Supporting Statement B for Request for Clearance:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0278
(Expires 08/31/2012)

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September 1, 2011

Revised November 28, 2011

B. Collections of Information Employing Statistical Methods

The primary goal of the National Hospital Ambulatory Medical Care Survey (NHAMCS) is to collect data on visits to emergency departments (EDs), outpatient departments (OPDs) and hospital-based ambulatory surgery locations (ASLs) and freestanding ambulatory surgery centers (FS-ASCs). According to the 2009 NHAMCS, the estimated number of U.S. hospital ED and OPD clinic visits were 136,072,000 and 96,132,000, respectively. In 2009, there were an estimated 14,065,000 visits to hospital-based ASLs. For hospitals, NHAMCS uses a four-stage probability design based on samples of geographic Primary Sampling Units (PSUs), hospitals within PSUs, OPD clinics within hospitals, and patient visits within OPD clinics, ASLs, and ED units. In FS-ASCs, NHAMCS uses a three-stage probability design based on PSUs, FS-ASC facilities within PSUs, and ASLs within FS-ASCs.

1. Respondent Universe and Sampling Methods

The NHAMCS universe and sampling design are outlined at http://www.cdc.gov/nchs/ahcd/ahcd_estimation_procedures.htm#nhamcs_procedures. The universe for the NHAMCS consists of non-Federal hospitals in the 50 states and District of Columbia which have six or more beds staffed for inpatient use which are either general hospitals or have an average length of stay for all patients of less than 30 days, but are not institutional hospitals. Until 2003, the hospital sampling frame was constructed from the SMG Hospital Market Database. Beginning with 2003, the sample frame sources are the annual “Verispan Healthcare Market Index" and Verispan’s "Second Quarter, Hospital Market Profiling Solution.” The initial NHAMCS sample of hospitals was selected in 1991 from the 1991 SMG data file. According to the 1991 SMG file, there were about 6,250 NHAMCS-eligible hospitals of which about 5,600 had EDs. The hospital sample was updated for 2001, 2004, 2007 and 2010 by extending the sampling process to new hospitals as if they had been in the sampling frame for 1991, when the original NHAMCS hospital sample was selected. The hospital universe frame and sample were most recently updated for the 2008-09 NHAMCS (see Table 1) using hospital data from Verispan, L.L.C., specifically their “Healthcare Market Index, Updated May 15, 2006” and their “Hospital Market Profiling Solution, Second Quarter, 2006.” These products were formerly known as the SMG Hospital Database. Using the 2009 data to update the sample allowed for the inclusion of hospitals that had opened or changed their eligibility status since the previous sample was updated for 2006.

Table 1: Hospitals in Core NHAMCS, by Region and ED/OPD Status

Region	ED and OPD	ED only	OPD only	Neither ED nor OPD	Total
Northeast					
Frame	545	116	69	117	847
Sample	74	15	4	16	109
Midwest					
Frame	1314	123	81	187	1705
Sample	81	11	5	12	109
South					
Frame	1641	259	201	422	2523
Sample	119	12	10	32	173
West					
Frame	792	112	82	169	1155
Sample	61	12	1	8	82
Total					
Frame	4292	610	433	895	6230
Sample	335	50	20	68	473

The NHAMCS sample is a multi-stage design with a first stage sample of two of the four PSU panels in the 1985-94 National Health Interview Survey (NHIS). The first-stage sample consists of 112 PSUs. From the sample PSUs, a stratified sample of approximately 600 hospitals was selected for the NHAMCS with hospital strata defined by whether hospitals had either EDs or OPDs according to the sampling frame data. Sample hospitals are randomly assigned to 16 4-week reporting periods as described below. We expect approximately 542 hospitals to be in-scope. This sample is sufficient to produce estimates with relative standard errors of 30 percent of less. See discussion of NCHS standards for reliability at http://www.cdc.gov/nchs/ahcd/ahcd_estimation_reliability.htm .

