Supporting Statement B for Request for Clearance:

NATIONAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0234

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B. Collections of Information Employing Statistical Methods

1. Respondent Universe and Sampling Methods

Revisions for the EMR/EHR mail survey

The target universe of the EMR/EHR mail survey (as it is with NAMCS) is nonfederally employed physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) practicing in the United States who were classified by the American Medical Association (AMA) and the American Osteopathic Association (AOA) as "office-based, patient care." A stratified sample of 10,302 office-based physicians will be selected with strata defined by 50 states and the District of Columbia. To minimize respondent burden, physicians in the Core NAMCS sample and physicians selected in the non-CHC NAMCS sample for the prior two years will be excluded from possible selection to the sample for the mail survey.

Core NAMCS

The basic statistical design and data collection methods for the 2010-2012 NAMCS will be the same as those of the 2008 NAMCS. There are two major components of the targeted NAMCS universe. First, the NAMCS universe consists of non-Federally employed physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) practicing in the United States who were classified by the American Medical Association (AMA) and the American Osteopathic Association (AOA) as "office-based, patient care." There are about 750,000 physicians in this first component of the NAMCS universe. Second, physicians (MDs and DOs) and mid-level providers (i.e., nurse practitioners, physician assistants, and nurse mid-wives) practicing at CHCs represent the second NAMCS target universe. Unlike physicians in the office-based NAMCS, physicians and mid-level providers working at CHCs are not individually selected because a complete sampling frame is unavailable. We will include three different types of CHCs in the sample: (1) CHCs that receive grant funds from the federal government through section 330 of the Public Health Service Act; (2) look-alike CHCs who meet all the requirements to receive 330 grant funding, but do not actually receive a grant; and (3) Tribal or Urban Indian Federally Qualified Health Centers. The list of federally funded CHCs (330 grant) and look-alike CHCs will be provided by the National Association of Community Health Centers, and the list of Indian Federally Qualified Health Centers will be provided by the Indian Health Service (IHS).

For the core NAMCS office-based physician universe, a multistage probability design is utilized with the elementary sampling unit being a physician-patient encounter or "visit." The first stage of selection is a probability sample of 112 primary sampling units (PSUs), a subset of the 1985-94 National Health Interview Survey sample of PSUs. PSUs are counties, groups of counties, county equivalents (such as parishes or independent cities), or towns and townships for some PSUs in New England. The physicians in the sample PSUs are grouped into 16 strata defined by physician specialty, including a stratum of oncologists first used in the 2006 sample. Within each specialty stratum, a systematic

random sample of physicians is selected. The total physician sample is divided into 52 sub-samples that are randomly assigned to the 52 weeks of the year. Each sample physician's practice is randomly assigned a one-week reporting period during the calendar year, and a systematic random sample of approximately 30 patient visits is taken during the assigned week. This provides for continuous data collection throughout the year to account for seasonal variation in disease and patient visit patterns. Data collection within a physician's practice, as well as CHCs, begins on Monday morning of the assigned reporting week and continues through the following Sunday (substitution of reporting week is not permitted). Visits are recorded on a "Patient Visit Worksheet" in the NAMCS Instruction Manual. This worksheet allows the office staff to easily keep track of the patients as they enter the office and select (via the sampling plan) those that fall into the sample for the survey.

As mentioned earlier, the sampling of CHCs is somewhat different from the office-based NAMCS. A multistage probability design is also utilized with the elementary sampling unit being a physician/provider-patient encounter or "visit." The first stage of selection is the same probability sample of 112 geographic area PSUs as in the office-based NAMCS. Next, 104 CHCs will be selected from the sample PSUs and randomly assigned to the 52 weeks of the year (two CHCs per week) for data collection to account for seasonality in disease and patient volume patterns. At each sampled CHC, a systematic random sample of three providers (MDs, DOs, and mid-level providers) will be sampled from those scheduled to see patients during the CHCs assigned sample week. Those three will be selected with probability proportional to the numbers of visits the providers are expected to see during the sample week. As done with office-based physicians, a systematic random sample of approximately 30 patient visits to each sampled provider will be utilized during the assigned week.

