

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

OMB No. 0920-0234
(Expires 12/31/2014)

Contact Information:

Melissa M. Park, M.P.H.
Health Scientist, Ambulatory and Hospital Care Statistics Branch
Division of Health Care Statistics
National Center for Health Statistics/CDC
3311 Toledo Road, Room 3334
Hyattsville, MD 20782
301-458-4203
301-458-4032 (fax)
mpark@cdc.gov

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Supporting Statement

National Center for Health Statistics National Ambulatory Medical Care Survey

The National Center for Health Statistics (NCHS) requests approval for a revision of an approved data collection, the ongoing National Ambulatory Medical Care Survey (NAMCS) (OMB No. 0920-0234: Expiration date 12/31/2014), for the purpose of

- continuing survey activities for the 3 years 2015, 2016, and 2017
- continuing to use an oversample of the most populated states to allow for state-based estimates
- modifying selected existing questions for clarification and to keep up-to-date with current medical practice and terminology
- adding new questions on emerging health topics to regular data collection activities
- acknowledging the removal of the National Electronic Health Records Survey (NEHRS) out of the NAMCS Information Collection Request (ICR) into a separate ICR

NAMCS is a national survey of patient visits to office-based physicians conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. Although the NAMCS, described in the next section, serves the country well by providing national data on ambulatory care, health care is changing and the survey continues to evolve to address these changes. For example, 2012 was a landmark year with the launch of the computerized data collection system, a roughly five-fold increase in sample size to 19,849 physicians/community health center (CHC) providers, and a change in sample design from a geographic-based primary sampling unit (PSU) to a list sample design. The increased sample size and new list sample design allowed for the collection of state-level estimates to monitor clinical preventive services provided in physician offices. This sample increase was largely due to 2011 prevention funds from the Patient Protection and Affordable Care Act (ACA). An oversampling of the most populated states has continued each year to allow estimates for 34 states in 2012; 22 states in 2013; and 18 states in 2014. The ACA funds will be depleted at the close of the 2014 survey year, but the CDC has earmarked NAMCS funds for 2015. Based on current funding information, 16 state-based estimates can be made in 2015 and a comparable number is projected for 2016-2017, depending on future potential funding. The annualized 2015-2017 NAMCS sample size is projected to be 12,085 office-based physicians and CHC providers. These data expand the capacity of CDC and its health department partners for monitoring the effects of expanded health coverage on use of appropriate preventive services.

New/modified activities planned for the 2015-2017 survey period:

- National Electronic Health Records Survey (NEHRS) has a stand-alone OMB Clearance package (OMB No. 0920-1015: Expiration date 04/30/2017) and will no longer be discussed in this NAMCS package; however, four EHR questions that are also captured in the NEHRS pertaining to methods of finding and incorporating electronic health data will also be added to the NAMCS, providing an opportunity for reliability and validity checks.

- Physician Induction Interview (NAMCS-1): Modify question text for clarity, add two new questions on Culturally and Linguistically Appropriate Services (CLAS) in health care, add 6 new questions on alcohol screening and brief intervention (SBI) by primary care physicians, modify workforce questions, add new EHR questions, and tailor wording for questions directed to CHC settings.
- Physician Induction Interview, CHC service delivery site (NAMCS-201): Add or modify 3 questions
- NAMCS Patient Record form (PRF): Delete one question; add 2 questions; modify question text, answer categories, and skip patterns

Continuing data collection activities:

- Patient visits to office-based NAMCS physicians
- Patient visits to physicians and mid-level providers at community health centers (CHCs)
- Continue oversampling the most populated states to produce estimates for 16 states annually during 2015-2017
- Continue a re-abstraction of patient visits from 500 respondents (office-based NAMCS physicians/CHC providers)

Typically throughout a survey period, slight modifications to the forms are needed. Therefore, in addition to the requested approval summarized above and herein, we are also requesting the ability to submit non-substantive change packages, as needed, for form modifications occurring throughout the 2015-2017 study period. A three-year clearance is requested.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

The National Ambulatory Medical Care Survey (NAMCS) has been conducted intermittently from 1973 through 1985, and annually since 1989. The survey is conducted under authority of Section 306 of the Public Health Service Act (42 USC 242k) (**Attachment A**). A copy of the most recently published Federal Register notice announcing the 60-day public comment period along with public comments can be found in **Attachment B**.

NAMCS Components

There are two main components of NAMCS: (1) the traditional sample of non-federal office-based physicians (including both Doctors of Medicine (MDs) and Doctors of Osteopathic Medicine (DOs)); and (2) physicians (both MDs and DOs), nurse practitioners (NPs), physician assistants (PAs), and nurse midwives (NMWs) sampled in community health centers (CHCs). The specific 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 as such, fulfills one of NCHS missions, to monitor the nation's health. Ambulatory services are rendered in a wide variety of settings, including physician offices and hospital outpatient and emergency

departments. Since more than 80 percent of all direct ambulatory medical care visits occur in physician offices, NAMCS provides data on the majority of ambulatory medical care services. To complement these data, the National Center for Health Statistics (NCHS) initiated the National Hospital Ambulatory Medical Care Survey (NHAMCS) (OMB No. 0920-0278) in 1992 to provide data on patient visits to hospital outpatient and emergency departments.

