Supporting Statement A: Revision Request for Clearance
NATIONAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0234
(Expires 07/31/2024)

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Table of Contents

List of Attachments

Attachment A – Authorizing Legislative
Attachment B1 - 60-day Federal Registry Notice (FRN)
Attachment B2 - 60-day FRN Public Comment
Attachment C1 – Traditional Office-based Physician Induction Interview
Attachment C2 – Draft Ambulatory Care Provider Interview (ACPI)
Attachment D – Tracing Questionnaire
Attachment E1 – Approved NAMCS Provider Facility Interview
Attachment E2 – Draft NAMCS Provider Facility Interview
Attachment F – Electronic Health Record (EHR) Variable List
Attachment G – EHR Implementation guide
Attachment H – EHR Implementation guide templates
Attachment I1 – Approved Health Center (HC) Facility Interview questionnaire
Attachment I2 – Marked Proposed Health Center (HC) Facility Interview questionnaire
Attachment I3 – Draft Health Center (HC) Facility Interview questionnaire
Attachment J – Set-up Fee Questionnaire
Attachment K – 2020 Board of Scientific Counselors (BSC) NAMCS Workgroup Summary
Attachment L – Consultants for NAMCS
Attachment M – NAMCS ERB Protocol Approval Letter
Attachment N1 – NAMCS Health Center Introductory Letter
Attachment N2 – 2023-2025 NAMCS Provider Introductory Letters
Attachment O1 – 2021-2022 NAMCS EHR Record Pulling Burden
Attachment O2 – 2023-2024 NAMCS EHR Record Pulling Burden
Attachment P – 2021 NAMCS Endorsing Organizations

Supporting Statement A

National Center for Health Statistics
National Ambulatory Medical Care Survey (NAMCS)

•Goal of the study: To assess the health of the population through 1) data on physicians and advance practice providers, and Health Centers (HCs), and 2) data on ambulatory patient visits collected through electronic health records.

- Intended use of the resulting data: These data are used to monitor public health, used by the U.S. Department of Health and Human Services for program planning and to inform national policies, and used by health care researchers, medical schools, policy analysts, congressional staff, the news media, and many others to improve our knowledge of medical practice patterns and patients.

- Methods to be used to collect data: A stratified, random sample of providers is selected from a universe of physicians and advanced practice providers of ambulatory care. Basic provider characteristics are collected. A separate sample will be used to collect electronic patient visit data. For Health Centers (HCs), a stratified random sample of HCs is selected from a universe of HCs which have electronic health record systems. Data from all electronic patient medical records are collected for the full calendar year from the sample of HCs.

- The subpopulation to be studied: The subpopulation is created from three separate populations. The Provider Interview Component samples ambulatory care providers to collect information on their characteristics and the characteristics of their practice. The Provider Electronic Component gathers information on a sample of electronic data providers including characteristics of the provider, as well as a full year of electronic patient visit data. Lastly, the HC Component samples HCs and collects characteristics of the center as well as a full year of electronic patient visit data.

- How data will be analyzed: NAMCS data are weighted and analyzed using appropriate statistical approaches. Public-use files will be made available where possible. Findings will be released in NCHS reports, journal articles, and research papers, as well as released to researchers for analysis.

The National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), requests a three-year approval for a revision to the ongoing National Ambulatory Medical Care Survey (NAMCS) (OMB No. 0920-0234: Exp. Date 07/31/2024).

There were Terms of Clearance attached to the current approval. It states: "Approved consistent with NCHS commitment to developmental work consistent with the recommendations of the Board of Scientific Advisors and public commenters with respect to increasing response, increasing the scope of care providers covered, and evaluation of the quality, including the utility of, EHRs for the goals of the NAMCS. Nonsubstantive change requests may be used to incorporate experimental and developmental work, as well as for the implementation of planned changes for which the methodology has been explained in the currently approved supporting statements."

NCHS agreed to undertake developmental work "consistent with the recommendations of the Board of Scientific Advisors and public commenters with respect to increasing response, increasing the scope of care providers covered, and evaluation of the quality, including the utility of, EHRs for the goals of the NAMCS. Nonsubstantive change requests may be used to incorporate experimental and developmental work, as well as for the implementation of planned changes for which the methodology has been explained in the currently approved supporting statements." Some of these activities are summarized below and others with be documented throughout the submission.

Also, a non-substantive change was approved on 07/01/2020, which included the addition of coronavirus disease (COVID-19) questions to the Physician Induction Interview and the Community Health Center Facility Interview questionnaires. This activity began in Q3 of 2020 and is ongoing in the current Provider Interview and Health Center (HC) Components.

New Clearance Request

The new target universe represents three major components:

- Provider Interview Component (formerly known as the Office-based Physicians Survey (Abstraction))
    - Ambulatory care providers submitting provider-specific interview data
- Provider Electronic Component (formerly known as the EHR Supplement)
    - Ambulatory care providers submitting provider facility interview data and electronic visit data
- Health Center Component
    - HCs which have EHR systems and will submit visit data in this format and interview data

This new request is to collect data in the 2023, 2024, and 2025 NAMCS cohorts using updated instruments and methods, and to continue current plans for the remaining NAMCS HC Component's 2022 data collection year. Data collection for the HC Component's 2021 data collection year was approved in the previous OMB package and is expected to be concluded in September 2022.

The **Provider Interview Component** (formerly known as the Office-based Physicians Survey (Abstraction)) is being redesigned starting with the 2023 data collection year. The 2021 data collection of the former Office-based Physicians Survey (Abstraction) will close out during the 2022 calendar year, and there will not be a 2022 data collection year prior to launch of the redesign. The universe was expanded in 2021 to broaden eligibility for participation among physicians, and in 2023 will begin to also include selected advanced practice providers (historically been defined in NAMCS as nurse practitioners (NPs), physician assistants/physician associates (PAs), and certified nurse midwives (CNMs)), as recommended by NCHS' Board of Scientific Counselors. Further, the historic NAMCS sampling methodology that linked physician and visit data collection has now been modified. Details are provided below.

The **Provider Interview Component** (formerly known as the Office-based Physicians Survey (Abstraction)) has historically surveyed a sample of office-based physicians (and a sample of their patients), as well as a sample of HCs (and all of their patients). In order to capture changes in current ambulatory health care NAMCS is conducting a redesign to expand eligible providers and settings. There will be some other changes made with the launch of the redesign; for example, tracing efforts will be introduced for sampled ambulatory care providers. In addition, we plan to decouple visit data from the providers sampled for the Provider Interview Component. Abstraction will remain paused as we launch the new Ambulatory Care Provider Interview (ACPI) (formerly known as the Office-based Physician Induction Interview in prior NAMCS).

The **Provider Electronic Component** (formerly known as the EHR Supplement) will be a stand-alone component. The Provider Facility Interview (PFI), from the former EHR supplement, will be redesigned for the new component. This redesign is due to the hold on medical record abstraction as the primary source of visit data; because NAMCS is not merging EHR visit data with abstracted data the PFI no longer needs certain questions that were used to connect the data. As recommended by NCHS' Board of Scientific Counselors, we also hope to leave the potential for change to samples/sampled populations and explore incorporation of data collected from third party entities.

