of 2017 NEHRS comes from previously approved NEHRS survey questionnaires with modifications that are responsive to decisions made in the context of the constantly evolving program goals of ONC. Moreover, some of the content come from the Physician Workflow Supplement (2011 – 2013) (OMB No. 0920 0234: Exp. Date 03/31/2019), which was a study that expanded on the 2011 NEHRS to help measure progress towards the HITECH program goals and to provide insight into where scarce resources need to be devoted to help physicians achieve Stage I and Stage II meaningful use of certified EHR technology. Following the design model used in the Physician Workflow Survey, the eligible respondents to the 2017 NEHRS and non-respondents to the 2017 NEHRS will each be sent a 4-page supplemental survey (20-minute survey) (**Attachments F1, F2, and F3**). There will be common content across all 3 types of respondents, but also tailored content that will allow delving into their experience (or lack thereof) with electronic exchange of information as described below.

- Respondents to the 2017 NEHRS who reported they either electronically send or receive data from outside sources. They will be asked to answer questions (**Attachment F1**) that relate to their experiences with electronically exchanging information.

- Respondents to the 2017 NEHRS who reported they neither electronically send nor receive data from outside sources. They will be asked tailored questions (**Attachment F2**) regarding why they are not engaging in electronic exchange of information (e.g., specific types of barriers).

- Non-respondents to the 2017 NEHRS are physicians who did not respond to the initial 2017 NEHRS survey and will receive a brief 4-page survey (**Attachment F3**) consisting of some content from the 2017 NEHRS and the NEHRS supplement. This will allow for more robust national estimates related to EHR interoperability (i.e., measured by electronically sending, receiving, integrating, and searching for patient health information) by offering non-respondents another opportunity to answer key questions related to interoperability.

The target universe of NEHRS includes 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."

NEHRS data collection for the 2017 NEHRS and the NEHRS supplement will use a sequential mixed mode, modified Tailored Design Method developed by Dillman.[1] This method is often regarded as the standard for mail surveys; it includes features that will be used in NEHRS: sending a personalized letter, the questionnaire with a return postage prepared envelope, a follow-up postcard, and duplicate packets will be sent to non-respondents. This method has been tested in physicians and other health care professionals and has yielded favorable response rates.

Data collection will occur by self-administered web questionnaire, self-administered paper questionnaire or computer-assisted telephone interviewing (CATI). The survey will be sent from the contractor to the sample of 10,302 physicians sampled from the AMA and AOA master files. Eligibility will be determined based on response to the 2017 NEHRS questions 2 and 4 (**Attachment E**) to assess that the physician typically provides care to the most patients in a solo or group practice, freestanding clinic or urgent care center, community health center, mental health center, non-federal government clinic, family planning clinic, health maintenance organization or faculty practice plan. The respondent is asked to select all settings that apply.

Sampled physicians will be invited to participate in NEHRS through the Internet by mail or, if available, through email as email addresses are obtained from a database of physicians; **Attachment G** represents letters for 2017 NEHRS while **Attachments H1 and H2** represent letters for 2017 NEHRS respondents (i.e., those who reported they either electronically sending or receiving data from outside sources) and non-respondents in the 2017 NEHRS supplement data collection, respectively. Mail and email will provide physicians with login instructions for the web version of the survey along with elements of informed consent. A follow-up email will be sent about 7-10 days later, and 7-10 days prior to each milestone for those we have email addresses.

About 4 weeks after inviting physicians to take the survey through the Internet, the contractor will mail the questionnaire along with an introductory letter (**Attachment G** for 2017 NEHRS **, Attachments H1 and H2** for 2017 NEHRS supplement), a 2017 NEHRS questionnaire (**Attachment E** for 2017 NEHRS**, Attachments F1, F2 and F3** for NEHRS supplement), a pen, and a previous data brief (**Attachment I1**) and a self-addressed return envelope for the paper questionnaire. For the NEHRS supplement, a previous QuickStats (**Attachment I2**) will be used in place of a data brief. One week after sending the questionnaire by mail, all sampled physicians will receive a postcard thanking them for their participation or reminding them that their participation is still needed (**Attachment G** for 2017 NEHRS**, Attachments H1 and H2** for 2017 NEHRS supplement). This postcard also allows sampled physicians to request additional information or another copy of the survey instrument. About 4 weeks after the initial questionnaire mailing, nonresponding physicians will be sent a 2nd mailing, which will include a modified introductory letter (**Attachment G** for 2017 NEHRS**, Attachments H1 and H2** for 2017 NEHRS supplement), a paper questionnaire and self-addressed return envelope for the paper questionnaire. Three to four weeks after the 2nd mailing, non-respondents will receive a third mailing that will include a modified introductory letter (**Attachment G** for 2017 NEHRS**,**

[1] The Dillman survey method, also known today as the Tailored Design Method (TDM) is often regarded as the standard for mail surveys. The Dillman survey method includes steps such as sending a personalized letter, the questionnaire with return postage prepared, a follow-up postcard, and duplicate packets to non-respondents.