In addition to health care provided in physician offices and outpatient and emergency departments, community health centers (CHCs) play an important role in the health care community by providing care to people who might not be able to afford it otherwise. CHCs are local, non-profit, community-owned health care providers which serve approximately 13 million individuals throughout the United States. Research has shown that up to 4 percent of all primary care visits and 10 percent of all visits by uninsured patients are made to CHCs. Prior to 2006, visits made to CHCs, although captured in NAMCS, were not purposely included in the sampling plan; at that time, CHCs did not represent a separate NAMCS stratum. In an attempt to obtain a more accurate picture of health care provided in the United States, a sample of 156 CHCs was included in the 2006 NAMCS panel. There has been annual data collection from CHCs since that time, and these settings will continue to be sampled in 2015-2017.

NAMCS is part of the ambulatory care component of the National Health Care Surveys (NHCS), a family of provider-based surveys that capture health care utilization from a variety of settings, including hospital inpatient and long-term care facilities. NCHS surveys of health care providers include NAMCS, NHAMCS, National Hospital Care Survey (OMB No. 0920-0212), and National Study of Long-term Care Providers (OMB No. 0920-0943).

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

NAMCS Sample Size

The currently approved and final fielded sample size for 2014 is 13,827 total office-based and CHC providers.

In 2015, allocated funds will cover a sample size of 12,085 office-based physicians and CHC providers. The same levels are anticipated for 2016 and 2017.

- Office-based Physicians

In each NAMCS survey year, since the survey’s inception, there has been a fresh core sample of 3,000 office-based physicians that NCHS commits to fund at a minimum. Starting in 2012 and continuing through the close of 2014, the Patient Protection and Affordable Care Act (ACA) provided a substantial pool of funding for an expansion sample that allowed for the creation of a computerized data collection system and the collection of state-based estimates for the first time. The combined core and expansion samples are collectively referred to as the “base” sample. Although ACA funds are not being used in 2015, CDC will fund the 2015 expansion sample from other sources. ACA funds may return in future years. The same level of funding is anticipated for 2016 and 2017. The proposed annual number of office-based physicians during 2015-2017 is 8,080. If additional funding is not obtained, sample sizes will be reduced.

- Community Health Centers (CHCs)

In each NAMCS survey year since 2006, there is a fresh core sample of 156 Community Health Centers (CHC) that NCHS commits to fund at a minimum. The ACA also provided funding for a CHC expansion sample for 2012, 2013, and 2014. Same as for the office-based physicians, core plus expansion samples are referred to as the base sample. The CDC will fund the CHC expansion sample for 2015 and it is anticipated that the same level of funding will continue in 2016 and 2017. There are a proposed 1,780 CHC service delivery sites annually for 2015-2017. A maximum of 3 providers will be selected from each CHC site, but the most recent field data has shown an average of 2.25 eligible providers per CHC site, resulting in 4,005 total CHC providers. If additional funding is not obtained, sample sizes will be reduced.

Annualized NAMCS Sample Counts for 2015-2017	
State-based estimates	16 states
Office-based Physicians	
Core Office-based Physicians	} Base
Expansion sample (Office-based)	
Total Office-based Physicians	8,080
Community Health Centers	
Core CHC service delivery sites	} Base
Expansion sample - CHC sites	
Total CHC service delivery sites	1,780
Total CHC Providers = CHC sites * 2.25 CHC providers	4,005
Combined Sample Size	12,085

- Continued use of sampling methodology introduced in 2012

The basic statistical design and data collection methods for the NAMCS were updated in 2012 to allow the NAMCS to make state-based estimates for 34 states in 2012; 22 states in 2013; 18 states in 2014; and a proposed 16 states for each year during 2015-2017. The two-component interview survey (office-based & CHC) uses multi-stage stratified samples of provider-patient encounters or visits selected from office-based physician practices and from CHCs. In 2012 and beyond, the physician sample uses two-stage design in which the first stage is a stratified list sample of office-based physicians and the second stage is visits to the sampled provider. The

CHC survey uses a three-stage design in which the first stage is a stratified list sample of CHC service delivery sites, the second stage is providers practicing at the sampled CHC site, and the third stage is visits to the sampled provider.

New/modified activities planned for the 2015-2017 survey period

Physician Induction Interview (NAMCS-1)

The Physician Induction Interview collects a variety of information, including physician and practice information. This instrument is used for both office-based physicians and providers in community health centers. **Attachment C1** shows the currently fielded 2014 Physician Induction Interview (NAMCS-1). **Attachment C2** describes the 2015 modifications and additions for both office-based physicians and CHC providers. **Attachment C3** provides the full list of 2015 questions in the order that it would appear in the instrument for both office-based physicians and CHC providers. As in 2014, the 2015 NAMCS-1 questions will be collected on a computer-assisted interviewing instrument.

DHCS staff and staff from the DHHS Office of Minority Health have begun collaborating to obtain information on physicians' use of the national standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. While a broader project is under discussion for the future, two new baseline questions will be added to the 2015 NAMCS – one on knowledge of the standards and one on the physician's participation in cultural competence training. These new questions have been inserted between questions 16 and 17 of the Physician Induction Interview (**Attachments C2 and C3**).