In 2012, an additional 167 hospitals will be added to the sample in order to allow state-based estimates of emergency department characteristics in the five most populous states: California, Texas, New York, Florida, and Illinois. Table 2 shows the number of hospitals in the core frame and sample and the number of supplement hospitals added in the 2012 sample to provide ED characteristics for the five states. These 167 hospitals will be divided into 13 groups and assigned to the four-week reporting periods for 2012. The supplement sample is a stratified list sample of ED hospitals (with emergency departments) in the five states targeted for state level estimates. The strata for this sample are defined by the five states and MSA (Metropolitan Statistical Areas defined by the Office of Management and Budget) status. Hospitals were selected with systematic random sampling and probability proportional to annual emergency department visit volume. The supplement sample was distributed to strata in a way that assures the combined total sample (original 2012 NHAMCS and supplement) includes at least 64 ED hospitals from each of the targeted states and representation from both MSA and non-MSA areas in each of those states. Based on precision levels observed in the 2009 NHAMCS, the total ED sample (in original 2012 NHAMCS plus supplemental sample) in each of the five targeted states is expected to produce RSEs of 20 percent or less for that state's estimates of the following parameters:

- Median length of visit among all patients seen in the ED
- Number of visits per population in state
- Among patients who are seen by a physician, the median wait time to see a physician
- Number of visits by each of the following paytypes: private pay, Medicare, Medicaid, and Self pay/nocharge.
- Median length of visit for patients admitted to the hospital through the ED

Table 2: ED hospitals in 2012 NHAMCS Sampling Frame, Regular Sample and Supplemental Sample by SR/NSR and MSA Status of Area

State	Data Source	Certainty PSUs		All other areas		Totals
	Sample	MSA	non-MSA	MSA	non-MSA	
California						
	Frame	247	0	84	32	363
	Sample	44		15	5	64
	Regular	37	0	11	1	49
	Supplement	7		4	4	15
Texas						
	Frame	125	0	154	150	429
	Sample	24		30	10	64
	Regular	13	0	18	6	37
	Supplement	11		12	4	27
New York						
	Frame	97	0	62	44	203

	Sample	36		23	5	64
	Regular	27	0	3	0	30
	Supplement	9		20	5	34
Florida						
	Frame	69	0	105	32	206
	Sample	24		35	5	64
	Regular	6	0	4	1	11
	Supplement	18		31	4	53
Illinois						
	Frame	92	0	35	64	191
	Sample	40		15	9	64
	Regular	13	0	8	5	26
	Supplement	27		7	4	38

Hospitals

Non-Federal, short-stay, and general hospitals in the sample PSUs are eligible for inclusion in the sample. Institutional hospitals and hospitals with fewer than 6 beds for inpatient use are excluded from the sample. Hospitals are stratified by whether they have an ED and/or OPD vs. have neither an ED nor OPD and by certainty status (self representing vs. non-self representing) of the sample area for their location. Prior to sampling, hospitals are arrayed within PSUs by type of ownership (voluntary nonprofit, non-Federal government, proprietary) and size, where size is measured by combined volume of ED and OPD visits reported in the hospital sampling frame (constructed from SMG data through 2002 and from Verispan data starting in 2003). From the arrayed hospital list, five hospitals are selected in each PSU without replacement and with probability proportional to the visit volume. If there are five or fewer hospitals, then all hospitals in the PSU are selected.

A sample of approximately 600 hospitals is randomly divided into 16 groups of hospitals (i.e., 37-38 hospitals in each group) in order to avoid hospitals participating during the same time period each year. One hospital group is assigned to each of the four-week reporting periods during 2012 through 2013, meaning that each hospital will be inducted approximately every 15 months. Substitution of the reporting period is not permitted. Based on the results of the 2009 NHAMCS, the projected unweighted and weighted response rates for 2012 are 83% and 82% for the ED and 73% and 74% for the OPD, respectively. The projected unweighted and weighted response rates for ambulatory surgery locations are 68% and 74%, respectively, based on 2009 response rates for hospital-based ASLs.