The **HC Component** will be adding a Set-up Fee Questionnaire to help gauge costs incurred by participating.

For both the HC Component and the Provider Interview Component the sample size will be increased.

In summary of this revision request, overall OMB approval is being sought to:

- Continue previously approved survey activities for the next 3 years, i.e., completion of the 2022 data year for HCs, conducting the full 2023, 2024, and 2025 data years.
- Use Non-substantive change requests to incorporate experimental and developmental work, as well as for the implementation of planned changes for which the methodology has been explained in the currently approved supporting statements.

Provider Interview Component:

- Expand sample of providers to include PAs (physician associates/physician assistants) in 2023, and in successive survey years possibly expand to other types of advanced practice providers as methodological research and funds permit.
- Field a redesigned Ambulatory Care Provider Interview questionnaire in 2023, 2024, and 2025.
- Conduct tracing on ambulatory care provider contact information beginning in 2023.
- Continue the pause on abstraction of patient visit data to allow for research in best methods to obtain these visit data.
- Increase sample sizes as budget allows.
- Discontinue the Office-based Physician Induction Interview after the 2021 survey year.
- Cancel the provider incentive experiment.
- Discontinue the reinterview study after the 2021 survey year.

Provider Electronic Component:

- Modify the PFI.
- Explore and potentially implement the provision of a set-up fee of up to $10,000 for the Provider Electronic Component.
- Conduct research on supplementing electronic visit data with electronic data obtained from third-party sources.

Health Center Component:

- Increase sample sizes as budget allows.
- Modify HC Facility Interview questionnaire due to implementation of self-administered web instrument.
- Conduct research on providing a set-up fee for the HCs.

A. Justification

1. Circumstances Making the Collection of Information Necessary

NAMCS is a national survey of ambulatory care providers (physicians and advanced practice providers) and HCs conducted by the NCHS, Centers for Disease Control and Prevention (CDC). The survey is conducted under authority of Section 306 of the Public Health Service Act (42 USC 242k) (**Attachment A**).

An overarching purpose of NAMCS is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States; and fulfill NCHS' mission to collect, analyze, and disseminate timely, relevant, and accurate health data and statistics. Additional justifications for conducting NAMCS include the need for more complete data to study: (1) the performance of the U.S. health care system, (2) care for the rapidly aging population, (3) changes in services such as health insurance coverage, (4) the introduction of new medical technologies, (5) the use of HCs in the health care community, and (6) the use of EHRs.

Due to OMB expiration dates and the annual survey year timetable, this package includes the ability to complete the remaining 2022 NAMCS activities for HCs, along with the requested 2023-2025 survey changes below.

New/modified activities planned for the 2023-2025 survey period:

As previously stated, NAMCS is in transition and has been redesigning its components in phases. The three proposed components of NAMCS are the Provider Interview Component, the Provider Electronic Component, and the HC Component.

The landscape of ambulatory health care is increasingly provided by a variety of providers and across diverse care settings. With this knowledge, NAMCS plans to expand its Provider Interview Component sample to these non-physician ambulatory care providers, such as PAs and nurse practitioners, as well as other eligible ambulatory care settings. Currently, physician assistants, or physician associates, increasingly referred to as PAs, are referred to as "PAs" or "PAs (physician associates/physician assistants" in the survey instrument and its related materials. If NAMCS receives future guidance from the American Academy of Physician Associates the name will be updated accordingly. We also hope to gain insight on major areas of health care such as advanced practice provider autonomy, EHR usage, cultural/language barriers, pain treatment and opioid prescription management, and COVID-19 vaccination.

In addition, we plan to separate visit data from the providers sampled for the Provider Interview Component. In the past the Office-based Physician Induction Interview and abstraction of visit data were for corresponding sampled physicians and their visits. However, patient visit abstraction was paused during the first quarter of the 2020 data collection and will remain paused as we launch the new ACPI. Also, due to the expanded scope of the new Provider Interview Component, we want to allow for the potential to change samples and sampled populations, from previous package submissions.

The Provider Electronic Component (former EHR Supplement) will be a stand-alone component. The PFI will be redesigned. This change is due to the hold on medical record abstraction as the source of visit data and the sole use of EHR data to provide visit information. Like the new Provider Interview Component, we want to allow for the potential to change samples and sampled populations. We would also hope to explore data collected from third party entities such as IQVIA, the American Board of Family Medicine, and others, to supplement the Provider Electronic Component.

Additionally, for the HC Component we will be adding a Set-up Fee Questionnaire to help gauge costs incurred by participating. The HC Component will also be implementing a self-administered web instrument and modifications have been made to the Facility Interview questionnaire due to that transition.

Finally, and very importantly, we seek approval to significantly increase the sample sizes for both the Provider Interview Component and the HC Component.

Details for these changes are shown below.

<u>Provider Interview Component</u>

In 2023, we propose discontinuing the usage of the Office-based Physician Induction Interview **(Attachment C1)** and launching a new questionnaire, labeled the ACPI (**Attachment C2**) to collect more relevant and timely information from ambulatory care providers beyond only physicians. The contents were created via discussions with subject matter experts and compiling questions included on other NCHS surveys, such as the current NAMCS Office-based Physician Induction Interview (**Attachment C1**), the National Electronic Health Records Survey (NEHRS) (OMB No. 0920-1015: Exp. Date 12/31/2022), the NAMCS Culturally and Linguistically Appropriate Services (CLAS) supplement (OMB No. 0920-1119: Exp. Date 03/31/2017), and the Physician Pain Management Questionnaire (PPMQ) (OMB No. 0920-1030: Exp. Date 06/30/2023). The Provider Interview Component of NAMCS is unique to NCHS. This current iteration has been cognitively tested and the updates are being sent to the NCHS ERB, minor changes to incorporate ERB feedback could occur.

The ACPI features a schedule consisting of annual, rotating, and (when available) sponsored content. The annual core content is scheduled to be fielded every year, while the rotating content will be fielded during certain years. The rotating content addresses new topics of growing interest to NAMCS, CDC, DHHS, and/or other stakeholders and sponsors. Externally-sponsored content will vary, and could be annual, periodical, or one-time, and could rotate at fixed intervals, or when funds are available.

With the introduction of the new ACPI (**Attachment C2**), we will also discontinue the monetary incentive experiment, previously approved for use after the completion of the Office-based Physician Induction Interview (**Attachment C1**). Lastly, the ACPI data will be collected using a mixed-mode design, with a self-administered web instrument and self-administered paper instrument format, and no longer using in-person field representatives (FRs) that the Office-based Physician Induction Interview has used in the past.

Along with the introduction of these new data collection modes, beginning in 2023, a Tracing Questionnaire (**Attachment D**) will be introduced for the Provider Interview Component to conduct additional locating of the sampled ambulatory care providers' contact information (potential phone numbers, addresses, emails, etc.). The goal of tracing is to increase the potential ambulatory care provider response rate and reduce the number of necessary follow-up contact attempts.