New questions were added to the Physician Induction Interview on Alcohol screening and brief intervention (SBI) (see questions 17-22 in **Attachments C2 and C3**). These questions are only administered to primary care providers. Like hypertension or tobacco screening, alcohol screening and brief intervention (SBI) is a clinical preventive service. To help advance the National Center on Birth Defects and Developmental Disabilities' new alcohol SBI initiative, it is imperative to survey primary care providers to determine the extent to which alcohol SBI is being conducted within their practices. Survey results will be used to inform future alcohol SBI implementation efforts within primary care settings. The intended target population of this data collection effort is Primary Care Providers. The NCBDDD-specific goals of data collection are to (1) learn the extent to which Alcohol Screening and Brief Intervention (SBI; Counseling) is conducted among primary care providers, (2) gain insight on the type(s) of alcohol screening instruments used, administration methods employed, and staff type(s) responsible for conducting alcohol SBI within the primary care setting and (3) assess the types of resources primary care providers would find helpful for implementing alcohol/substance SBI in their setting.

Additional proposed changes to the NAMCS-1 Induction include additions and modifications to the Physician Workforce questions (see questions 23-34 in **Attachments C2 and C3**). Practice-level questions are grouped together at the beginning of the Workforce block and the location-specific questions follow. This change was done for clarity. In the past two years that the Workforce questions have been on the survey, practice-level questions were interspersed with

location-specific questions, which caused confusion. Part-time staffing types were added as answer choices to complement the already-existing full-time staffing types. A physician assistant (PA) billing question was added after consultation with practicing PAs revealed that they often have their own NPI number for billing.

New questions are proposed for addition to the EHR section (see questions 48-51 on **Attachments C2 and C3**). The Office of the National Coordinator for Health Information Technology (ONC) sponsors the National Electronic Health Record Survey (NEHRS), a self-administered mailed survey that was previously included as a part of this NAMCS package before it was approved as a separate information collection request. The NEHRS measures progress in EHR adoption and meaningful use among office-based physicians. ONC updates the questions every year to remain current with rapidly changing technology and medical practices. The four new questions added in 2015 pertain to specific questions on methods of finding and incorporating electronic health data. NAMCS uses the same EHR questions in its survey, which provides a valuable opportunity for reliability and validity checks.

CHC providers use the same instrument as the one used for office-based physicians, but we propose that wording be tailored for questions directed to the CHC. The content of the questions remain the same as those for traditional office-based physicians. Specifically, the wording of the induction questions are changed for CHC providers so they relate only to the sampled CHC location and NOT the practice or other location with the most visits (**Attachments C2 and C3**).

Community Health Center Induction Interview (NAMCS-201)

Three questions were modified or added (**Attachments C4 and C5**). On the first screen that starts the CHC Induction Interview, one of the answer choices was updated. We no longer interview at the CHC Headquarter level. Instead, we sample the individual service delivery sites. A question was added to determine the number of weeks out of the year that patients are seen at the sampled CHC. A follow-up question was added if the number of weeks was zero.

Patient Record form (Attachments D2 and D3)

Several modifications were made to clarify data collection and improve data quality. For pregnant patients, the follow-up question on last menstrual period is deleted due to poor data quality and reliability. Gestational weeks will remain as the only follow-up question. For tobacco use, “smoker” was removed because we want to include all types of tobacco use, including chewing tobacco. Also, “not current” tobacco use will have follow-up categories “Never”, “Former”, and “Unknown”. Skip patterns for injury questions were modified. A follow-up question on intent of injury was added to capture suicidal ideation (see bottom of page 2 in Attachment D3). Several modifications were made to the answer list of chronic conditions for clarity. Several minor modifications were made to the Services tab, including the addition of a follow-up question asking if an “Upper gastrointestinal endoscopy/EGD” was provided (see page 5 in Attachment D3) .

2. Purpose and Use of the Information Collection

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

If NAMCS data were not collected, there would be no national estimates on health care issues faced by office-based physicians and CHC providers. The additional items on the NAMCS-1 will allow research to focus on the following: (1) measurement of EHR system adoption and associated system characteristics, (2) adoption rates of financial incentives for the “meaningful use” of certified EHR technology to improve patient care, (3) determination of the extent to which alcohol screening and brief intervention is being conducted within medical practices, (4) characterization of the physician workforce including staffing composition of office-based practice, autonomy of mid-level providers, and coordination of care.