Freestanding ASCs

Ambulatory surgery locations that are not affiliated with a hospital are considered to be freestanding ASCs. The universe of freestanding ASCs includes ones that are regulated by the states or certified by the Centers for Medicare and Medicaid Services (CMS) for Medicare participation. Out-of-scope freestanding ASCs include those dedicated exclusively to dentistry, podiatry, abortion, births, and family planning. The sampling frame for the 2006 NSAS consisted of facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database and Medicare-certified facilities listed in the CMS Provider-of-Services (POS) file. The 2006 NSAS FS-ASC sample was a stratified list sample of 472 FS-ASCs with strata defined by surgery specialty groups. Of those 472 FS-ASCs, 74 were out-of-scope leaving 398 in-scope facilities from which to select the 2010-12 sample.

A total of 246 FS-ASC facilities were selected from the 2006 NSAS sample. All of the inscope NSAS sample facilities located within the NHAMCS sample area PSUs were selected. The area sample included only 216 NSAS facilities. A stratified list sample of 30 additional inscope facilities was selected from the remaining inscope NSAS sample with strata defined by the four regions and five ASC specialty groups (general, multi-specialty, ophthalmic, gastroenterologic, and other). To assure the annual NHAMCS sample would include at least two facilities from each stratum as the sample is rotated over 16 four-week reporting periods, the 30 facilities from outside the area sample were allocated to strata which had fewer than three sample facilities in the area sample. Systematic random sampling was used to select the additional sample facilities from each stratum.

The FS-ASC sample was divided into 16 nationally representative groups which were randomly assigned to 4-week reporting periods so that an average of 200 FS-ASCs are included in the sample annually. FS-ASCs are inducted through a facility induction form that is similar to the hospital induction form. A list of ASLs within the facility and satellite locations are obtained during the FS-ASC induction.

Outpatient Clinics, Emergency Service Areas, and Ambulatory Surgery Locations

Within each selected hospital, outpatient departments, emergency departments, and ambulatory surgery locations are inducted into the survey. For each OPD, a sample of clinics is selected if more than 5 clinics exist. Clinics are in-scope if ambulatory medical care is provided under the supervision of a physician and under the auspices of the hospital. Clinics providing only ancillary services, such as diagnostic X-rays or radiation therapy, are out-of-scope. Services provided in dental or dental surgery clinics, pharmacies, or other settings in which physician services are not typically provided also are out-of-scope. In addition, freestanding medical clinics or physician groups that are physically located within a hospital, but not affiliated with the hospital (i.e., the hospital basically serves as landlord) are out-of-scope because they are included in the National Ambulatory Medical Care Survey (NAMCS). Emergency services contracted by the hospital under the "hospital as landlord" arrangement, however, are eligible for the ED component of the study.

During the visit by a field representative to induct a hospital into the survey, a list of all outpatient clinics is obtained from the sample hospital. Hospitals may determine what constitutes a distinct clinic differently, for example, by physical location within the hospital, staff providing the services, specialty or subspecialty, schedules, or patients' source of payment. Because of these differences, "separate clinics" in the NHAMCS are defined as the smallest administrative units for which the hospital keeps separate patient volume statistics. Each clinic's function, specialty, and expected number of visits during the assigned reporting period are also collected. This clinic frame is stratified by specialty: general medicine, surgery, pediatrics, obstetrics/gynecology, substance abuse, and other clinics. For sampling purposes, clinics with very low volumes are combined to form clinic sampling units of a minimum size. If a sample hospital has more than 5 clinic sampling units, then 2 units from each of the 6 specialty strata are selected with probability proportionate to the total expected number of visits to the clinics. If there are 5 or fewer clinic sampling units, then all are included in the sample. On average, hospitals in the sample have 3.6 clinics per OPD.

Within the hospital’s ED, a list of all emergency service areas (ESAs) is obtained during the hospital induction interview. ESAs are defined as the smallest administrative unit of an ED where separate

patient statistics are kept. It may be located on hospital grounds or operated off site by the hospital. The ED is treated as a separate stratum and all ESAs within a sample hospital are included.

