Request for Approval of A Non-Substantive Change to the National Electronic Health Records Survey

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A1. Circumstances making the collection of information necessary

This request is for a nonsubstantive change to an approved data collection - the National Electronic Health Records Survey (NEHRS) (OMB No. 0920-1015 Exp. Date 7/13/2020). On July 13, 2017, OMB approved the NEHRS annual data collection. The approved supporting statement included permission to submit non-substantive change packages, as needed, for form modifications occurring throughout the 2017-2019 study period. Some questions change on a periodic basis to collect new and/or updated information as needed. The modifications captured in this change request were developed subsequent to the submission of the currently approved package.

The National Center for Health Statistics (NCHS) is modifying the content for the currently approved NEHRS to obtain data about the constantly evolving health information exchange (HIE), particularly with respect to sending, receiving, and integrating patient health information. Changes to the content for 2018 are presented in **Attachment A**, highlighted below, and described in more detail in section A2. A clean copy of the proposed 2018 NEHRS instrument is captured in Attachment B. Overall, the changes do not alter the currently approved average response times and total burden hours for the NEHRS.

2. Purpose and Use of Information Collected

Several minimal question modifications are proposed for the 2018 NEHRS data collection instrument; they are summarized in **Attachment A.**

The new questions on the 2018 NEHRS are designed to update the currently approved NEHRS**,** including expanding content to measure health information exchange; expand the investigation of provider burden (see Section 16. Plans for Tabulation and Publication and Project Time Schedule for more detail); and provide information in the context of the meaningful use rule promulgated in Medicare and Medicaid Programs (Electronic Health Record Incentive Program — Stage 2, 42 CFR §§ 412-413-495 (2012)). 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 Stages 2 and 3 (2014 and 2018, respectively) added additional requirements and new reports. The NEHRS survey instrument will continue to evolve as these requirements for functionality evolve.

NCHS also proposes to delete several questions relating to computerized capabilities, as these topics are no longer a priority for the Office of the National Coordinator for Health Information Technology (ONC), sponsor of NEHRS. Meanwhile, other items were modified to capture data on sending, receiving, and integrating patient health information within health information exchanges. Overall, the changes do not alter the currently approved average response times and total burden hours for the NEHRS.

NEHRS samples 10,302 physicians annually. In 2018, the NEHRS sample will receive the updated NEHRS questionnaire **(Attachment B).** In turn, updates were made to the Computer-Assisted Telephone Interviewing (CATI) script (**Attachment C**) to reflect the updated

Cybersecurity language and survey instrument; whereas the NEHRS advance letters (**Attachment D**) were updated to reflect the updated Cybersecurity language.

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 the NEHRS. The 2018 NEHRS continues the use of web data collection. Similar to the 2015 and 2017 NEHRS, the 2018 NEHRS will be administered via a sequential mixed mode design of web and mail recruitment. Recruitment will start with email and mail invitations to a web-based survey, and will then be followed by three mailings and phone follow-up for non-responses.

12. Estimates of Annualized Burden Hours and Costs

A. Burden Hours

This submission requests OMB approval for minimum changes to the approved 2017 NEHRS form (OMB No. 0920-1015, Exp. Date 07/13/2020). Although the 2017 NEHRS and NEHRS Supplement had been previously approved, data collection for the NEHRS Supplement was delayed until 2018. In 2017 the sample (n = 10,302) received the 2017 NEHRS questionnaire in the third quarter; these same sampled physicians will receive the NEHRS supplemental questionnaires starting in June 2018. While NEHRS will be administered each year of the approval period (2017-2019) to 10,302 physicians, current plans are to administer the NEHRS Supplements starting in June 2018 and the 2018 NEHRS starting in September 2018, which will overlap part of the NEHRS Supplement data collection. The annualized burden for the 2018 NEHRS and NEHRS Supplement remain the same as previously approved as shown in the burden table below (6,295 total burden hours).

The table represents an estimate for one year of data collection over the approval period (2017-2019). The estimated annualized burden hours were based on previous years' response experience in administering the NEHRS and National Ambulatory Medical Care Survey (NAMCS) Physician Workflow mail supplement, i.e., the response rate is assumed to be 50 percent.

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 $622,135. 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 2016 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 2016 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 $98.83 (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	$98.83	$622,135
Total			$622,135

15. Explanation for Program Changes or Adjustments

There is no change to the burden times for the 2018 NEHRS or the NEHRS supplemental survey.