NAMCS Office-based physicians and CHC providers

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

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

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

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

- Researchers within and outside NCHS have published findings from NAMCS data in scholarly journals and conferences:
 - Cohen D, Coco A. Do physicians address other medical problems during preventive gynecologic visits? *J Am Board Fam Med*. 2014 Jan-Feb;27(1)
 - Ritsema TS, Bingenheimer JB, Scholting P, Cawley JF. Differences in the delivery of health education to patients with chronic disease by provider type, 2005-2009. *Prev Chronic Dis*. 2014 Mar 6;11
- Cherry D, Park M. Basic and Advanced Hands-On Learning Institutes on Understanding and Analyzing Ambulatory Health Care Data. Presentation at the 2012 National Conference on Health Statistics.
- Talwalkar A, Uddin S. Impact of Prostate Cancer Screening Recommendations on PSA Testing at Routine Office Visits by Males 35 Years and Older, United States, 2006-07 and 2009-2010. Presentation at Preventive Medicine 2014 Annual Meeting, February 21, 2014.
- The Department of Health and Human Services is currently using NAMCS 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 NAMCS data support efforts to quantify national improvement.
- The Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency, is required by law to make recommendations to Congress on payment updates to Medicare providers. MedPAC uses NAMCS data in its analysis of physician services, such as trends in physician willingness to serve Medicare beneficiaries. MedPAC presents this indicator yearly in its public meetings and in its official reports to the Congress to help determine payment updates for Medicare services.

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

Impact on the privacy of the patient is negligible, as the only piece of sensitive information being collected is the medical record number. Medical record number will only be used for internal survey operations purposes, and will be eliminated from the dataset prior to transmittal to NCHS. No information in identifiable form (IIF) data are shared with researchers.

3. Use of Improved Information Technology and Burden Reduction

Respondent burden in NAMCS data collection is minimized through sampling procedures, which are discussed in more detail in items A.5 and B.1.

A move to electronic collection has significantly reduced the burden for NAMCS respondents when answering both the NAMCS-1 and CHC induction interview questions. Using a computer assisted interviewing instrument of the induction interview allows field representatives (FRs) to skip unneeded questions, reduce incorrect or inconsistent entries, and eliminate the need for paper flashcards that highlight item choices. In the end, the time that a respondent spends during the induction interview is reduced.

Use of a computerized data entry system for PRF data significantly simplifies the data collection activities by reducing data entry errors and omissions, as well as providing on-screen look-up tables for items such as reason for visit, diagnosis, and medications. Overall, using a computerized data entry system reduces FR and respondent burden, and ultimately improves overall data quality. In addition, collecting the data electronically speeds up editing, transmission, and processing, thereby making release of the yearly statistics more timely.

There are no legal obstacles to reducing the burden.

4. Efforts to Identify Duplication and Use of Similar Information

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

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

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

IMS America, Inc., a private organization, conducts a study titled the National Disease and Therapeutic Index (NDTI) that produces data somewhat similar to those collected in NAMCS. These data are focused on the drug prescribing habits of physicians, and results are sold to drug companies for drug marketing purposes. The data collected are limited to only drug data and the corresponding patient's age, sex, and diagnosis, whereas NAMCS collects information on expected source of payment, reasons for visit, and other diagnostic and therapeutic services. Although the NDTI data are available for purchase by the government, the cost is prohibitive for most agencies. The data also have limitations that preclude their use for many purposes: data on response rates are proprietary and may be under 50 percent, and the survey and sampling procedures are of unknown validity. Efforts to obtain such information from IMS America have been unsuccessful.

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

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

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

5. Impact on Small Businesses or Other Small Entities

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

representatives (FRs) complete abstraction in order to further minimize burden.

6. Consequences of Collecting the Information Less Frequently

The rapidly changing environment of ambulatory care delivery makes it important to have annual data for decision making, describing the public's use of physician services, monitoring the effects of change, and planning possible changes in payment policies. This information has become even more crucial with the need to track the effects of the health care industry's changing arrangements for delivering care, by having continuous data collection before, during, and after the restructuring. To increase reliability, data from NAMCS are often analyzed by combining data across years. Less frequent collection would limit the study of rare visit characteristics. The current design asks a sampled physician/provider to participate for a 1-week period no more than once every 3 years, and only a small proportion of all physicians/providers are included in the survey each year. There are no legal obstacles to reduce the burden.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. Federal Register Notice

This project fully complies with all guidelines of 5 CFR 1320.8(d). A 60-day Federal Register Notice was published in the Federal Register on June 19, 2014, Vol. 79, No. 118, pages 35161-35163 (**Attachment B**).

Two public comments were received in response to the notice and shown in **Attachment B**. The standard CDC response was sent.

B. Efforts to Consult Outside the Agency

The following consultants both within and outside CDC were instrumental to the development of the NAMCS. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) was consulted along with other government agencies, such as the Food and Drug Administration, National Institutes of Health, and Centers for Medicare and Medicaid Services. In addition, representatives from the American Medical Association and other major national medical organizations as well as private and public health services researchers were contacted for their input. We collaborated with the U.S. Census Bureau to implement the computerized data collection instruments.

Considerable consultation was solicited prior to the introduction of the CHC sampling strata.