All data are weighted to national estimates using the inverses of selection probabilities with non-response adjustments done within specialty, and when feasible, within PSU. Calibration adjustment factors are used to adjust estimated total physicians to known totals within specialty strata. Sampling errors are computed using the linearized Taylor series method of approximation as applied in the SUDAAN software package. Additional details of the statistical design are provided in the "Technical Notes" section of the 2006 National Health Statistics Report (http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf).

The 2006 NAMCS ended with an unweighted response rate of 64 percent, and a weighted response rate of 58 percent. Efforts to raise the response rate are currently ongoing.

A motivational insert that was introduced in 2001 will continue to be included with the introductory letter that addresses physicians' concerns about participation. The insert covers confidentiality issues, including requirements pertaining to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Approximately four years ago we initiated a windowed, multi-colored envelope to send the introductory letter and insert to sampled physicians. Using this type of envelope increases visibility and exposure to office gatekeepers who, in many cases, decide which mail a physician receives. We are

continually in contact with those administering the survey, assisting with any problems that arise while in the field. We provide our Field Representatives (FRs) with the most current data so they can encourage participation in the survey as well as promotional material that gives physicians examples of how the survey is used and how important it is for research. In the summer of 2008, we held a training conference for the FRs, and during this training they had an opportunity to learn from each other how to convert physicians that initially refuse to participate.

No matter how well we train and equip our FRs, the atmosphere of the physician office makes it very difficult to obtain response rates higher than 70 percent. Because the physician and office staff are already very busy with patients and their associated paperwork, some may view such a survey as additional, volunteer work that they do not have the time or desire to complete. In addition, because of the many Medicaid and Medicare regulations from the government, numerous physicians may view this survey as a further intrusion into their private practice. Our efforts are many times overshadowed by private industry, which may pay the physician and office staff for their time.

Each year we publish weighted response rates by a variety of physician characteristics available from the sampling frame and the physicians themselves. Additional information concerning 2006 nonresponse is described in section B.3.

Laboratory Values

Following a successful pretest of laboratory values, we added the six new items to the 2010 PRF (**Attachment J**) per the approved protocol and plan on including items through 2012.

2. Procedures for the Collection of Information

Revisions for the EMR/EHR mail survey

NCHS will field the EMR/EHR mail survey in 2010-2012 using the same methodology as in previous years. In order to keep costs as low as possible, the questions will be conducted using a mail-out/mail back format. The initial main mail survey will include an introductory letter **(see Attachment S)**, along with the survey questionnaire. The questions that will be asked of the additional physicians will be similar to those in the Physician Induction Interview (PII) of the core NAMCS. Slight changes were made to account for the difference in survey mode. Please see **Attachment T** for a copy of the questionnaire which will be used in the 2010 mail survey.

Approximately seven days after the initial survey is sent to physicians, a postcard will be mailed thanking them for their participation or reminding them that their cooperation is still needed. Please see **Attachment S** for a copy of the text that will be used for the thank-you/reminder card. This postcard also allows sampled physicians to request additional information or request another copy of the survey instrument. For physicians

from whom we have not heard back after three weeks, a second mailing will be sent. This mailing will consist of a modified introductory letter (see **Attachment S**) and a second copy of the questionnaire. After five weeks, a third mailing will be sent which includes an introductory letter (Attachment S) and another copy of the questionnaire. This will be the final wave that includes both a questionnaire and letter. Approximately seven weeks after the initial mail out, telephone calls will be made to all non-responding physicians in a final attempt to obtain survey data. If the physician is contacted and agrees to participate, the information will be obtained via telephone. Please see **Attachment S** for a copy of the script which will be used during the follow-up call. **Attachment S** also includes script that will be used to obtain an updated physician address when surveys are returned from the post office.