Hospital-based ASLs are treated as a separate stratum. A list of ASLs within the hospital and satellite locations is obtained during the hospital induction. In-scope locations include all dedicated ambulatory surgery rooms, cystoscopy and endoscopy units, cardiac catheterization labs, laser procedure, and pain block rooms. Out-of-scope locations include those dedicated exclusively to dentistry, podiatry, abortion, births, family planning, and small procedures.

Visits in all locations

Within sampling units, patient visits are systematically selected over the 4-week reporting period assigned to hospitals and FS-ASCs. Sampling units are defined as an ambulatory care unit, such as an ESA, clinic, or ASL, from which patient visits are sampled. A visit is defined as a direct, personal exchange between an ambulatory patient and a physician, or a staff member acting under a physician's direction, for the purpose of seeking care and rendering health services. Visits solely for administrative purposes, such as payment of a bill, and visits in which no medical care is provided, such as visits to deliver a specimen, are out-of-scope.

Samples of approximately 100 visits are targeted from each hospital ED and across all ASLs in a hospital, while 200 visits are targeted from OPDs. Within FS-ASCs, 100 visits are targeted for sampling across all of the ASLs within that facility. If there are more than five clinics in a hospital, then up to 30 visits are targeted from each clinic included in the survey. In clinics with volumes higher than these desired figures, visits are sampled by a systematic procedure which selects every nth visit after a random start. Sampling rates are determined from the expected number of patients to be seen during the reporting period and the desired number of sample records. This basic procedure is adapted, as necessary, to the record keeping systems of the particular hospitals. Previous studies found that many clinics keep their own logs which are used as the sampling frame for visits.

Samples of approximately 100 ambulatory surgery visits are targeted from FS-ASCs and hospitals with ASLs. The procedures used to select AS visits are the same as that for visits in EDs and OPDs. Sampled visits will be drawn from all in-scope locations within a facility where ambulatory surgery is performed.

2. Procedures for the Collection of Information

Training

Training in data collection procedures is conducted at different times with four different types of staff. Census Bureau Headquarters staff are responsible for training the Regional Office staff. Regional Office staff have the primary responsibility for training the field representatives and supervising hospital data collection activities. Field representative training covers the following topics: inducting facilities (hospitals and FS-ASCs), confidentiality, Health Insurance Portability and Accountability Act (HIPAA), supervising patient visit sampling, retrieving missing data, and medical record abstraction. Where the facility staff insist upon performing PRF abstraction, field representatives train

the staff on visit sampling and completion of the computerized Patient Record forms. In most cases, we anticipate that the field representative will perform PRF abstraction.

Census Bureau Headquarters staff are responsible for writing the field manual which contains the following: the purposes of the survey; interviewing techniques; a description of the NHAMCS induction questionnaire and related forms; and the procedures for inducting hospitals, conducting hospital visits, sampling clinics, supervising patient visit sampling, and retrieving missing data.

Initial Contact

An introductory letter is sent from the Director of NCHS (Attachment G) to the chief executive officer of each sampled hospital or FS-ASC. The letter describes the purpose of the survey, the authority for data collection, that participation is voluntary and that all collected information is confidential including the identity of the hospital or freestanding ASC [308(d) confidentiality requirements and Confidential Information Protection and Statistical Efficiency Act (PL-107-347)]. It also covers requirements related to Health Insurance Portability and Accountability Act (HIPAA). At no time are the patients contacted to obtain information. Letters of endorsement by the American College of Emergency Physicians, Society for Academic Emergency Medicine, Emergency Nurses Association, American College of Osteopathic Emergency Physicians, American College of Surgeons (ACS), American Health Information Management Association (AHIMA), American Academy of Ophthalmology (AAO), Society for Ambulatory Anesthesia (SAMBA), and the Surgeon General (Attachment H) are included in the mailing.

Hospital Induction

The introductory letter is followed by a telephone call from the field representative to verify hospital eligibility for the survey and to arrange for an appointment with the chief executive officer, directors of the ED, OPD, and ASLs, and whoever is designated as hospital coordinator for this survey. During the meeting, the field representative explains the purpose of the survey, describes the data collection methods and length of data collection, and obtains both general descriptive information about the organization of the ED, OPD, and ASLs and specific information needed to sample ambulatory units within the hospitals. The Hospital Induction Interview (Attachment I) is administered to screen sample hospitals, verify the hospital sampling frame information, induct the sample hospitals, and obtain ED, OPD, and ASL data. For the new sample of 167 hospitals, only general hospital information and ED data will be obtained (Attachment J).