First, The National Association of Community Health Centers (NACHC) worked closely with NCHS in reviewing and providing comments on all the CHC forms and procedures. Numerous developmental meetings were held in early 2005 with individuals identified as having an interest in data collection from CHCs. A total of 15 people attended whose affiliation ranged from the federal government (NCHS, HRSA, and the Census Bureau) to professional association (NACHC) to academia (The Johns Hopkins Bloomberg School of Public Health). During this meeting, NCHS presented the methodological plan as well as the survey instrument for comment and discussion. Based on comments received during this meeting and those afterwards, changes were made to the CHC survey instruments. Finally, NCHS met with representatives from the Indian Health Service (IHS) to present our plan for including Indian Federally Qualified Health Centers in the CHC sample. During this meeting, NCHS explained our methodological plan and provided all forms for comment. The IHS commented on the forms and agreed to provide their list of health center locations.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsors the Physician Workforce component of the core NAMCS Physician Induction Interview (PII). These questions have been fielded since 2013. NCHS has maintained close contact with ASPE during discussions of modifications to the 2015-2017 workforce questions.

The National Center on Birth Defects and Developmental Disabilities (NCBDDD) at the Centers for Disease Control and Prevention (CDC) sponsors the 6 new questions on alcohol screening and brief intervention (SBI) that are proposed for the 2015 core NAMCS Physician Induction Interview (PII).

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 for 2015-2017 is provided in **Attachment F**.

9. Explanation of Any Payment or Gift to Respondents

NAMCS will not offer a payment or gift to respondents for participation. OMB will be notified of any plans to offer payment or gifts in the future.

10. Assurance of Confidentiality Provided to Respondents

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

"No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section...306 (NCHS legislation),...may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and (1) in the case of information obtained in the course of health statistical or epidemiological activities under section...306, such information may not be published or released in other form if the particular establishment or person supplying the information or described in it

is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release in other form,..."

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

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

10.1 Privacy Impact Assessment Information

This submission has been reviewed by Information Collection Review Office (ICRO), who 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. The applicable System of Records Notice is 09-20-0167 Health Resources Utilization Statistics.

Overview of the NAMCS Office-based and CHC Data Collection System

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

Physician Induction Interview (NAMCS-1)

Questions from the physician induction interview (NAMCS-1) computerized instrument are asked over the telephone and/or during an initial personal interview. Both traditional office-based physicians and CHC providers use the NAMCS-1. The questions in the first-half of the computer-based NAMCS-1 induction interview are designed to be completed over the telephone and are used to guide Census Field Representatives (FRs) through the induction process and verify the physician/ CHC provider's eligibility. The second-half of the induction instrument, which is completed in person with the physician/CHC provider, is dedicated to obtaining information concerning selected practice characteristics and determining a sampling strategy to collect the PRFs (**Attachments C1-C3**).

CHC Induction Questionnaire (NAMCS-201)

The CHC Induction Questionnaire (NAMCS-201) is used to collect information on the CHC service delivery site and to select the sample of providers at the site. These questions permit the collection of general CHC contact information including type of center, various sources of revenue, and identification of sampled providers. Within this instrument, the FR will also list all the providers who are scheduled to work at the specific service delivery site during the reporting period. Based on a selection probability proportional to the expected number of visits each provider expects to see during the reporting period, a sample of up to three providers is selected into sample. Changes to the 2015 NAMCS-201 are presented in **Attachment C4** and a listing of all proposed questions for the 2015 NAMCS-201 are presented in **Attachment C5**.

Patient Record form (PRF)

The majority of the data collection occurs with the completion of patient record forms (PRFs) for both office-based physicians and CHC providers. As with the induction instruments mentioned above, the PRFs are abstracted using the computer-based instrument. A PRF is completed for each sampled patient visit. **Attachment D2** shows the layout of the proposed 2015 NAMCS PRF. Samples of 30 visits are targeted per sampled provider. The current 2014 PRF can be found in **Attachment D1**. The proposed 2015 PRF can be found in **Attachment D2**. Changes from the 2014 PRF to the 2015 PRF can be found in **Attachment D3**.

Re-abstraction

Since 2012, medical record number has been used for re-abstraction to evaluate the reliability of the abstraction process. Specifically, a total of 500 physicians/CHC providers spread proportionally across all Census regional offices are selected randomly for re-abstraction. A different Census Field Representative (FR) visits the physician, and using medical record numbers, selects 10 patient visits that had been previously abstracted for re-abstraction. The re-abstraction would be conducted by the Census FR using the same data collection tool that was used for the original abstraction. See **Attachment E** for computer screen shots of the 2014 re-abstraction Patient Record form (PRF). Re-abstraction data are compared directly with original abstraction data, with rates of agreement computed for each data field. The comparison is used to identify any particular fields with low agreement between abstraction/re-abstraction. If any are identified, we will explore possible reasons for the low agreement with Census. Results will be used to design supplemental training to improve abstraction quality and advise modifications of instructions and data collection tools. Also, while re-abstraction will not be used to evaluate individual FRs, it will be used to track the level of abstraction/re-abstraction agreement in Census regional offices, and may identify a need for supplemental training. Medical record numbers will be maintained by the contractor on a separate file to facilitate record selection. Without medical record number, there would be no connection between the original visit and the visits that the second FR will abstract.

Items of Information to Be Collected

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

Data collected on the current patient visits include demographic characteristics, biometrics/vital signs, reasons for visit, injury/poisoning/adverse effects, continuity of care, diagnoses, diagnostic/screening services, health education, non-medication treatment, medications, providers seen, visit disposition, time spent with provider, laboratory test results, and current procedural terminology (CPT) or healthcare common coding system (HCPCS) codes.