With the introduction of the ACPI (**Attachment C2**) there will be no abstraction of patient visit information.

<u>Provider Electronic Component</u>

The Provider Electronic Component was previously referred to as the EHR supplement in prior NAMCS packages. It includes the PFI and electronic visit data submission. The PFI collects a variety of information, including provider and practice information, needed to weight the visit data and for analysis. **Attachment E1** shows the currently approved PFI and emphasizes changes via marked track changes. **Attachment E2** provides the updated version. These changes include variable updates due to changes in the Provider Electronic Component's sampling methodology. A list of the data elements collected can be found in **Attachment F**. The Health Level Seven International (HL7) Clinical Document Architecture (CDA®) R2 Implementation Guide (IG):

National Health Care Surveys, DTSU Release 1, Release 1.2, or Release 3 -US Realm and its templates can be found in **Attachments G** and **H**. They provide the specifications for how to provide the data.

The Provider Electronic Component will have a separate sample of providers than those who complete the ACPI. Previously, the Provider Electronic Component providers were sampled from the National Health Care Surveys Registry. In the future we may continue to sample these providers from the Registry, sample them from American Medical Association (AMA) or American Osteopathic Association (AOA), or a combination. These providers will submit EHR visit data to NCHS.

Along with physicians, NAMCS will also be exploring the possibility of collecting electronic data from advanced practice providers, large medical conglomerates, medical groups, and practices. To garner participation from physicians that are not in the National Health Care Surveys Registry, a one-time set-up fee, up to $10,000, may be offered to physician groups/large conglomerates not currently enrolled to help offset the costs (pending funding availability). NAMCS will also be exploring the utilization of data collected from third party entities such as IQVIA, the American Board of Family Medicine, or others to supplement NAMCS visit data.

Health Center Component

The main change to the HC Component is the addition of a brief Set-Up Fee Questionnaire. Based on feedback from the previous OMB approval, we believe this questionnaire would be an opportunity to learn more about how set-up fees provided to HCs can be utilized and help NAMCS plan and expand future EHR opportunities.

In 2021, the HC Component of NAMCS introduced a Facility Interview questionnaire (**Attachment I1**) and EHR visit data submission. A set-up fee of up to $10,000 was also offered to every new participating HC in order to defray the cost of installing certified National Health Care Surveys IG module developed by their EHR vendor (or the cost of creating a custom extract) and preparing the EHR data for transmission to NCHS. (**Attachments G** and **H**). We are proposing the addition of a Set-Up Fee Questionnaire (**Attachment J**) starting survey year 2022 and forward, to better gauge the costs associated with installing the National Health Care Survey IG (or the cost of creating a custom extract) and submitting EHR data to NCHS. Through this brief questionnaire, HCs will be asked to report on the specific types of costs incurred in submitting their visit data. At present, NCHS only has received expert advice as information on the cost to HCs for the activation of a certified EHR module that their EHR vendor has developed. This is an opportunity to more thoroughly document the cost incurred by the HCs and will help NCHS plan for its further expansion of the HC Component.

Additionally, modifications have been made to the HC Facility Interview questionnaire. The Facility Interview questionnaire collects facility-level information necessary for eligibility screening of sampled HCs and weighing the transmitted visit data. **Attachment I2** shows the currently approved questionnaire and highlights changes via marked track changes. **Attachment I3** provides the updated draft version, which will be implemented in the 2023 survey year. In the future, NAMCS plans to implement a self-administered web instrument as a method to complete

the questionnaire; this web instrument mode of data collection will allow for the questionnaire to be streamlined and require less burden from participating HCs.

Sample Size

The final change we propose is to increase the sample sizes for both the Provider Interview and the HC Components. The currently approved and fielded sample size for 2021 is 3,000 physicians and a target of 50 HCs.

The 2022 Provider Interview Component data collection will be pushed to 2023, due to redesigning the survey. For the NAMCS Provider Interview Component, we are proposing to increase from 3,000 to 5,000 physicians and an additional 5,000 advanced practice providers in 2023. If funding allows, in 2024 the sample size will increase to a total of 10,000 physicians and 20,000 advanced practice providers. Lastly, we are proposing to increase up to a total of 20,000 physicians and 40,000 advanced practice providers in 2025 (pending funding availability). Advanced practice providers may include nurse practitioners, PAs, and certified nurse midwives. The goal is to start with the inclusion of PAs in 2023, and in successive years expand to nurse practitioners and possibly other types of advance practice providers (e.g., certified nurse midwives) as methodological research and funds permit. Visit data will no longer be collected.

For the Provider Electronic Component, we are proposing to continue with the previously approved 3,000 providers a year.

For the HC Component, 46 health centers initially agreed to participate in the 2021 data year, although at the time of submitting this package we have testing and validation data for 28 HCs. We plan to target 54 new HCs for 2022, totaling 100 HCs overall. The previous package approved a target of 110 HCs. In the time since previous package's approval, the 2022 NAMCS HC Component target sample was lowered from 60 to 54 because of budget restraints, resulting in patient visit data being collected for 100 FQHCs and FQHC look-alikes total. We plan to increase the target sample up to 150 HCs for the 2023 survey year, up to 200 HCs for the 2024, and up to 250 HCs for survey year 2025. To ensure we have the maximum chance to reach our targeted number of HCs in each survey year we developed a primary and reserve sample. As we receive declines from the primary sample, we activate a corresponding HC in the reserve sample. Since we cannot predict how many HCs will be contacted for participation burden for the HC Facility Interview Questionnaire, we have included all of the primary and the reserve sample in the burden and cost calculations. Also, all who were contacted will not submit visit data so burden for data submission and completion of the Set-up Fee Questionnaire will be based solely on the target sample for each data year (i.e., up to 100 HCs in 2022, up to 150 HCs in 2023, up to 200 HCs for 2024, and up to 250 HCs in 2025).

The proposed NAMCS sampling methodology has been extensively expanded in both scope and number for 2023 and beyond. These changes were made to consider how the nature of health care service delivery has changed in recent years (and continues to change), as well as to expand the capacity of NCHS/CDC and partners for monitoring the effects of expanded health insurance coverage on use of appropriate preventive services. With the expansion in NAMCS scope/eligibility, the sample size increase will help ensure the survey was fielded to enough providers, to see any positive variations in response rates in large enough numbers for eventual

evaluation. In addition, increasing the sample size would also help offset declining response rates, as well as the high out-of-scope rate. Finally, funding allowances/available budget play a part in sample size selection.

2. Purpose and Use of the Information Collection

The purpose of this study is to collect information about ambulatory care providers and patient characteristics and clinical data (e.g., diagnoses, services/tests, medications, and visit disposition). The resulting published statistics and data sets help health care providers and professionals plan for more effective health services, improve medical and health 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 of health care issues faced by ambulatory care providers, HCs, or their patients. Items on the ACPI (**Attachment C2**) will result in data that will allow researchers to examine a variety of health topics, including COVID-19 vaccinations, telemedicine/telehealth, health equity, and the autonomy of advanced practice providers.