Attachments H1 and H2 for 2017 NEHRS supplement), the paper questionnaire and a self-addressed return envelope. All letters inform respondents of the voluntary nature of the survey.

Roughly three weeks after the 3rd mailing, telephone calls using computerized-assisted telephone interviewing will be made over the next 9 to 10 weeks to all remaining non-responding physicians in a final attempt to obtain survey data. If the physician is contacted and agrees to participate, the survey will be administered via telephone. If the physician declines participation this will be documented by the interviewer.

The contractor will track, document and collect response to the web-based questionnaire and the paper questionnaires. No individual patient data will be collected. See **Attachment E** for a list of questions that will be used for data collection and **Attachment J** for the phone script in 2017 NEHRS. See **Attachments K1, K2, and K3** for the phone scripts for the supplemental survey (**Attachments F1, F2 and F3**), respectively.

Items of Information To Be Collected

NEHRS collects information on a range of data to address evaluation and research questions about measuring EHR adoption and meaningful use. The specific data involved in such data collected on the NEHRS includes:

Demographic and practice characteristics:

- Address verification
- Telephone number verification
- Specialty/Practice eligibility
- Extent of ambulatory patient care
- Office location information (e.g., number of office locations, types of office settings, etc.)
- Practice information (e.g., number of midlevel providers, accepting new patients, practice size, ownership, insurance of patients, etc.)

Electronic health record use characteristics:

- Routine use of computerized capabilities
- Coordination of care capabilities
- Physician ability to share patient health information and with whom
- Policies, services, and experiences related to using EHRs

NEHRS, which is affiliated with the NAMCS, provides a range of baseline data on the characteristics of the providers of ambulatory medical care with a focus on electronic health records adoption and use among office based physicians. Having data that identify a physician office's ability to perform a particular computerized task helps track the adoption of new health information technologies across various physician and practice characteristics (e.g., specialty, office type, and ownership) over time. 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 use, organization, and delivery of ambulatory care.

NEHRS information is useful to health planning agencies, managers of health care delivery systems, and others concerned with planning, monitoring, and managing health care resources for health information exchange, care coordination, safety implications, and use of health information technology. It is valuable to those who develop and evaluate new and modified health care systems and arrangements. It also provides valuable information about the speed and effectiveness with which certain advances in medical practice are adopted by the office-based physician.

Users of NEHRS 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 NEHRS data set covering multiple years.
The examples listed below illustrate selected users and uses of NEHRS data, and include researchers within and outside NCHS.

Journal articles using NEHRS data

- Garrety L, McLoughlin I, Wilson R, Zelle G, Martin M. National electronic health records and the digital disruption of moral orders. Soc Sci Med. 2014. Jan; 101:70-7.
- Jamoom EW, Patel V, Furukawa MF, King J. EHR adopters vs. non-adopters: Impacts of barriers to, and federal initiatives for EHR adoption. Healthc (Amst). 2014 Mar; 2(1)33-9.
- King J, Patel V, Jamoom EW, Furukawa MF. Clinical benefits of electronic health record use: national findings. Health Serv Res. 2014 Feb (1 Pt 2): 392-404.
- Patel V, Jamoom E, Hsiao CJ, Furukawa MF, Buntin M. Variation in electronic health record adoption and readiness for meaningful use: 2008-2011. J Gen Intern Med. 2013 Jul; 28(7):957-64.
- Xierali IM, Hsiao, CJ, Puffer JC, Green LA, Rinaldo JC, Bazemore AW, Burke MT, Phillips RL Jr. The rise of electronic health record adoption among family physicians. Ann Fam Med. 2013, Jan-Feb; 11(1):14-9.
- Decker SL, Jamoom EW, Sisk JE. Physicians in nonprimary care and small practices and those age 55 and older lag in adopting electronic health record systems. Health Aff (Millwood). 2012 May; 31(5):1108-14.