16. Plans for Tabulation and Publication and Project Time Schedule

The Congressional report, which is still in progress, will outline potential sources of provider burden and make recommendations to ameliorate this burden. One of the key sources of provider burden identified in this report is clinical care documentation.

Currently there is no standardized measure for assessing provider burden associated with clinical care documentation. However, in the proposed 2018 NEHRS instrument there are quantitative measures and measures on provider perception of burden, which in combination can describe the extent of provider burden associated with clinical care documentation. The quantitative measures include: total number of hours spent on clinical care documentation outside of office hours (item

44), and whether there is staff support to assist in documenting clinical care (item 45). The qualitative measures include providers' perceptions of ease/difficulty documenting clinical care using their medical record system (item 46), appropriateness of time spent on documentation (item 47, 1st statement), impact on patient care (e.g., amount of time spent with patients; item 47, 2nd statement), documentation required for billing that exceeds what is required for clinical care (item 47, 3rd statement) and alignment of private insurers with Medicare requirements (item 48). Some of these are also potential factors that may contribute to clinical care documentation as a source of provider burden. These factors include the presence of staff support, such as a scribe (item 45), could diminish burden associated with clinical care documentation whereas the absence of staff support could increase burden. Another factor relates to the ease/difficulty of using an EHR for documenting clinical care (item 46). Others relate to documentation that exceeds what is required for clinical care and is only for billing purposes (item 47, 3rd statement) and lack of alignment between private insurers with CMS requirements for clinical care documentation (item 48). Each of these factors would impact the amount of time spent by providers documenting clinical care.

The newly proposed questions would first be examined individually. Then, bivariate and multivariate analyses would be used to examine them by certain factors such as geographic location (rural/urban), provider specialty (item 1), a number of practice characteristics (items 4-16), IPA participation (item 13), practice ownership (item 16), acceptance of Medicare and/or Medicaid payments (item 12), Medicare program participation (item 18) and other care delivery reform programs (item 17), use of documentation templates (items 24, 24a-c), and EHR vendor (item 20). These bivariate and multivariate analyses would allow for identification of key characteristics that are associated with increased provider burden.

The results from these data would inform healthcare providers and policy makers on provider burden related to clinical care documentation. These data would specifically be used by ONC to address provider burden in a number of ways including modifying EHR certification criteria, and developing provider tools to improve workflow. If the data show, for example, that EHRs are considered easy to use (item 46) but clinical care documentation burden is high based upon the qualitative and quantitative measures previously described, then ONC (in its role as a coordinator) would work with CMS and private payers to address the clinical care documentation requirements. If instead providers report that EHRs are difficult to use for clinical care documentation (item 46) and clinical care documentation burden is high based upon qualitative and quantitative measures previously described, ONC would consider updating its EHR certification requirements on clinical care documentation to make them more stringent so that usability and functionality associated with clinical care documentation is improved.

The analyses and results by practice characteristics (e.g., small practices) could inform the need to develop tools and resources targeting specific types of practices. Analyses and results by vendor could inform the need to improve usability and functionality of specific EHR vendor products. ONC would reach out to these vendors (in its role as coordinator) to communicate these issues that contribute to provider burden that should be addressed. Results by Medicaid and Medicare provider types (item 12) would also be informative. If Medicaid and Medicare providers had higher burden related to clinical care documentation requirements, ONC could coordinate with CMS on a plan to address these issues. Furthermore, if alignment of

requirements was an issue, ONC would coordinate with CMS and private payers to address these issues.

In sum, there are a variety of analyses that would be conducted using the newly-proposed NEHRS items, which would provide a better understanding of provider burden related to clinical care documentation. These data are essential to inform actions by ONC and other federal partners in addressing provider burden associated with clinical care documentation and EHR use. Unfortunately, given its timing, the results of this survey will not inform the Congressional Report. However, they will be used to directly inform which recommendations should be implemented, and allow an assessment of the impact of the recommendations over time.

2018 NEHRS

Month of OMB approval	Sample selection
Three months after OMB approval	Begin data collection for 2018 NEHRS
Eight months after OMB approval	End data collection
Twelve months after OMB approval	Begin data analysis
Fifteen months after OMB approval	Publish Data Brief

Attachments

Att A - Changes to 2017 NEHRS

Att B - 2018 NEHRS Questionnaire

Att C - 2018 NEHRS CATI Script

Att D - 2018 NEHRS Letters