A. Core NAMCS

Training

Primary training in data collection procedures is conducted at different times with three types of staff. First, Census Bureau Headquarters staff are responsible for training the Regional Office staff. Second, Regional Office staff have the primary responsibility for training the FRs and for supervising physician/provider data collection activities. Field representative training covers the following topics: inducting the physician/provider, confidentiality, HIPAA, determination of the "take every" and "start with" numbers, instructing physicians'/providers' staff, supervising patient visit sampling, editing completed forms, retrieving missing data, and medical record abstraction. Finally, FRs induct the physicians/providers and train their staff on visit sampling and completion of the PRFs. If the physician/provider chooses, he/she may use the worksheet in the back of the NAMCS Instruction Manual for sampling (**Attachment H**) visits. However, if the physician or physician's staff prefer, FRs abstract the data. In preparation for each survey year, NCHS staff provide initial training to FRs and RO staff on changes related to the forms, items, and procedures.

Census Bureau Headquarters staff are also responsible for writing the field manual (**Attachment H**). The field manual contains topics that cover the following: purposes of the survey; interviewing techniques; a description of NAMCS physician induction interview (PII) questionnaire and related forms; and procedures that cover inducting office-based physicians/CHC providers, conducting physician visits, determining the take every and random start numbers, instructing the physician's staff, supervising patient visit sampling, editing completed forms, and retrieving missing data.

Throughout the year, conference calls are held among Ambulatory and Hospital Care Statistics Branch (AHCSB) staff, Census Bureau Headquarters staff, Census Field Division staff, and NAMCS supervisory staff from all of the Regional Offices to discuss issues relevant to the ongoing NAMCS data collection.

Initial Contact

Depending on the setting, initial contact is made at varying times prior to the beginning of NAMCS. Six weeks prior to the CHCs assigned data collection week, notification is sent to each CHC director that his/her particular center has been randomly selected to participate in NAMCS. CHC physicians/providers also receive an introductory letter, patterned after the letter sent to office-based physicians 5 weeks before their assigned reporting period. Finally, office-based physicians who have been selected to participate in the survey receive an introductory letter approximately 4 weeks before their 1-week reporting periods are to begin. All three types of letters are similar, signed by the Director of NCHS, and explain the basics of the survey. Specifically, the letters (1) highlight the voluntary nature of participation, (2) describe the planned contact with a representative from the Bureau of the Census who will act as NCHS's data collection agent, and (3) provide additional instructions and support. See **Attachment L** for copies of all three types of letters. As mentioned earlier, we include a motivational insert with the introductory letter. This short brochure contains reasons for participation, and questions and answers on confidentiality issues, including the HIPAA Privacy Rule. In addition, the package sent to sampled NAMCS participants contains endorsing letters from specialty medical colleges and/or associations corresponding to the physician's particular specialty (**Attachment M**).

During the initial interview with the CHC director, a Census FR completes a NAMCS-201, which is the Community Health Center Induction Interview (**Attachment N**). This form allows for the collection of general CHC contact information, along with the type of center and sources of revenue. The major purpose of the NAMCS-201 is to list all eligible providers at all in-scope locations, including those that will not, be subjected to sampling because they are not scheduled to see patients during the CHCs sampled week. This list of providers will include those that work at satellite locations of the CHC as well as mobile units. School-based locations of the CHC are not eligible, as institutional and occupational settings are not within the scope of NAMCS. When the list of providers has been supplied, the FR will select three providers to be sampled. This selection will be proportional to visit volume. The FR will then obtain the locations and telephone numbers of the selected providers so they can be contacted and inducted.

Physician/Provider Induction

The introductory letter (**Attachment L**) is followed by a telephone call to the office-based physician from a Census Bureau FR to schedule an appointment so that the physician can be inducted into NAMCS by personal interview (**Attachment O**). Each CHC physician/provider is also inducted with a letter followed by appointment scheduling and personal interview (**Attachment O**). Instructions for the FR on how to complete these interviews are shown in Attachment H. During the induction visit, the interviewer provides the physician/provider and staff with verbal and written instructions on the completion of patient records. At this time the interviewer also instructs the physician/provider and staff on the sampling procedures, which vary according to how many visits the physician/provider expects to see during the sample week. Sampling only a fraction of the visits is intended to reduce the burden to busy physicians/providers. Printed on the folder containing PRFs are general instructions and definitions for easy

reference by the physician/provider. More detailed definitions and instructions for selected PRF items are provided on a printed card placed in a pocket of the folder.