Information in Identifiable Form (IIF)

The NAMCS and related supplements provide numerous and varied national estimates on provider, visit, and practice characteristics. Although a majority of the data collected are not considered personally identifiable, some fit the definition of information in identifiable form (IIF). A list of all IIF data items is highlighted below, and all were approved in the past packages by OMB to be collected on survey forms. None of these data are released to the public or become part of public-use files. All forms are automated for data collection by the FR or sampled physician.

The automation of the survey eliminates the need to record potentially identifiable information on paper. Medical record numbers are entered into the computerized instruments but will only be used for survey operations purposes. The medical record number will aid field representatives in abstracting data from the various record systems in the facility. The medical record number may also be used during re-abstraction efforts to verify the quality of initial abstraction. Once the case is complete and the data are ready to be transmitted to NCHS, the medical record number will be wiped from the dataset and will not be retained beyond that time.

Information in Identifiable Form Categories:

- Physician/CHC provider name
- Physician/CHC provider mailing address
- Physician/CHC provider telephone number
- Physician/CHC provider National Provider identifier (NPI)
- Physician/CHC provider Federal Tax ID/EIN
- CHC executive director name
- CHC mailing address
- CHC contact person
- Physician office/CHC staff name
- Patient medical record number
- Patient date of birth

In this survey, as in others, NAMCS will include a routine set of measures to safeguard confidentiality, including the following: all staff, including contractors at the U.S. Census Bureau and SRA International, 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. The FR enters patient medical record data directly into his or her assigned laptop alone and nowhere else. Once the data collection is completed, the FR electronically transmits the data onto a secure server and the data are wiped from the FR's laptop.

In keeping with NCHS policy, NAMCS data are made 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 physician/provider name, address, patient date of birth, and any other specific information are removed from the public release files. All data releases are reviewed by the NCHS Disclosure Review Board to avoid data breaches, such as release of detailed geographic information that may allow anyone to identify practices or individuals in the general population.

The ambulatory health care data website dedicated to NAMCS and NHAMCS (http://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 for NAMCS.

The NAMCS data collection plan has been approved by NCHS's Research Ethics Review Board (ERB) (Protocol #2010-02) based on 45 CFR 46. In addition, the Board has granted (1) a waiver of the requirement to obtain informed consent from the patient, (2) a waiver of the documentation of informed consent by physicians, and (3) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation (45 CFR 164.512), a waiver of patient authorization for release of patient medical record data by health care providers. In the introductory letter from the NCHS director, it states that participation in the NAMCS is voluntary. There is no effect on the respondent for not participating. The Research Ethics Review Board's letter granting approval for continuation of Protocol #2010-02 NAMCS for the maximum allowable period of one year is presented in **Attachment G**.

11. Justification for Sensitive Questions

It is necessary for NAMCS to collect some protected and approved health information, such as date of visit, birth date, and ZIP code. These data are used internally to create certain composite variables, such as patient age, which contains 6 mutually exclusive groups. Also, in cases when the Census Bureau abstracts the data from the medical record, the patient's name or address may be viewed in the process of collecting the survey data. Strict procedures are utilized to prevent disclosure of identified NAMCS data. Individual patient names or other identifying information are not collected. At no time are the patients contacted to obtain information.

After the data have been collected from the physicians/providers and processed, a file of the sample visits will be sent to NCHS. The only identifiable elements on the file are date of visit, ZIP code, and birth date. For the public use files, date of visit is converted to month and day of week, birth date is converted to patient's age, and ZIP code is deleted. Patient's ZIP code is used within NCHS to match the visit data to characteristics of the patient's residential area, such as median household income or percent of the population who are high school graduates.

Medical Record Number

Since 2012, we have been collecting medical record number for internal survey operations purposes. This process will continue throughout the 2015-2017 survey years. The medical record number will be collected in the Patient Record form instrument to aid the field representative in abstracting data from the various record systems in the facility. Some facilities maintain patient visit information in more than one electronic or paper system, and the medical record number would help the field representative to ensure that they are abstracting data for the correct patient. All information, including medical record number, recorded on laptop-based survey instruments are encrypted and securely transmitted to databases at the Census bureau. In these cases, no actual data remain on the FRs Patient Record form instrument.

After the final case is transmitted forward from Census and the medical record number is no longer necessary, the medical record numbers will be deleted from the dataset. NCHS will never receive any medical record number.

As mentioned earlier, medical record number will also be used for re-abstraction efforts, where a second field representative would revisit a physician's office or CHC to re-abstract patient visit information to check data quality. In such a situation, medical record number will be used in identifying the exact patient visits that were originally abstracted.

In 2015-2017, we will continue to collect both Federal Tax Identification number and National Provider Identifier (NPI) number. A federal tax identification number, also known as an Employer Identification Number (EIN), is used to identify a business entity (e.g. medical practice) in the administration of tax laws. NPI is used to uniquely identify a health care provider in standard transactions, such as health care claims. HIPAA requires that covered entities use NPIs in standard transactions. NPI of physicians participating in NAMCS is collected as part of the interview, offering the ability to link the individual 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 Costs

A. Burden Hours

This submission requests OMB approval for three years of NAMCS data collection, 2015-2017. The burdens for one complete survey cycle are summarized in the tables below. The estimated annualized burden hours are based on the number of respondents projected for an annualized average during 2015-2017 multiplied by the average time to complete each record (number of respondents * number of responses per respondent * hours per response).