NAMCS provides a range of data on the characteristics of ambulatory care providers and HC facilities providing ambulatory medical care. Visit data, collected through the Provider Electronic Component and the HC Component, include the demographic characteristics of patients, medical diagnoses, medications, and visit disposition that are used to make annual estimates as well as estimate trends that are used to monitor the effects of change in the health care system and provide new insights into ambulatory medical care.

NAMCS is shifting to the collection of electronic visit data in a continued effort to modernize data collection and further enhance the use of the data. More specifically, through the Office of the HHS Secretary Patient Center Outcomes Research Trust Fund (PCORTF), NCHS was awarded monies to perform a project expanding the utility of EHR data collected from HCs. The specific goals of this PCORTF project are to: (1) leverage existing infrastructure and optimize advances in health information technology (health IT) in order to expand the collection and processing of EHRs for maternal health visits to HRSA supported HCs; (2) link these clinical visit data to mortality data available in the National Death Index (NDI) and to social determinants of health measures available in administrative data from the U.S. Department of Housing and Urban Development (HUD); and (3) make available a nationally representative dataset on maternal health care, including its relation to COVID-19, from HC visits in the United States.

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 in-depth analyses of the entire NAMCS data set covering multiple years.

3. Use of Improved Information Technology and Burden Reduction

Ambulatory Care Provider Interview

Beginning with the 2023 redesign, the NAMCS Provider Interview Component will utilize a new mode of data collection, without additional respondent burden, with the introduction of the ACPI (**Attachment C2**), a self-administered web instrument. Along with the web instrument, a self-administered paper version of the ACPI will also be utilized. The web instrument will be offered via email, for providers for whom we have an email address, and via mail to all sampled providers. The web and paper instruments will incorporate skip patterns and logic checks to reduce respondent burden and improve data quality.

Beginning in 2023, the Provider Interview Component will conduct additional tracing (**Attachment D**) of the sampled ambulatory care providers' contact information (potential phone numbers, addresses, emails, etc.), due to these new data collection modes. The goal of tracing is to increase response rate and decrease needed follow-up contact attempts.

Health Center Facility Interview

Currently, the HC Facility Interview questionnaire (**Attachment I1**) utilizes a computer-assisted telephone interview (CATI) but also plans on implementing a self-administered web instrument in the near future. Both the CATI and web instrument incorporate skip patterns and logic checks with the goal of reducing burden and improving data quality.

Visit Data

For NAMCS all visit data will be now acquired electronically. NAMCS electronic visit data are submitted to the NCHS Healthcare Electronic Health Record (HEHR) System as described in Section A10. The HEHR system and the adoption of a standardized transmission format for the electronic data also reducing respondent burden by simplifying data transmission.

NAMCS is included in the Centers for Medicare and Medicaid Services Electronic Health Record Incentive Program (Promoting Interoperability [PI]). Registered providers who are selected to participate in NAMCS can use their electronic visit data submission to fulfill the program's requirements. Multiple CMS and Office of the National Coordinator for Health Information Technology (ONC) rules require those in the PI Incentive Program to use the 2015 Edition Certified Electronic Health Record Technology (CEHRT) from 2019 and later. The standard, and format requested for NAMCS, is the Health Level Seven International (HL7) Clinical Document Architecture (CDA®) R2 Implementation Guide (IG): National Health Care Surveys, DTSU Release 1, Release 1.2, or Release 3 -US Realm; created by NCHS for the National Health Care Surveys.

To meet the requirements of the Provider Electronic and HC Components, the goal is for respondents to transmit electronic data in the format of the National Health Care Surveys IG (or a custom extract, Fast Health Interoperability Resources [FHIR] messaging, or potentially other future updated IGs with similar data elements) and go through testing and validation before final production can be submitted. NCHS staff and/or contractors will work with HCs during the testing and validation stage to ensure all the critical HCs data elements of interest are included.

To further reduce burden, HCs in the HC Component are offered a one-time set-up fee of up to $10,000 to help offset the cost of installing and activating a module already developed by their EHR vendor based on the National Health Care Surveys IG. For the Provider Electronic Component, a one-time set-up fee, up to $10,000, may be offered to physician groups/conglomerates not enrolled in the National Health Care Surveys Registry to help offset costs pending available funding. EHR sampled providers and the HCs will be asked to provide all patient visits for a designated reporting period (a full calendar year).

To gauge the exact costs associated with the electronic visit data process, we have added the Set-Up Fee Questionnaire (**Attachment J**). Through completing this questionnaire, we hope to learn the specific sources and amounts of costs incurred by the HCs when submitting their EHR visit data.

Lastly, to further reduce respondent burden, NAMCS will explore the use of electronic visit data collected from third party entities such as IQVIA, the American Board of Family Medicine, and others to supplement electronic data collected for the Provider Electronic Component. IQVIA collects uniform billing (UB)-04 administrative claims and electronic data with similar data elements required by the NAMCS. These third-party data sources would be used to research if/how third-party data can increase the reliability of national visit data estimates made by NAMCS while reducing respondent 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 ambulatory care provider and HC utilization data. Advice from consultants, attendance at relevant meetings, and literature reviews have been used to identify other sources that collect nationally representative data similar to those collected by NAMCS, and three have been identified and are discussed below.

The National Health Interview Survey, or NHIS (OMB No. 0920-0214, Exp. Date 12/31/2023) 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, NHIS respondents cannot provide the detailed medical information about diagnoses, diagnostic/therapeutic procedures, or medications. They can only be expected to provide counts of physician visits and general medical information.

The Medical Expenditures Panel Survey, or MEPS (Agency for Healthcare Research and Quality, OMB No. 0935-0118, Exp. Date 11/30/2023), is a survey of households and their members' health care providers (including physicians in office-based practices), health insurance companies, and employers. As with NHIS, household respondents cannot supply detailed medical information. Medical information collected from physician respondents does not include detailed data on medications, and other therapeutic services. Both NHIS and MEPS also experience an unknown degree of reporting bias because it is likely that respondents may be reluctant to report medical contacts for sensitive problems (e.g., psychiatric disorders).

The Bureau of Primary Health Care at HRSA has their Uniform Data System (UDS) (OMB No. 0915-0193: Exp. Date 02/28/2023), which is a mandatory reporting system of FQHCs who are

funded under Section 330 of the Public Health Service Act. Urban Indian Health Centers are not required to submit these data to the UDS. NAMCS collects data on these types of HCs. While the UDS collects general characteristics and information on the funded HCs, it does not include visit data to the extent of which are collected by NAMCS.

These data sources include useful information but are not adequate for collecting and providing the detailed health care provider and patient visit data from ambulatory care providers and HC facilities that are collected by NAMCS. The depth of visit data collected in NAMCS about ambulatory patients allows for rich analysis regarding the provision of ambulatory medical care and is an ideal source of data for understanding the care provided in these settings.