Conferences

- Jamoom, EW. How do physicians with certified systems use their EHRs? 2015 National Conference on Health Statistics. North Bethesda, MD. August 25, 2015
- Jamoom, EW, Hsiao C-J. What does Meaningful Use Mean to Physicians? AcademyHealth Annual Research Meeting, Baltimore, MD, June 24, 2013.

Other Publications

- The Department of Health and Human Services is currently using NEHRS data to evaluate certain Healthy People 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 2020, and NEHRS data support efforts to quantify national improvement.

- The Office of the National Coordinator uses NEHRS data for benchmarking EHR adoption and use across the United States and for evaluating progress toward Health Information Technology for Economic and Clinical Health (HITECH) Act program goals.

3. Use of Improved Information Technology and Burden Reduction

Initially, NEHRS used mail and phone follow up as the only modes of data collection. The 2015 NEHRS used a web modality to determine the impact of electronic data collection via the web on physicians responding to NEHRS. Similar to 2015 NEHRS, 2017-2019 NEHRS will use self-administered web questionnaire, self-administered paper questionnaire, or telephone interview for modes of data collection. Participation via the web questionnaire is the only mode offered in the first survey invitation; however, the web questionnaire will be available during the complete data collection period. The paper questionnaire will only be offered after non-response to the web questionnaire. Burden will be minimized by using sampling procedures designed to prevent overlap of the 2017 NEHRS sample and samples for all other physician surveys fielded by NCHS (2015—2017 NAMCS (OMB No. 0920-0234, Exp. Date 03/31/2019), the National Ambulatory Medical Care Survey Supplement on Culturally and Linguistically Appropriate Services (NAMCS CLAS) (OMB No. 0920-1119, Expires 06/30/17), AHRQ Feasibility Study, NAMCS Supplement of Primary Care Policies (OMB No. 0920-1063, Exp. Date 05/31/2017) in the past two years. There are no known legal obstacles to reduce 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 EHR adoption. Advice from consultants, attendance at relevant meetings, and literature reviews have been used to identify other sources that collect data on EHR adoption similar to those collected by NEHRS; however, outside of NEHRS and the traditional NAMCS PII data, there have been no other sources that would be able to provide annual national and state-level estimates.

5. Impact on Small Businesses or Other Small Entities

Many NEHRS respondents are physicians in solo practices. In order to reduce respondent burden for these and all respondents, the survey procedures provide that only a sample of physicians will be contacted, the sample will not overlap samples used for any other NAMCS data collection in the past two years, and data topics will be kept to the minimum necessary for the study.

6. Consequences of Collecting the Information Less Frequently

The rapidly changing environment of health information technology makes it important to have annual data for decision making, describing the current EHR adoption rate, monitoring the trend, and planning possible changes in policies.

NEHRS will assist in measuring the progress of EHR adoption and the overarching goals of the HITECH Act and ACA. The items for NEHRS will help guide the policymaking process surrounding Stage III 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 (questions related to the health information exchange and the EHR functionality questions) will provide great value to ONC and NCHS. If not collected annually this will make measuring trends and the progress of EHR adoption and the overarching goals of the HITECH Act and ACA more difficult.

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). A 60-day Federal Register Notice was published in the Federal Register on September 19, 2016 (**Attachments B1).** CDC received one comment **(Attachment B2)** and replied with a standard CDC response.

B. Efforts to Consult Outside the Agency

Both ONC and NCHS have worked closely on the development of the EHR questions currently used in the survey. 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 L.**

9. Explanation of Any Payment or Gift to Respondents

NEHRS will not offer a monetary incentive to respondents for participation. However, a non-monetary token has been shown to boost physician response rates.[2] The decision to use a non-monetary token would be based on available funds and the need for NCHS to boost physician response rates to maintain nationally representative data. An example of a potential non-monetary item would be a pen valued at $1.83, and would cost $20,778 annually. NCHS will request clearance from OMB for any change to paid incentives.

10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This submission has been reviewed by the 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

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[2] Beatty, P. Jamoom, E.W. “The Effect of Non-Monetary Incentives in a Longitudinal Physician Survey.” AAPOR, Boston, MA, May 17, 2013.

NCHS Confidentiality Officer have also reviewed this package and have determined that the Privacy Act is applicable.