Freestanding Ambulatory Surgery Center (ASC) Induction

The introductory letter (Attachment G) to the freestanding ambulatory surgery center director is followed by a telephone call from the field representative to verify the facility's eligibility for the survey and to arrange for an appointment with the director and whoever is designated as the facility's coordinator for this survey. During the meeting, the field representative explains the purpose of the survey and describes the data collection methods and length of data collection. The Freestanding ASC Induction Form (Attachment K) is administered to screen sample FS-ASCs, verify FS-ASC sampling frame information, induct the ASLs within the FS-ASC, and obtain general descriptive information about the organization of the FS-ASC.

Completion of Patient Record Forms

In order to decrease burden to facility staff and to facilitate the data collection procedures, field representatives will complete the Patient Record forms. We anticipate that approximately 75% of facilities will allow abstraction by field representatives. The remaining 25% of facilities that insist upon doing the abstraction will be supplied with laptops from the Census Bureau which are outfitted with the computerized Patient Record form. The laptop will have no other applications and users will only be allowed to access the Patient Record form instrument. After abstraction is completed, the laptop will be collected by the Field Representative and the patient record data will be securely transmitted to Census Bureau data servers.

Patient visit data are recorded for each sample visit using either the ED Patient Record form (PRF) (Attachment M), OPD PRF (Attachment N), or AS PRF (Attachment O). Instructions on completing the PRFs and definitions of terms are provided in the computerized instrument through help screens.

The Patient Record forms for the NHAMCS routinely collect data on patient characteristics such as age, sex, race, and ethnicity, and visit characteristics such as date of visit, reason for visit in patient's own words, physician diagnoses, medications provided or prescribed, and expected source of payment. Periodically specific items on diagnostic tests, procedures or non-medication therapies are added or deleted.

For the 2012 ED PRF (Attachment M), we will remove a question on the Glasgow Coma scale due to poor item response and we will add checkboxes to the list of the patient's current conditions in Item 6b.

The Outpatient Department Patient Record form (OPD PRF, Attachment N), will be modified for 2012. We will add checkboxes to assess the patient's asthma severity and control practices. Also on the OPD PRF we will combine the checkboxes under Diagnostic/Screening Services, Health Education, and Non-medication treatment into one new item entitled Services to eliminate confusion in the classification of certain services. We will remove checkboxes that say "other blood test," "other imaging," and "other health education" and replace them with write-in fields at the end of the item. We will also add checkboxes based on services that are commonly written into blank spaces on the form to save the abstractor from having to write out the name of the service. The additional checkboxes are: 5-General medical exam, 6-Neurologic, 23-Audiometry, 24-Provided (under Biopsy), 25-Cardiac stress test, 26-Colonscopy, 26-Provided (under Colonoscopy), 28-EEG (Electroencephalogram), 30-EMG (Electromyography), 32-Fetal monitoring, 31-Provided (under Excision of tissue), 36-Peak flow, 38-Sigmoidoscopy, 38-Provided (under Sigmoidoscopy), 39-Spirometry, 40-Tonometry.

We will also modify the Ambulatory Surgery (AS) PRF (Attachment O) for 2012 by removing External Cause of Injury and adding checkboxes for additional diagnoses that could impact the surgery. Also on the AS PRF, we've deleted a question administration of oxygen and added checkboxes of the most commonly administered drugs and anesthetics to reduce the time and effort needed to write out the names. Last, we've added additional checkboxes to Disposition in order to get a more accurate response to the item.

Monitoring Data Collection and Quality Control

Census Bureau Headquarters staff from the Demographic Surveys Division, Housing Surveys Branch, is responsible for overseeing the data collection. Census Bureau Headquarters staff, Field Division, is responsible for the supervision of staff in the Bureau's Regional Offices who in turn supervise the field representatives.