5. Impact on Small Businesses or Other Small Entities

A portion of the Provider Interview Component respondents are physicians and advanced practice providers who work in solo or small group practices. To reduce burden for these, and all respondents, NAMCS selects only a sample of ambulatory care providers to be contacted. The sample each year will not overlap with samples from which data were collected for any NEHRS, NAMCS, NAMCS supplement, or other physician surveys conducted by NCHS in the prior two years.

A reduction in NAMCS respondent burden has been noted for providers who submit electronic visit data relative to those whose visit data were collected through abstraction (as done previously). For this package we are no longer collecting visit data via abstraction, reducing visit data burden. We assume that most of our sampled providers who work in large medical group practices or are employed by large health care integrated delivery networks will not be personally involved in submitting electronic visit data. For the remaining providers who submit data electronically and are practicing in small medical practices, we expect they will have their staff work on NAMCS tasks. Also, use of the National Health Care Surveys' IG (**Attachments F, G,** and **H**) will allow for NAMCS data elements to come from already available information captured by their respective EHR systems. Furthermore, once a HC is sampled for participation in NAMCS and the initial set-up is completed, burden will be further reduced in future years.

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 provider and HC 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 major health care and public health changes, such as the opioid epidemic and the COVID-19 pandemic. Less frequent collection would also limit the study of rare visit characteristics, for which NAMCS data can be used to study by combining data across years to increase reliability.

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

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 March 18, 2022, volume 87, No. 53 page number 15429 (**Attachment B1)**. One non-substantive public comment was received, see **Attachment B2**.

Efforts to Consult Outside the Agency

NCHS has worked closely with consultants both within and outside CDC on the development and procedures for NAMCS; planning for future years of data collection. Most recently NCHS has consulted its Board of Scientific Counselors (BSC) in an effort to improve NAMCS data collection efforts. This resulted in a report produced by a special BSC Workgroup convened to formulize recommendations for improvement (**Attachment K**). With this package, NCHS is incorporating their suggestions in several ways. First, as noted previously, NCHS will introduce changes to the Provider Interview Component sample, transitioning from collecting interview data from just office-based physicians to include other advanced practice providers as well. The BSC Workgroup has also suggested expanding the Provider Interview Component to more diverse settings, which is also planned for NAMCS moving forward. For example, the BSC suggested NAMCS broaden data collection strategies which we plan to accomplish by including not only electronic visit data submission, but also by exploring third-party data sources. NCHS will continue to work closely with these outside individuals and agencies as the need for consultation arises. A list containing the names of additional consultants is provided in **Attachment L**.

9. Explanation of Any Payment or Gift to Respondents

Due to operational reasons, timing of OMB approval and other financial constraints, NAMCS was not able to conduct the previously-approved physician incentive experiment for the 2021 survey year. With the discontinuation of the Office-based Physician Induction Interview and the usage of FRs, the experiment is on hold. However, if funds allow and/or the need arises, NAMCS would like to utilize non-monetary tokens for the Provider Interview Component. Some studies have shown that non-monetary incentives have been shown to boost physician response rates.[1] Other studies have shown that, while non-monetary incentives did not increase overall response, they did encourage earlier response, which saved survey costs.[2] Examples of potential non-monetary tokens that NAMCS might include are pens, post-it notes or other items of similar value, around $1.00 per sampled provider.

[1] Beatty, P., Jamoom, E.W. “The Effect of Non-Monetary Incentives in a Longitudinal Physician Survey.” AAPOR, Boston, MA, May 17, 2013.
[2] Jamoom, E.W., Beatty, P. “Investigating the Relationship Between Nonmonetary Incentives, Questionnaire Length and Response Rates in a Physician Survey.” AAPOR, Hollywood, Florida, May 15, 2015.

Per previous OMB approval, NCHS is employing a one-time set-up fee of up to $10,000 provided to every HC which participates in the HC Component. This fee will assist HCs with the administrative and technical costs of installing the National Health Care Surveys' IG (**Attachments F, G,** and **H**) (or the cost of creating a custom extract), and the activation of this certified EHR module that their respective EHR vendor has developed. While the exact costs incurred are currently unknown, the Set-Up Fee Questionnaire (**Attachment J**) in this package will serve as an opportunity for NCHS to garner that data and help plan for future expansion. The questionnaire will be administered when the respondent receives the final payment of their set-up fee.

For the Provider Electronic Component, a one-time set-up fee, up to $10,000, will be offered to physician groups/conglomerates not enrolled in the National Health Care Surveys Registry to help offset participation costs and to obtain participation from providers that are not enrolled.

Any future plans to offer additional payment or gifts would be submitted to OMB for review and potential approval.

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

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

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."

Information in Identifiable Form (IIF)

NAMCS provides numerous and varied national estimates on provider, visit, and practice characteristics. The medical record number aids in the identification of separate visits among records. An example of the value of PII is that it allows the potential for linkage to the NDI, HUD administrative data, and other sources for the electronic visit data collection. The list of requested PII includes the data elements listed in the following for patients, providers, and HCs. A list of all IIF data items is highlighted below, and all were approved by OMB in the previous packages 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:

Provider/Facility Information (**Attachment F**):

- Provider name
- Provider mailing address
- Provider telephone number
- Provider National Provider Identifier (NPI)
- Provider Federal Tax ID/Employer Identification Number (EIN)
- HC executive director name
- HC mailing address
- HC contact person
- Provider/HC office staff name

*Patient information (***Attachment F***):*

- Name
- Birth date
- Address
- ZIP Code
- Date of visit
- Date of departure
- Encounter number
- Social security number (where available)
- Medical record number (where available)
- Medicare health insurance benefit/claim number
- NPI number of physicians

NAMCS 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; are required to sign a pledge to maintain confidentiality; and 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. Transmission of NAMCS electronic visit data will be sent to NCHS via Secured File Transmission Protocol (SFTP) through the Secure Access Management Services (SAMS) and/or DIRECT secure messaging. SAMS is accessed through a website and will provide secure transmission for the NAMCS data submissions.

Participating providers and HCs who submit EHR data will be asked to transmit all data to the HEHR system at NCHS, which was developed to support the receipt of data from eligible providers in accordance with the PI Program rules and comply with the Confidential Information Protection Statistical Efficiency Act (CIPSEA). This includes, but is not limited to, planning, designing, developing, and maintaining the infrastructure necessary to operate the surveys registry portal to allow for registration of eligible providers and hospitals that intend to participate in the survey and submit data. Upload interfaces via CDC's SAMS and/or DIRECT secure messaging are also included.

SAMS provides a secure data transfer service along with a strong suite of security controls to host applications and exchange data between CDC programs and public health partners while providing a high level of data integrity, confidentiality, reliability, and security. This meets NCHS/CDC policies for data transmission via the Internet. Users accessing systems protected by SAMS are required to adhere to the identity verification and authentication requirements for the Electronic Authentication Assurance Level (EAAL) of the protected system. SAMS provides system monitoring on a 24/7 basis, data redundancy features, and disaster recovery features for select information systems. DIRECT is a national encryption standard for securely exchanging clinical healthcare messages/data via the internet. DIRECT provides strong security and privacy protection using a unified standard that all systems can leverage.