An assurance of confidentiality is provided to all respondents according to section 308 (d) of the Public Health Service Act (42 U.S.C. 242m(d)) and Confidential Information Protection and Statistical Efficiency Act (CIPSEA, Title 5 of PL 107-347) which state:

> "We take your privacy very seriously. The answers you give us are used for statistical research only. This means that your answers will be combined with other people's answers in a way that protects everyone's identity. As required by federal law, only those NCHS employees, our specially designated agents (such as the U.S. Census Bureau), and our full research partners who must use your personal information for a specific reason can see your answers. Anyone else is allowed to use your data only after all information that could identify you has been removed.
> Strict laws prevent us from releasing information that could identify you to anyone else without your consent. A number of federal laws require that all information we collect be held in strict confidence: Section 308(d) of the Public Health Service Act (42 U.S.C. 242m(d)), the Confidential Information Protection and Statistical Efficiency Act (CIPSEA, Title 5 of Public Law 107-347), and the Privacy Act of 1974 (5 U.S.C. § 552a). Every NCHS employee, contractor, research partner, and agent has taken an oath to keep your information private. Anyone who willfully discloses ANY identifiable information could get a jail term of up to five years, a fine of up to $250,000, or both. In addition, NCHS complies with the Federal Cybersecurity Enhancement Act of 2015 (6 U.S.C. §§ 151 & 151 note). This law requires the federal government to protect federal computer networks by using computer security programs to identify cybersecurity risks like hacking, internet attacks, and other security weaknesses. If information sent through government networks triggers a cyber threat indicator, the information may be intercepted and reviewed for cyber threats by computer network experts working for, or on behalf, of the government.
>
> The Cybersecurity Act of 2015 permits monitoring information systems for the purpose of protecting a network from hacking, denial of service attacks and other security vulnerabilities.[1] The software used for monitoring may scan information that is transiting, stored on, or processed by the system. If the information triggers a cyber threat indicator, the information may be intercepted and reviewed for cyber threats. The Cybersecurity Act specifies that the cyber threat indicator or defensive measure taken to remove the threat may be shared with others only after any information not directly related to a cybersecurity threat has been removed, including removal of personal information of a specific individual or information that identifies a specific individual. Monitoring under the Cybersecurity Act may be done by a system owner or another entity the system owner allows to monitor its network and operate defensive measures on its behalf.

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[1] "Monitor" means "to acquire, identify, or scan, or to possess, information that is stored on, processed by, or transiting an information system"; "information system" means "a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of information"; "cyber threat

> indicator" means "information that is necessary to describe or identify security vulnerabilities of an information system, enable the exploitation of a security vulnerability, or unauthorized remote access or use of an information system"."

The survey collects personal identifiable information for analysis purposes and because we may contact physicians for future surveys. 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.

This survey, as in others, will include a routine set of measures to safeguard confidentiality, including the following: all staff, including contractors, 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 information is not in use, it is stored in secure conditions.

In keeping with NCHS policy, NEHRS data are made available via the Research Data Center. NCHS is working on creating public-use data files. Confidential data are never released to the public. All personal identifiers such as physician name, address, and any other specific information will be removed from the public release files. All public data releases are reviewed by the NCHS Disclosure Review Board to avoid data breaches, such as release of detailed geographic information that may allow a person to identify practices or individuals in the general population.

<u>Information in Identifiable Form (IIF)</u>

NEHRS provides numerous and varied national estimates on provider and practice characteristics. Although a majority of the data collected is 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 are all included in the currently approved NEHRS Information Collection (OMB No. 0920-1015, Exp. Date 04/30/2017). None of these data are released to the public or become part of public-use files.

Information in Identifiable Form Categories:
- Physician provider name
- Physician provider mailing address
- Physician provider telephone number
- Physician provider e-mail address
- Physician provider National Provider Identifier (NPI)

NPI (National Provider Identifier) number is a unique identifier for healthcare providers. This data element will allow for linkage of physician specialty information to other administrative

sources of information. Information linking provider identifiers to their characteristics (e.g., specialty, provider age) is also available from CMS for research purposes (https://nppes.cms.hhs.gov/NPPES/).

11. Institutional Review Board (IRB) and Justification for Sensitive Questions

NEHRS data collection plan has been approved by NCHS' Research Ethics Review Board (ERB) (Protocol #2016-07, **Attachment M**) based on 45 CFR 46. In addition, the Board has granted a waiver of the documentation of informed consent by physicians. In the introductory letter from the NCHS Director, it states that participation in NEHRS is voluntary. There is no effect on the respondent for not participating. NEHRS data are used to monitor adoption of EHR.