The field representative visits the sampled ESAs, clinics, and ASLs each week during the data collection period and maintains telephone contact with the staff involved in the data collection effort. 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 Patient Record form is completely filled out for every sample patient visit. Computerization of the Patient Record form has allowed for automated edits to be built into the instrument, so that keying errors are automatically detected as the data entry person is entering data.

Once a case is completed, the survey data are encrypted and sent to a secure Census Bureau database through a secure internet connection. The data are then sent to our keying and coding contractor who will do medical and drug coding on the verbatim text fields. Keying and data entry activities are performed under contract. All medical and drug coding, as well as all data entry operations, are subject to quality control procedures—specifically, a 10-percent quality control sample of survey records are independently keyed and coded. Computer edits for code ranges and inconsistencies are also performed.

For some items, missing values are imputed by randomly assigning a value from Patient Record forms with similar characteristics. For the ED data, imputations for birth year and sex are based on ED volume, geographic region, immediacy with which patient should be seen, and the three-digit ICD-9-CM code for primary diagnosis and for immediacy it is based on ED volume, region, and primary diagnosis. For the OPD data, all imputations are based on geographic region, OPD volume by clinic type, and the three-digit ICD-9-CM code for primary diagnosis. For the ambulatory surgery data, all imputations will be based on geographic region, AS volume, and the three-digit ICD-9-CM code for primary diagnosis.

Estimation Procedures

Estimation procedure for NHAMCS are described at http://www.cdc.gov/nchs/ahcd/ahcd_estimation_procedures.htm#nhamcs_procedures . Separate national estimates will be produced for visits to hospital EDs, OPDs, ASLs, and freestanding ASCs. The estimation procedure has three basic components: (a) inflation by reciprocals of the sampling selection probabilities, (b) adjustments for nonresponse, and (c) calibration ratio adjustment. Beginning in 1997, the calibration ratio adjustment for OPD estimates was replaced by an adjustment that controls for effects of rotating hospital sample panels into and out of the sample each year. (The full NHAMCS hospital and freestanding ASC samples are partitioned into 16 panels that are rotated into the sample over 16 periods of 4 weeks each so that only 13 panels are used in any one year.) Also, beginning with 1997 data, the sampling weights of some OPDs were permanently trimmed to prevent single OPDs from contributing more than 15% of their region's total to OPD visit estimates.

For visits to EDs, the calibration adjustments are based on current ED visit counts recorded in the Verispan Healthcare Market Index and Verispan's "Second Quarter, Hospital Market Profiling Solution" for hospitals in the NHAMCS universe.

Separate national estimates for both hospital-based and freestanding ASCs will be produced. For the ASL and FS-ASC components of NHAMCS, the weighting will be similar to that used for visits to EDs described above.

Beginning in 2004, the nonresponse adjustment factor was changed to account for the seasonality of the reporting period. Extra weights for nonresponding hospitals were shifted to responding hospitals in reporting periods within the same quarter of the year. The shift in nonresponse adjustment did not significantly affect any of the overall annual estimates.

State level estimates of ED visits will be produced for states targeted for the supplemental sample. The procedures for these estimates will be similar to methods used for the national NHAMCS estimates. That is, the estimation procedure for each state has three basic components: (a) inflation by reciprocals of the selection probabilities, (b) adjustments for nonresponse, and (c) calibration ratio adjustment. The calibration adjustments will use ED visit counts recorded for state hospitals in the Second Quarter release of Hospital Market data base available from SDI (http://sdihealth.com/healthcare-lists/hrp.aspx). This data based was formerly known as the Verispan Healthcare Market Index and Verispan's "Second Quarter, Hospital Market Profiling Solution".

For the state level estimates, the weights will be adjusted within each of the five states to account for non-response at the hospital level and for non-response at the ESA (emergency service area) level. Weights of visits to hospitals similar to a non-respondent hospital will be inflated to account for visits represented by the non-respondent hospital where hospitals will be judged to be similar if they are in the same ownership control group (government, voluntary non-profit, or proprietary) and MSA status (in an MSA or not in an MSA). Weights of visits to ESAs similar to the non-respondent ESA will be inflated to account for visits represented by the non-respondent ESA were ESAs are judged to be similar if they are in hospitals of the same ownership control group and MSA status group.