On receipt of the data within the HEHR system, all data considered PII, both direct and indirect, and non-PII will be loaded/saved to specially designated and configured file servers and database servers that are in accordance with the CIPSEA. HEHR system servers are secured physical components that are only accessible by NCHS-designated staff. The HEHR system will communicate with Consolidated Statistical Platform (CSP) (another CIPSEA compliant system) primarily for analytic purposes.

In keeping with NCHS policy, NAMCS has a goal to make data available via public-use data files on the NAMCS website once individually identified information is removed. Confidential data are never released to the public. All personal identifiers such as provider name, patient name, patient 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.

The ambulatory health care data website dedicated to the NAMCS Provider Interview Component (https://www.cdc.gov/nchs/ahcd/namcs_participant.htm) describes the survey, answers questions respondents may have on why they should participate and describes how the Privacy Rule permits data collection. The ambulatory health care data website dedicated to the NAMCS HC Component (https://www.cdc.gov/nchs/namcs/hcc/participant.htm) describes the survey, answers questions respondents may have on why they should participate and describes

how the Privacy Rule permits data collection.

11. Ethics Review Board (ERB) and Justification for Sensitive Questions

The NAMCS data collection plan has been approved by NCHS's Ethics Review Board (ERB) (Protocol #2021-03) based on 45 CFR 46 and is presented in **Attachment M**. The NCHS Human Subjects Contact determined that NAMCS is a public health surveillance activity under the 2018 requirements of the Common Rule (45 CFR 46.102(l)(2)). As a surveillance activity, HIPAA permits sharing of PII with public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability without a waiver; therefore, justifications for waiver of informed consent are not necessary.

For each sampled provider or HC, an introductory letter (**Attachments N1 and N2**) is sent that states that participation in NAMCS is voluntary and there is no effect on the respondent for not participating. The letter describes the purpose of the survey and highlights the benefits of participation. The introductory letters are the primary tools to obtain informed consent to participate in the study. The legal authority for NAMCS data collection is Section 306 of the Public Health Service Act (42 U.S.C. 242k).

NAMCS collects PII. These PII elements have been cleared in a prior approval of this package (OMB # 0920-0234, Exp. Date 07/31/2024). One example of the value of PII is that it allows linkage to the NDI and other data sources such as CMS and HUD data. The list of requested items considered to be sensitive includes the following data elements for patients, providers, and HCs:

Provider/Facility Information (**Attachment F**):

- Provider name
- Provider mailing address
- Provider telephone number
- Provider National Provider Identifier (NPI)
- Provider Federal Tax ID/Employer Identification Number (EIN)
- HC executive director name
- HC mailing address
- HC contact person
- Provider/HC office staff name

*Patient information (***Attachment F***):*

- Name
- Birth date
- Address
- ZIP Code
- Date of visit
- Date of departure
- Encounter number
- Social security number (where available)
- Medical record number (where available)

- Medicare health insurance benefit/claim number
- NPI number of physicians

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. Strict procedures are utilized to prevent disclosure of identified PII data. At no time are the patients contacted to obtain information.

Electronic visit data are submitted to NCHS via the IG. These data include patient first and last name, social security number (SSN), and patient address in their submitted visit records. This is in addition to birth date, zip code, and sex which are also collected in the visit data. These PII data elements are be collected and retained to aid in the goal of linking to the NDI, HUD, and other data sources. Although linkages could be made to the NDI without the SSN, researchers planning to use the NDI are encouraged to collect or compile as many of the NDI data linkage items as possible. For more information on the NDI, see the web link, NCHS -National Death Index Home Page at http://www.cdc.gov/nchs/ndi.htm.

Since 2012, we have been collecting medical record numbers for internal survey operations purposes. This process will continue throughout this package's survey years, but through electronic visit data and not abstraction. The retention of the medical record number for electronic visit data submissions will allow the collection of a single patient's data from several sources within a provider's office or the HC. This will provide access to more comprehensive and detailed clinical information, as well as additional outcomes and quality measures. It will also aid the identification of separate visits among electronic records.

Federal Tax Identification number and NPI number will also be collected. A federal tax identification number, also known as an EIN, is used to identify a business entity (e.g., medical practice) in the administration of tax laws and helps in the identification of sampled provider offices and HCs. NPI is used to uniquely identify a health care provider in standard transactions. HIPAA requires that covered entities use NPIs in standard transactions. NPI of providers participating in NAMCS is collected as part of the Office-based Physician Induction Interview and along with electronic visit data submission, offering the ability to link the patient's care with the specialty of the providers from whom care was received. Information linking provider identifiers to their characteristics (e.g., specialty, provider age) is available from CMS for research purposes (https://nppes.cms.hhs.gov/NPPES/). We will not disclose in any manner the identity of specific providers but only analyze the data in aggregate according to physician characteristics.

12. Estimates of Annualized Burden Hours and Cost

Burden Hours

For the 2022 data collection, the NAMCS Provider Interview Component is on hold, and the HC Component will target 100 HCs. In 2023, the goal is to sample 5,000 physicians, 5,000 advanced practice providers, and target 150 HCs. In 2024 we plan to sample up to 10,000 physicians, up to 20,000 advanced practice providers, and target 200 HCs (if funds are available). Lastly, if funds

allow, in 2025 we will sample up to 20,000 physicians, up to 40,000 advanced practice providers, and target 250 HCs. For 2023-2025, there will be an additional 3,000 providers sampled yearly for the Provider Electronic Component. Once selected HCs are retained in the sample for 5 years, unless they request to no longer participate. HCs that are retained repeat some of the Facility Interview Questionnaire in order to update weights and year specific data. A primary and reserve sample of new HCs (See **"Sample Size"** of **Section A1** for details**)**, is utilized for each survey year's Facility Interview questionnaire, to ensure we maximize the chance to reach our targeted number of HCs for electronic visit data submission. Since we cannot predict how many HCs in the reserve sample will be contacted to participate and complete the Facility Interview questionnaire, we include the total number of HCs included in the primary and reserve sample in the tables below. We will only collect visit data from our target (or primary) sample so burden hours for data submission and the Set-up Fee Questionnaire will only include the target sample.

This submission requests OMB approval for the completion of the 2022 NAMCS data collection for HCs and for the following three survey years, 2023-2025, of NAMCS data collection.

The estimated annualized burden is 37,744 hours and is summarized in Table 1 below. As done in past submissions, NAMCS activities are presented separately for the Provider Interview, Provider Electronic, and HC Components.

Completion of 2022 data collection

Health Center Component

For the 2022 HC Component respondents receive a welcome packet with an introductory letter (**Attachment N1**), FAQ, and Public Relations (PR) materials (endorsement letters, postcard, etc.). Respondents receive additional outreach letters phone calls, emails, PR materials, etc. if there is no response to the initial welcome packet. For the 2022 HC Component, while we have begun data collection for the HC Facility Interview questionnaire the burden table includes 100% of the 2022 HC Component data collection (HC Facility Interview questionnaire [**Attachment I1**], patient visit data transmission [**Attachment O1** and **O2**], and the new Set-Up Fee Questionnaire [**Attachment J**]) due to the adjustments in sample size. We are decreasing the 2022 target sample due to budget constraints and lessons learned from 2021 data collection. Please note that the 46 HCs that agreed to participate from 2021, the 54 target (or primary) HCs) from 2022, and the 2022 reserve sample of 120 HCs are included in the burden calculation of the HC Facility Interview questionnaire for 2022, which results in an annualized number of 73 HCs.