The Research Ethics Review Board's letter granting approval of Protocol #2016-07 for the maximum allowable period of one year is presented in **Attachment M**. A request to continue approval for the 2017 NEHRS supplement is expected to be submitted to ERB by August.

It is necessary for NEHRS to collect some protected and approved information, such as practice's county, and ZIP code. These data are used internally to create geographic variables, such as region and Metropolitan Statistical Area status. Strict procedures are utilized to prevent disclosure of respondent identities. Name and other contact information are collected in order to re-contact the participants for future surveys. No sensitive data are shared.

12. Estimates of Annualized Burden Hours and Costs

A. Burden Hours

This submission requests OMB approval for three years of NEHRS data collection. The current design prevents selection of an individual to new NAMCS samples more than once every 3 years, and only eligible respondent physicians in the 2017 NEHRS are included in the supplemental survey. The burdens for one complete survey cycle are summarized in the tables below. NEHRS samples 10,302 physicians annually. In 2017, the sample (10,302) will receive the 2017 NEHRS questionnaire in the third quarter of 2017 and the same sampled physicians will receive the NEHRS supplemental questionnaire in the first quarter of 2018. The estimated annualized burden hours were based on previous years' response experience in administering the NEHRS mail supplement and NAMCS Physician Workflow mail supplement, i.e., the response rate is assumed to be 50 percent.

The table represents an estimate for one year of data collection over the approval period (2017-2019). While NEHRS will be administered each year of the approval period to 10,302 physicians, current plans are to only administer the NEHRS supplement in 2017. Consequently, the annualized burden for the NEHRS supplement is based on 3,434 physicians (10,302/3).

Table of Estimated Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (Hours)	Total Burden (Hours)
Office-based physicians	NEHRS	10,302	1	30/60	5,151
Office-based physicians	NEHRS Supp Quest-hie	858	1	20/60	286
	NEHRS Supp Quest-nonhie	859	1	20/60	286
	NEHRS Supp Quest-nonresp	1,717	1	20/60	572
Total					6,295

Note: "Supp" is acronym for "supplemental"; "hie" is for "health information exchange"; "nonresp" is for "nonrespondent".

B. Burden Cost

The average cost to providers for each of the three data collection cycles is estimated to be $598,340. The hourly wage estimates for completing the forms mentioned above in the burden hours table are based on information from the Bureau of Labor Statistics web site (http://www.bls.gov). Specifically, NCHS used the "May 2015 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 2015 for physicians and other professionals involved in managing a private office based practice (e.g., nurses, receptionists, etc.). The total cost estimate for office-based physicians includes estimates for completing NEHRS. The average hourly wage for these respondents is weighted based on who typically completes the form. For example, to better approximate costs, the estimate of $95.05 (office-based physicians) was an average based on the hourly salary of family and general practitioners, general internists, obstetricians and gynecologists, general pediatricians, psychiatrists, surgeons, and a catch-all category "Physicians and Surgeons, All Other." The following table shows 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, mail survey	6,295	$95.05	$ 598,340
Total			$598,340

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

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 cost to the government for the 2017-2019 NEHRS is as follows:

$ 161,765 Printing, mailing and postage
$ 22,668 Web data collection
$ 216,685 Telephone follow-up of initial non-respondents
$ 20,778 Cost of pens
$ 344,629 Coding, processing, and data entry
$ 298,140 Staff salaries

$ 1,064,665 Average Total cost for 12 months

15. Explanation for Program Changes or Adjustments

This is a revision request.

16. Plans for Tabulation and Publication and Project Time Schedule

The timetable for key activities for the 2017 survey is:

2017 NEHRS (approved by OMB (OMB No. 0920-1015: Exp. Date 4/30/2017)

Month of OMB approval	Finish sample selection
One month after OMB approval	Begin data collection for 2017 NEHRS
Five months after OMB approval	End data collection
Eight months after OMB approval	Begin data analysis
Eleven months after OMB approval	Publish Data Brief

2017 NEHRS Supplement:

Eight months after OMB approval	Begin data collection for 2017 NEHRS supplement
Thirteen months after OMB approval	End data collection
Sixteen months after OMB approval	Begin data analysis
Nineteen months after OMB approval	Publish Data Brief

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.