Data Collection

A Physician Induction Interview (NAMCS-1) is completed for each sampled physician and CHC provider during the induction visit (**Attachment O**). Questions on the 2010-2012 NAMCS-1 will be basically the same as the ones currently used in 2009, except that we plan to add race and ethnicity in items 7c and 7d. As mentioned above, the questions in the first-half of the NAMCS-1 are used to guide the FRs through the induction process and verify the physician/provider's eligibility. The second-half of the form is dedicated to obtaining information concerning selected practice characteristics. In order to safeguard participant confidentiality, all personally identifiable data that once was recorded on the NAMCS-1 will be collected on a supplemental form, the NAMCS-1 Control Card (**Attachment P**). The Control Card was implemented in 2008, and the plan is to continue using this card for the 2010-2012 survey period. To further guarantee respondent protection, Census FRs and RO staff always ship the Control Card and NAMCS-1 separately.

The bulk of data collection occurs with the completion of Patient Record forms (PRFs) (**Attachment J**) by the sampled physician/provider and/or office staff. Based on a "start with" and "take every" number, the physician/provider records each patient visit in sequence during the reporting week and completes PRFs for the designated sampled visits. This record of patient visits may be completed whichever way works best for the physician. We provide a worksheet in the back of the PRF Instruction Booklet (**Attachment H**) for the physician/provider to use if he/she finds it easier than other methods. Patient sampling rates, based on the "start with" and "take every" number, are assigned to physicians/providers according to practice size so that the physician/provider will complete about 30 PRFs during his/her reporting week. A random start is provided for each physician/provider, after which every nth patient is sampled throughout the 1-week reporting period. The patient name is retained by the physician for confidentiality reasons.

A PRF is completed for each sampled patient visit. Questions on the 2010-2012 PRF will be basically the same as the ones currently used in 2009, except that we plan to add (1) five distinct cancer stages under the existing cancer check box in item 5b, (2) a check box for radiation therapy in the non-medication treatment section of the form, and (3) a set of laboratory values on the back of the form. Please see **Attachment J** for a prototype of the 2010 PRF. Instructions for completing the PRFs and definitions of terms are provided in the 2010 NAMCS Instruction Booklet (**Attachment H**).

The NAMCS PRF collects data on patient characteristics, such as age, sex, race, and ethnicity, and visit characteristics, such as date, expected source of payment, reason for visit in patient’s own words, physician diagnoses, and medications provided or prescribed.

Monitoring Data Collection and Quality Control

Census Bureau Headquarters staff, Demographic Surveys Division, Housing Surveys Branch, is responsible for overseeing the data collection for the core NAMCS, and cervical cancer screening supplement. Census Bureau Headquarters staff, Field Division, is responsible for the supervision of staff in the Bureau's 12 Regional Offices, who in turn supervise the field representatives.

The FR calls the physician's office or CHC 3 times during the sampled week. Calls are intended to answer any questions the office may have and to make sure sampling is being carried out as instructed. Specifically, the first phone call at the beginning of the week is to remind the office to start sampling; mid-week contact is to handle any problems the office may be having; and the final contact, on the last day of the physician's reporting week, is to answer questions and arrange for pick-up or delivery of the forms. An essential part of this effort is quality control, which focuses on the completeness of the patient sampling frame, adherence to the sampling procedures, and assurance that a PRF is completed for every sampled visit.

During the week after the physician's/provider's reporting period, the FR will return to the office to retrieve all completed survey materials and to do a brief edit of the PRFs. The FR reviews the log or other record used for visit sampling to determine if any cases are missing, and also edits completed forms for missing data, inconsistencies, or unclear entries. Attempts are made to retrieve both missing cases and missing data on specific cases. A record of this retrieval effort is also made. When excessive travel or other expense is involved in the return visit, the physician/provider is instructed to mail the materials to the FR (at no cost to the respondent).

Completed survey materials are sent on a weekly basis from the Census Bureau Regional Offices to the Census Bureau's National Processing Center in Jeffersonville, Indiana. The Center is responsible for completing a quality control edit before packaging and shipping work to the NCHS data processing contractor, where further editing, coding, and data entry are done. All medical and drug coding as well as all data entry operations are subject to quality control procedures by both NCHS and our contractors. Computer edits for code ranges and inconsistencies are also performed. Missing and incorrect data are imputed using data from randomly selected patient visits with similar characteristics.