We propose an increase in the burden time for completing the NAMCS-1 from 35 minutes to 45 minutes. The average time to complete each record has remained the same since the inception of the automated instrument in 2012, except for a slight increase in time to complete the Physician Induction Interview (NAMCS-1) in order to account for EHR questions, Physician Workforce questions, and the proposed addition of questions on culturally and linguistically appropriate services (CLAS); and alcohol screening and brief intervention (SBI) questions. Results from a convenience sample of less than 10 polled field representatives indicated that the duration of induction completion ranged from 19 to 75 minutes.

Office-based physicians and CHCs comprise the two overarching components of the NAMCS. Within each component, there are 2 different instruments: Provider Induction interview and Patient Record form (PRF) abstraction. The CHC has an additional induction for the service delivery site. In addition, a sample of PRFs are selected for re-abstraction. The burden table represents an estimate for one year of data collection. A detailed description of the table is explained below. Several assumptions are made for the table calculations. For office-based settings, it is assumed that 70% of physicians complete the induction, 20% of those physicians abstract patient records, and FRs abstract patient records for the remaining 80% of those physicians. (Field data has shown that FRs abstract nearly all of patient record forms, but we have used a conservative 80% FR abstraction estimate for the burden table below.) For CHC sites, it is assumed that 100% complete the induction, 2.25 CHC providers are selected from each CHC service delivery site (a maximum of 3 CHC providers are selected per CHC service delivery site, but an average is used), 20% of those CHC providers abstract patient records, and FRs abstract patient records for the remaining 80% of sampled providers. (Similar to office-based physicians, field data for CHC providers has shown that FRs abstract nearly all of patient record forms, but we have used a conservative 80% FR abstraction estimate for the burden table below.)

Eligible physicians in private practice (n=5,656=70% of 8,080) and CHC providers (n=4,005=2.25 providers * 1,780) will be asked to complete induction items (NAMCS-1) (**Attachments C1-C3**). All sampled CHC providers are considered eligible. All community health center executive/medical directors from sampled CHCs (n=1,780) will be asked to complete the automated CHC facility-level induction items (NAMCS-201) (**Attachments C4 and C5**). A minority of participants will complete electronic Patient Record forms (NAMCS-30) (**Attachments D1 and D2**) themselves (n=1,932) (1,131+801), while a majority will rely on Census abstractors to complete the forms. In cases abstracted by Census FRs, the only responsibility for office staff will be to pull and re-file the medical records (n=7,729) (**Attachment H**). Approximately 30 forms are expected from each sampled physician's practice. Since the procedure for the re-abstraction study involves randomly selecting 10 patient visits that

had been previously abstracted by the original FR, the only burden will be for office staff to pull and re-file medical records (n=500) (**Attachment I**).

The estimated annual burden is 25,311 hours. A detailed description of the table is located below. Several assumptions were made for the calculations.

Office-based physicians

- Assume 70% response rate = $70\% * 8,080$ total office-based physicians = 5,656
- Assume only 20% of physicians choose to abstract data themselves
= $20\% * 5,656 = 1,131$
- Assume FRs abstract 80% of PRFs = $80\% * 5,656 = 4,525$

Community Health Centers (CHCs)

- Assume 100% response rate of all sampled CHC service delivery sites = 1,780
- Assume 2.25 CHC providers (out of 3 maximum) per CHC choose to participate
= $2.25 * 1,780 = 4,005$
- Assume only 20% of CHC providers choose to abstract data themselves
= $20\% * 4,005 = 801$
- Assume FRs abstract 80% of PRFs = $80\% * 4,005 = 3,204$

Table of 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.)
Office-based physicians (Core plus Expansion Sample)	Physician Induction Interview (NAMCS-1)	5,656	1	45/60	4,242
	Patient Record form (NAMCS-30) (Physician abstracts on web)	1,131	30	14/60	7,917
	Pulling, re-filing medical record forms (FR abstracts)	4,525	30	1/60	2,263
Community Health Centers (Core plus Expansion Sample)	Induction Interview – service delivery site (NAMCS-201)	1,780	1	20/60	593
	Induction Interview – Providers (NAMCS-1)	4,005	1	45/60	3,004
	Patient Record form (NAMCS-30) (Provider abstracts)	801	30	14/60	5,607
	Pulling, re-filing medical record forms (FR abstracts)	3,204	30	1/60	1,602

Re-abstraction study	Pulling, re-filing medical record forms (FR abstracts)	500	10	1/60	83
Total					25,311