After completion of the HC Facility Interview questionnaire, HCs will prepare and transmit EHR visit data. This entails submitting a file for testing and validation, then submitting the HC's annual visit data. Then the HC will also complete the Set-Up Fee Questionnaire. In 2022, 54 new HCs were targeted and 46 were rolled over from 2021, totaling 100 HCs. The expected response burden for the HC Facility Interview questionnaire is estimated at 55 hours annualized over three years. The HC Facility Interview questionnaire burden includes all of the target and reserve sample because we cannot predict how much of the reserve sample will be contacted in order to reach the target sample goal. The expected response burden to prepare and transmit EHR visit data quarterly, including testing and validation, is estimated at 132 hours annualized over three

years. The expected response burden for the Set-Up Fee Questionnaire is estimated at 8 hours annualized over three years. Please be reminded only the target sample was used to calculate burden for preparing and transmitting EHR visit data and the completion of the Set-Up Fee Questionnaire.

2023-2025

Provider Interview Component

For the 2023-2025 data collection, each sampled provider will receive email and mail invitations (**Attachment N2**), PR materials (if funds allow), and non-monetary incentives (if funds allow). Respondents receive additional invitations and survey packets with a paper ACPI (**Attachment C2**) via mail and email dependent on their response status. The ACPI takes approximately 30 minutes, the same amount of time as the Physician Induction Interview questionnaire the redesign is replacing. Abstraction will remain paused and is not included in the burden table for the Provider Interview Component. This interview contains fixed and rotational components. Providers will be able to complete the survey via web or a mailed paper instrument. Previously, approximately 3,000 physicians were expected to be interviewed. We plan to increase to 5,000 physicians and 5,000 advanced practice providers in 2023; up to 10,000 physicians and 20,000 advanced practice providers in 2024; and up to 20,000 physicians and 40,000 advanced practice providers in 2025. The previously approved 2021-2023 Physician Induction Interview questionnaire was expected to be 1,500 hours and abstraction was estimated at 1,000 hours, annualized over three years. The 2023-2025 NAMCS ACPI is expected to be 5,834 hours annualized over three years for physicians and 10,834 hours annualized over three years for advanced practice providers.

Beginning with the 2023 data collection, a tracing questionnaire (**Attachment C2**) will be implemented to conduct additional locating of ambulatory care provider contact information (potential phone numbers, addresses, emails, etc.). The tracing questionnaire takes approximately 10 minutes. The goal is for tracing to be conducted for the entire targeted sample of 5,000 physicians and 5,000 advanced practice providers in 2023; up to 10,000 physicians and 20,000 advanced practice providers in 2024; and up to 20,000 physicians and 40,000 advanced practice providers in 2025. The 2023-2025 NAMCS tracing questionnaire is expected to be 1,945 hours annualized over three years for physicians and 3,611 hours annualized over three years for advanced practice providers.

Provider Electronic Component

In the 2023-2025 Provider Electronic Component, each sampled provider will receive an introductory letter (**Attachment N2**). Staff will submit their PFI (**Attachment E2**) or electronic visit data (**Attachment O2**); all burden associated with electronic data submission will be with their staff. The three-year annualized average burden associated with completing the modified PFI for each of 3,000 providers is still 45 minutes. The only other burden associated with submitting visit data will be preparing and transmitting electronic files quarterly for a full year's worth of data. Previously, data was submitted by sampled physicians for one week, increasing the burden for visit data submission. Also, the 2021-2023 package did not have this component taking place in 2021, thus there was an annualized average of 2,000 physicians, versus the

current annualized average of 3,000 providers. For each year, approximately 3,000 providers will be asked to complete the PFI and submit electronic visit data. The total response burden for the 2023-2025 PFI is expected to be 2,250 hours annualized over three years. The total expected response burden for the 2023-2025 electronic transmission is expected to be 12,000 hours annualized over three years.

We also plan to supplement our Provider Electronic Component data with data collected from third party entities such as IQVIA, the American Board of Family Medicine, etc. There should be no respondent burden from this activity as we will be utilizing data already collected for other sources as a resource. Due to the lack of respondent burden, this activity is not mentioned in Table 1 or Table 2 below.

Health Center Component

For the 2023-2025 HC Component, respondents receive a welcome packet with an introductory letter (**Attachment N1**), FAQ, and PR materials, (endorsement letters [**Attachment P**], postcard, etc.). Respondents receive additional outreach letters phone calls, emails, PR materials, etc. if there is no response to the initial welcome packet. HCs will be asked to complete the HC Facility Interview questionnaire (**Attachment I3**), prepare and transmit EHR visit data (**Attachment** O1 or **O2**), and complete the Set-Up Fee Questionnaire (**Attachment J)**. The modified HC Facility Interview questionnaire (**Attachment I3**) takes approximately 45 minutes, the same amount of time as the currently approved HC Facility Interview questionnaire (**Attachment I1**). The new Set-Up Fee Questionnaire (**Attachment J)** takes approximately 15 minutes. The respondent will complete the interview by phone, mail, or web portal. The HC will then submit a file for testing and validation and transmit their annual visit data. Then they will complete the Set-Up Fee Questionnaire. We plan to increase to a total of 150 HCs in 2023, then up to 200 HCs in 2024, and up to 250 in 2025, with each of these years having a reserve sample of 100 HCs. The total expected response burden for the 2021-2023 HC Facility Interview Questionnaire was estimated at 69 hours and the burden for the HCS to prepare and transmit EHR visit data was estimated at 368 hours, both annualized over three years. The sample size has increased, increasing the burden hours. The total expected response burden for the 2023-2025 HC Facility Interview questionnaire is estimated at 225 hours annualized over three years. The HC Facility Interview questionnaire burden includes both the primary and reserve samples that will be contacted to reach the target sample goal. The total 2023-2025 expected response burden for the HCs to prepare and transmit EHR visit data quarterly, including testing and validation, is estimated at 800 hours annualized over three years. The total 2023-2025 expected response burden for the Set-Up Fee Questionnaire is estimated at 50 hours annualized over three years.

Table 1. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)	Total Burden (in hrs.)