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors, as well as biases due to nonresponse and incomplete response. To eliminate ambiguities and encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions. To help eliminate nonsampling errors, pretesting of proposed PRF changes, the CHC induction form, and CCSS was completed in August of 2005 with subsequent modifications to the forms made before the 2006 survey year. These changes were implemented and included in the survey from 2007-2008, and will remain for the 2010-2012 study period.

Quality control procedures and consistency and edit checks reduce errors in data coding and processing. During processing, our data processing contractor takes a 10 percent systematic random sample of PRFs, which is independently rekeyed and recoded. If 5 percent of selected PRF items in the resample fail, the original batch must be again coded and keyed by two new, independent coders. PRF item coding error rates made during original keying, as determined from the 10 percent resample, ranged from 0.2 to 1.4 percent for the 2006 data year.

Missing values for a few items on the survey are imputed by randomly assigning a value from a PRF with similar characteristics. These imputations are based on physician identity, physician specialty, geographic region, and the 3-digit ICD-9-CM code for primary diagnosis. In 2006 (most recent data), imputations were performed for the following variables: birth year (2.5 percent), sex (1.6 percent), ethnicity (29.9 percent), race (27.0 percent), patient seen before in practice (3.5 percent), number of visits patient made to that physician/provider in the last 12 months (7.1 percent), and time spent with physician (23.3 percent).

Estimation Procedures

Revisions for the EMR/EHR mail survey

State estimates of physicians will be produced from the EMR mail survey. The survey weights will have four basic components: (1) inflation by reciprocals of the sampling selection probabilities, (2) adjustments for nonresponse, and (3) weight smoothing.

Core NAMCS

National visit estimates will be produced based on two fundamental sources of data: (1) private non-federal office-based physicians, and (2) physicians at CHCs designated as 330 grant-supported federally funded qualified health centers, federally qualified look-alikes, and Tribal or Urban Indian Federally Qualified Health Centers. The estimation procedure has four basic components: (1) inflation by reciprocals of the sampling selection probabilities, (2) adjustments for nonresponse, (3) calibration ratio adjustment, and (4) weight smoothing. Starting in 2003, the non-response adjustment factor utilized variation in responses by physicians who see more patients in their reporting period and the number of weeks they work during the year. In addition, starting in 2004, the estimation process was modified to (1) take into account season of reporting week, and (2) produce unbiased quarterly estimates.

NAMCS data can also be used to make national estimates of office-based physicians and associated medical practices. These estimates are unbiased and based on a complex sampling design with multistage estimation. Physician weights are used to estimate national numbers and characteristics of office-based physicians (e.g., sex, age, and specialty) and their practices (e.g., numbers of physicians in the practice, single-specialty compared with multispecialty practices, and types and numbers of patient encounters in

last full week of practice). The NAMCS physician sampling weight can also be modified to produce a national medical practice estimator (e.g., practice size, breadth of specialization, and selected diagnostic and therapeutic services available onsite).

The lowest reliable NAMCS estimate for all non-Federal, office-based physicians in 2006 is 1,028,000 patient visits. The relative standard error is one criterion that NCHS uses to determine reliability. Reliable estimates have relative standard errors (standard error/estimate) of 30 percent or less. This relative standard error is the maximum that is allowable for an estimate to be considered reliable. Such precision is adequate for the analyses planned, but any improvement that can be attained is highly desirable.

Sampling Errors

Standard errors are calculated using a first-order Taylor series approximation method as applied in SUDAAN software.

B. Cervical Cancer Screening Supplement

We initiated a Cervical Cancer Screening Supplement (CCSS) in 2006, and plan to continue its use in 2010-2012 for the Core NAMCS. See **Attachment U** for a copy of the 2010 CCSS. This supplement is sponsored by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and is conducted in conjunction with NAMCS and NHAMCS.