B. Burden Cost

The cost to providers for each data collection cycle is estimated to be \$2,036,502. The hourly wage estimates for completing the automated items mentioned above in the burden hours table along with pulling and re-filing medical records are based on information obtained from the Bureau of Labor Statistics web site (<http://www.bls.gov>). Specifically, we used the "May 2013 National Occupational Employment and Wage Estimates" for (1) health care practitioners and technical occupations, (2) office and administrative support occupations, and (3) management operations. Data were gathered on mean hourly wages in 2013 for (1) physicians, (2) mid-level providers (i.e., physician assistants) working at CHCs, and (3) other professionals involved in managing either a private office-based practice (e.g., nurses, receptionists, etc.) or CHC. The total cost estimate for NAMCS is detailed by the type of respondent who will complete the automated items. Specifically, the respondent costs include estimates for completing the Physician Induction Interview items (NAMCS-1), CHC facility induction items, PRF (NAMCS-30), pulling and re-filing medical records. Overall, the average hourly wages presented in the table below was averaged across different specialties, and who may complete each applicable form. For example, to better approximate costs, the estimate of \$93.30 (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." Any category that included physicians and CHC providers combined (\$87.31) included the above categories plus physician assistants (as a proxy for all mid-level providers). Similarly, the average hourly wage for pulling and re-filing medical records (\$25.68) was based on office staff that might perform this activity: registered and licensed nurses, office supervisors and support staff, receptionists, medical secretaries, and physician assistants. Finally, the estimate used for those individuals completing the CHC facility items (\$82.39) included (1) medical and health services managers (as a proxy for medical directors), and (2) family and general practitioners, general internists, obstetricians and gynecologists, and general pediatricians. The medical specialties in the last group were used as a proxy for physicians that might be CHC medical directors. The following table shows the breakdown of the total annual respondent cost.

Table of Annualized Respondent Cost

Type of Respondents	Form Name	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
Office-based physicians (Base Sample)	Physician Induction Interview (NAMCS-1)	4,242	\$93.30	\$395,779
	Patient Record form (NAMCS-30) (Physician abstracts on web)	7,917	\$93.30	\$738,656
	Pulling, re-filing medical record forms (FR abstracts)	2,263	\$25.68	\$58,114
Community Health Centers (Base Sample)	Induction Interview – service delivery site (NAMCS-201)	593	\$82.39	\$48,857
	Induction Interview – Providers (NAMCS-1)	3,004	\$87.31	\$262,279
	Patient Record form (NAMCS-30) (Provider abstracts)	5,607	\$87.31	\$489,547
	Pulling, re-filing medical record forms (FR abstracts)	1,602	\$25.68	\$41,139
Re-abstraction study	Pulling, re-filing medical record forms (FR abstracts)	83	\$25.68	\$2,131
Total				\$2,036,502

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 2015-2017 survey is \$11,302,329. Printing costs were based off the actual 2012 annual printing cost of \$22,247.

Expense Description	Total Cost
Interagency Agreement for data collection with the Bureau of the Census	\$8,814,216
Printing	\$10,901
Contract costs for coding and keying data	\$1,636,858
Sponsoring agency expenses: Staff salaries, benefits, other miscellaneous costs	\$840,354
Total cost for 12 months	\$ 11,302,329

15. Explanation for Program Changes or Adjustments

The removal of the National Electronic Health Records Survey (NEHRS) and pretests from the NAMCS OMB package will decrease the requested burden by 25,612 hours from the 50,923 total hours reported in the most previously approved package. The total NAMCS burden will now equal 25,311 hours.

16. Plans for Tabulation and Publication and Project Time Schedule

The duration of activities for core NAMCS (office-based physicians and CHCs) will span 12 months. The desired timetable for key activities for the 2015 survey is as follows:

Steps	Timeline	Activity
1	Within one month of OMB approval	Begin data collection for 2015 survey
2	One year after OMB approval	Formally end reporting period
3	Three months after reporting period ends	Close out fieldwork
4	Two months after close-out	Begin cleaning and weighting
5	One month after weighting	Begin data analysis
6	Two months after data analysis	Publish National Health Statistics Report and on-line data summary tables
7	Two years after OMB approval	Public use data available on Internet
8	Three months after public data release	Publish additional reports

Plans for types of data analyses will parallel the analyses completed for the NHAMCS because a majority of the data items from NAMCS and the outpatient department are the same. For example, data will be presented in the following tables: patient visits by age, sex, and race; expected source(s) of payment; principal reason for visit; primary diagnosis; diagnostic service; disposition; and provider type seen. NCHS publishes the data on the Web and in various data briefs.

The most recent combined NAMCS and NHAMCS data brief titled “Routine Prenatal Care Visits By Provider Specialty in the United States, 2009-2010 can be found on-line at <http://www.cdc.gov/nchs/data/databriefs/db145.htm>.

Highlights from each new year of NAMCS and NHAMCS data are featured in the Data Brief series, which can be found on-line at http://www.cdc.gov/nchs/ahcd/ahcd_reports.htm.

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 2010 Summary Tables are available here http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf.

Other tables are also available, some combining data across surveys or across years. Finally, NCHS reports examining (1) characteristics of office-based physicians and their practices (on-line copy: http://www.cdc.gov/nchs/data/series/sr_13/sr13_166.pdf) and (2) Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001–2013 (on-line copy: <http://www.cdc.gov/nchs/data/databriefs/db143.htm>) have also been released.

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

An exception for displaying the expiration date is not requested.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

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