HC's Staff	HC Facility Interview questionnaire (Survey year: 2022)	73	1	45/60	55
	Prepare and transmit EHR for Visit Data (quarterly) (Survey year: 2022)	33	4	60/60	132
	Set-up Fee Questionnaire (Survey year: 2022)	33	1	15/60	8
Physician or Staff	ACPI (Survey year: 2023-2025)	11,667	1	30/60	5,834
	Contact Tracing (Survey year: 2023-2025)	11,667	1	10/60	1,945
Advanced Practice Provider or Staff	ACPI (Survey year: 2023-2025)	21,667	1	30/60	10,834
	Contact Tracing (Survey year: 2023-2025)	21,667	1	10/60	3,611
Ambulatory Care Provider's or Group's or Conglomerate's Staff	PFI Survey year: 2023-2025)	3,000	1	45/60	2,250
	Prepare and transmit Electronic Visit Data (quarterly) (Survey year: 2023-2025)	3,000	4	60/60	12,000
HC's Staff	HC Facility Interview questionnaire (Survey year: 2023-2025)	300	1	45/60	225
	Prepare and transmit EHR for Visit Data (quarterly) (Survey year: 2023-2025)	200	4	60/60	800
	Set-up Fee Questionnaire (Survey year: 2023-2025)	200	1	15/60	50
Total					37,744

Note: Burden hours annualized over three years.

Burden Cost

The cost to providers for each data collection cycle is estimated to be $1,331,338.89. This is an increase of $1,072,744.14 from the current estimate of $258,594.75 that was submitted in the last OMB change package. This increase is due to the increase in burden hours, caused primarily by the increase in sample sizes, increased frequency in EHR data submission for the Provider Electronic Component, and the additions of the Contact Tracing and the Set-up Fee questionnaire. The hourly wage estimates for completing various NAMCS forms and activities used in the table below are based on information obtained from the Bureau of Labor Statistics (BLS) web site (http://www.bls.gov). Specifically, we used the "May 2021 National Occupational Employment and Wage Estimates" for the categories including: (1) management occupations, (2) healthcare practitioners and technical occupations, and (3) office and administrative support occupations.

Data were gathered on mean hourly wages in 2021 for (1) physicians ("physicians, broad" and "surgeons, broad" wages used as a proxy for physicians), (2) advanced practice providers (physician assistants, nurse practitioners, and nurse midwives' wages used as a proxy for advanced practice providers), (3) other professionals involved in managing either an physician or ambulatory care provider's practice (e.g., nurses, receptionists, etc. wages as a proxy for Physician or Advanced Practice Provider's Staff), and (4) other professionals involved in managing either an HC (e.g., nurses, receptionists, "physicians, broad", physician assistants, etc. wages as a proxy for HC Staff). The total cost estimate for NAMCS is detailed by the type of respondent who will complete the associated components of the survey.

Overall, the average hourly wages presented in Table 2 were averaged across different positions to capture who may complete each applicable form. The numbers indicated below represent an estimated annualized respondent cost for survey years 2023-2025.

Table 2. Annualized Respondent Cost

Type of Respondents	Form Name	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
Physician	ACPI	1,459	$131.49	$191,843.91
Physician's Staff	ACPI	4,376	$26.38	$115,438.88
Physician	Contact Tracing	486	$131.49	$63,904.14
Physician's Staff	Contact Tracing	1,459	$26.38	$38,488.42
Advanced Practice Provider	ACPI	2,709	$56.36	$152,679.24
Advanced Practice Provider's Staff	ACPI	8,126	$26.38	$214,363.88
Advanced Practice Provider	Contact Tracing	903	$56.36	$50,893.08
Advanced Practice Provider's Staff	Contact Tracing	2,708	$26.38	$71,437.04
Ambulatory Care Provider's or Group's or Conglomerate's Staff	PFI	2,250	$26.38	$59,355.00

Ambulatory Care Provider's or Group's or Conglomerate's Staff	Prepare and transmit Electronic Visit Data (quarterly)	12,000	$26.38	$316,560.00
HC''s Staff	HC Facility Interview questionnaire	280	$44.39	$12,429.20
HC's Staff	Prepare and transmit EHR for Visit Data (quarterly)	932	$44.39	$41,371.48
HC's Staff	Set-up Fee Questionnaire	58	$44.39	$2,574.62
Total				$1,331,338.89

13. Estimates of Other Total Annual Cost Burden to Respondents and 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 Federal Government

The estimate of average annual (one-data cycle) cost to the government for the NAMCS is given below.

Table 3. Annualized Cost to the Government

Expense Description	Total Cost
Interagency Agreement for data collection with the U.S. Census Bureau	$2,500,000
Printing	$10,901
Contract costs for collecting and processing physician EHR data	$3,000,000
Contract costs for collecting and processing HC EHR data	$2,434,000
Sponsoring agency expenses: Staff salaries, benefits, other miscellaneous costs	$802,440
Total cost for 12 months	**$8,747,341**

15. Explanation for Program Changes or Adjustments

Currently there are 6,819 burden hours in the OMB inventory. A total burden of 37,744 hours is requested for NAMCS. This an increase of 30,925 burden hours due to program changes. There is an increase of 19,404 burden hours because of the revision of the Provider Interview Component (redesign of the interview questionnaire and additions to the sample and scope). There is an increase of 772 burden hours because of changes to the HC Component (new Set-Up Fee Questionnaire and additions to the sample). Lastly, there is an increase of 10,750 attributed to the Provider Electronic Component, because of the revision sample and submission method. Please note that due to rounding the total change in burden hours differs by 1 hour for the Provider Interview Component.

16. Plans for Tabulation and Publication and Project Time Schedule

This clearance request covers the completion of the 2022 survey year for the HC Component and the following three survey years, 2023-2025, of data collection. The planned timetable for the tabulation and publication and project timeline for the 2023 survey is provided in Table 4.

Table 4. Project Time Schedule

Timeline	Activity
Within one month of OMB approval	Begin data collection for 2023 survey
Within six months of OMB approval	Begin processing and cleaning of data on flow basis
One year after OMB approval	Formally end reporting period
One year and three months after OMB approval	Begin preliminary data linkage work on collected data
One year and six months after OMB approval	Begin data analysis
Two years and five months after OMB approval	Public-use data available on Internet Publish reports and on-line data summary tables

The NCHS regularly publishes NAMCS data on the Internet and in various *NCHS Data Briefs* and other reports, such as the most recent NAMCS *Data Brief* titled "Characteristics of Office-based Physician Visits, 2018.[3]

The standard tables from the traditional summaries, referred to as *Summary Tables*, will continue to be produced in PDF format on the web. The NAMCS 2018 *Summary Tables* are available at: https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2018-namcs-web-tables-508.pdf. Other tables are also available, some combining data across surveys or across years at: https://www.cdc.gov/nchs/ahcd/web_tables.htm.

NCHS is also exploring methods to publish preliminary estimates and dashboards that highlight areas of interest, for researchers to have access to more timely data. NAMCS datasets are made available to researchers through the NCHS Research Data Center (RDC). NAMCS will also publish public use files containing information visit data when possible.

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

The OMB expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

The data collection fully complies with the guidelines in 5 CFR 1320.9, and no exception is requested to the certification for Paperwork Reduction Act for this submission.

[3] Ashman JJ, Santo L, Okeyode T. Characteristics of office-based physician visits, 2018. NCHS Data Brief, no 408. Hyattsville, MD: National Center for Health Statistics. 2021.
DOI: https://dx.doi.org/10.15620/cdc:105509