The CCSS will be administered to (1) physicians with a specialty of general/family practice, internal medicine, or obstetrics/gynecology and (2) all types of physicians and mid-level providers at CHCs. When NAMCS providers are contacted for participation, they will be asked if they perform any cervical cancer screening. If screening is performed, at the end of the 1-week reporting period, the respondent will be asked to complete the CCSS. The timing, after the core NAMCS is completed, is intended so as not to bias the data collected on the PRF (i.e., conventional Pap test, liquid-based Pap test, Pap test-unspecified, HPV DNA test ordered or performed).

3. Methods to Maximize Response Rates and Deal with Nonresponse

Revisions for the EMR/EHR mail survey

The data collection procedures mentioned above in section B2 will also maximize response rates and reduce nonresponse. The initial mail survey will include an introductory letter **(see Attachment S)**, along with the survey questionnaire. Approximately seven days after the initial survey is sent to physicians, a postcard will be mailed thanking them for their participation or reminding them that their cooperation is still needed. Please see **Attachment S** for a copy of the text that will be used for the thank-you/reminder card. This postcard also allows sampled physicians to request additional information or request another copy of the survey instrument. For physicians from whom we have not heard back after three weeks, a second mailing will be sent.

This mailing will consist of a modified introductory letter (see **Attachment S**) and a second copy of the questionnaire. After five weeks, a third mailing will be sent which includes an introductory letter (Attachment S) and another copy of the questionnaire. This will be the final wave that includes both a questionnaire and letter. Approximately seven weeks after the initial mail out, telephone calls will be made to all non-responding physicians in a final attempt to obtain survey data. If the physician is contacted and agrees to participate, the information will be obtained via telephone. Please see **Attachment S** for a copy of the script which will be used during the follow-up call. **Attachment S** also includes script that will be used to obtain an updated physician address when surveys are returned from the post office.

Core NAMCS

NAMCS uses multiple methods for maximizing physician response. The medical community, including the American Medical Association and the American Osteopathic Association, is informed and consulted about the study. Twenty major medical societies have endorsed NAMCS and have provided letters of support for use in enlisting sampled physicians during the 2009-2010 survey years (**Attachment M**). These letters are typically updated every two years, as our contacts change annually. Survey procedures and forms are designed to minimize the time required of physicians to participate. Physicians selected in the non-CHC NAMCS sample are excluded from possible selection again for the following two years. The Census Bureau assigns only the most experienced FRs to work on NAMCS. A video provides scenarios on getting past difficult "gate keepers" in the physician's office and persuading reluctant physicians. In addition, the FRs are given detailed training in survey procedures with special modules on gaining physician cooperation. FR "nurturing" sessions are conducted periodically, as survey funds permit. In the summer of 2008, field representatives from the 12 regional offices across the country participated in a day-long NAMCS/NHAMCS conference highlighting issues related to (1) administering surveys in the field, including efforts to increase respondent participation; (2) abstracting data; and (3) addressing FR questions and concerns. The nurturing session represented a unique opportunity for FRs to exchange ideas and methods on how to work on a survey that presents unique challenges not faced by other Census FRs.

As mentioned in a previous section, NCHS has designed a mailing insert to help persuade the physician, gate keeper, or CHC provider to participate. The insert (**Attachment L**) includes motivational statements from the Secretary of Health and Human Services and the Director of CDC/ATSDR. It also has answers to questions that physicians may have on why they should participate, describes how the Privacy Rule permits data collection for NAMCS, and provides a link (www.cdc.gov/NAMCS) to our participant Web site. This Web site makes available further material that physicians can use to verify, under the requirements of the Privacy Rule, that they are indeed allowed to disclose to NCHS/CDC the information requested as part of this survey. This includes the authority under which NCHS is collecting this information and that the information being collected is the minimum necessary.

The FRs provide the sampled physician with materials that show the importance of NAMCS, including the most recent survey report (for a sample of the most recent NAMCS summary, see http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf), and specialty-specific lists of journal articles using NAMCS data (subsets of **Attachment B**).

Survey procedures were also developed to verify the status of the out-of-scope physicians to ensure they were not just refusal cases that were erroneously labeled as out-of-scope. A 20 percent sample of all out-of-scope cases from each FR is reinterviewed over the telephone to confirm that the physician is not within the scope of the survey. If one case is found to be in error, then all out-of-scope cases from that FR are reinterviewed.

This survey requires a commitment from the physicians and their staffs, along with CHC directors and sampled providers. Any of these groups may refuse to participate for many different reasons. Through years of experience with NAMCS, techniques for converting refusals have been developed that are quite effective, each flexible and responsive to individual concerns. Primarily using supervisory personnel, interviewers have successfully converted approximately 15 percent of initial refusals to successful participants. Conversion is successful by emphasizing the following ideas: professional responsibility to enhance knowledge of the utilization of ambulatory care in the United States, and the fact that no confidential information is collected on any patient resulting in only descriptive statistical reports.

If all else fails to bring the response rates up to the expected levels, then NCHS requests the option to investigate the specific causes of nonresponse, so as to devise additional corrective measures, funding permitting.

A study of nonresponse cases in NAMCS found that break off was most likely to occur at the stage of the telephone screener (43 percent) and that often the refusal is from the office staff rather than the physician. This is consistent with information that shows that a majority of nonresponding physicians do not remember being contacted about NAMCS. Each year in our annual statistical report, we describe weighted characteristics of NAMCS physician respondents and nonrespondents on numerous variables including age, gender, geographic region, metropolitan statistical area (MSA) status, type of doctor, specialty, specialty type, type of practice, and annual visit volume. In 2006, responding versus nonresponding physician distributions were similar for a majority of physician characteristics categories with the exception of metropolitan status, type of doctor, practice type, and annual visit volume. Examining the weighted response rates, higher cooperation was gained among physicians in nonmetropolitan statistical areas (rural), CHCs, and physicians in the lowest and highest quartiles associated with visit volume compared with physicians grouped in the middle two visit volume quartiles. The effect of this differential response is minimized in the visit estimates in most cases as NAMCS uses a nonresponse adjustment factor that takes annual visit volume, specialty, geographic region, MSA, and CHC status into account.

Since January 2007, we have provided physicians and nurses the opportunity to learn more about NAMCS through web-based educational modules presented on the CDC

Public Health Training Network. The module presents key NAMCS concepts, interspersed with quiz questions after each concept to reinforce learning. The goal of the web-based material is for physicians and nurses to increase their understanding of NAMCS methodology, and to improve their ability to read critically those articles in peer-related literature that use national estimates of office-based practice parameters. Providing this NAMCS education module to physicians and nurses will not only give participants a chance to receive valuable continuing education credits, but also expand the level of NAMCS exposure to potential survey participants.

4. Tests of Procedures or Methods to be Undertaken

Nonresponse investigations (with 9 or fewer physicians) may be conducted under DHHS task order contracts should such studies be deemed necessary. If nonresponse studies are undertaken, OMB will be notified of the findings.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The statistician responsible for the survey sample design is:

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The data collection for the EMR/EHR mail survey is SRA International, Inc. and the contact person is:

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The data will be analyzed under the direction of:

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Supporting Statement
List of Attachments

A. Public Health Service Act, Section 306

B. List of NAMCS Publications

C. Federal Register: Public Comments

D. Consultants for 2009-2012 NAMCS

E. IRB Continuation of Protocol Approval Letter

F. Pulling and Re-filing Patient Record forms

G. Instruction on NAMCS Physician Induction Interview for Field Representatives

H. 2010 NAMCS Instruction Booklet

I. Attachment Not Used

J. 2010 NAMCS Patient Record form

K. Attachment Not Used

L. NAMCS Introductory Letters and Motivational Insert

M. NAMCS Endorsing Organizational Letters

N. 2010 NAMCS Community Health Center Induction Interview form

O. 2010 NAMCS Physician Induction Interview form

P. 2010 NAMCS Control Card

Q. Attachment Not Used

R. Attachment Not Used

S. 2010 NAMCS EMR/EHR Mail Survey Letters and Narrative Script

T. NAMCS EMR supplement 2010

U. 2010 Cervical Cancer Screening Supplement

V. Justification for Changes to NAMCS Annual Survey to Collect State-level EMR/EHR data for ONC