Sampling Errors

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

3. Methods to Maximize Response Rates and Deal with Nonresponse

Based on the results of the 2009 NHAMCS, the projected unweighted and weighted response rates for 2012 are 83% and 82% for the ED and 73% and 74% for the OPD, respectively. The projected unweighted and weighted response rates for ASLs are 68% and 74%, respectively, based on 2009 response rates for hospital-based ASLs. Endorsements were solicited from several prominent national organizations, including the American College of Emergency Physicians, Society for Academic

Emergency Medicine, Emergency Nurses Association, American College of Osteopathic Emergency Physicians, American College of Surgeons (ACS), American Health Information Management Association (AHIMA), American Academy of Ophthalmology (AAO), Society for Ambulatory Anesthesia (SAMBA), and the Surgeon General. NCHS developed a participant web page at www.cdc.gov/nhamcs, which gives a brief background on the NHAMCS, as well as provides information regarding selection and participation, confidentiality and privacy, the HIPAA Privacy Rule, new data components, data utilization, and contact information.

Data collection procedures are designed to minimize response burden, a major concern and influence on response rates. This survey does require commitment from a large number of persons within each hospital and FS-ASC, including the director, clinic, ESA, and ASL directors, and medical and clerical staff. Refusals to participate may occur at any one of the stages of induction or data collection. At the time of refusal, a refusal report is completed and the Census Bureau Regional Office is notified. Reasons for refusal vary considerably, necessitating refusal conversion procedures which are flexible and responsive to individual concerns. In general, the following survey features are stressed: the data are needed by the hospital and medical professions for a variety of purposes and do not exist elsewhere; all data about facilities, ambulatory units, and patients are kept confidential; and every effort is made to minimize the disruption of facility routine. Based on earlier experiences, these features are often persuasive in converting refusals.

4. Tests of Procedures or Methods to be Undertaken

In 2012, a pretest in hospital-based ASLs and freestanding ASCs will assess the feasibility of obtaining information on colorectal cancer screening during ambulatory surgery visits where a colonoscopy is performed. In fall 2011, a small pilot test will be conducted in 5 hospitals and 4 freestanding ASCs. Based on the results of the pilot test, we will use 4-5 questions from the pilot test in the pretest (Attachment Q). The pilot questions were drafted based on consultations with experts in colorectal cancer screening research and federal partners and submitted to OMB for final approval. The questions will be added to the AS Patient Record form and will be completed for patients that have a colonoscopy performed at the sampled visit. Because the pretest will only add a few questions to the AS Patient Record form, and because the questions will only be asked of patients with a colonoscopy at the sample visit, we do not anticipate that the pretest will change the burden of the AS Patient Record form. Final pretest questions will be submitted to OMB prior to the pretest.

Colonoscopy is a highly effective clinical preventive service delivered in a variety of ambulatory settings, including hospital-based ASLs and freestanding ASCs. Most data on patterns of colorectal screening are self-reported and collected directly from patients. However this approach limits the level of clinical detail available, and is subject to reporting bias. Moreover, self-reported data provide no information about the relationships between practice and provider characteristics and the performance of these procedures. Obtaining visit-level data on colonoscopy procedures through NHAMCS will allow researchers to analyze these relationships. The endeavor is sponsored jointly by the National Center for Chronic Disease Prevention and Promotion and the National Cancer Institute.

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 agent is the Census Bureau and the contact person is:
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The data will be analyzed under the direction of:
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ATTACHMENTS

A. Applicable Laws and Regulations

B. List of NHAMCS Publications

C. Federal Register 60-Day Notice

D. Public Comment on Federal Register 60-Day Notice

E. List of Consultants for NHAMCS

F. CDC #2010-03 IRB Approval for Continuation of Protocol

G. (1) Introductory Letters to NHAMCS Hospitals

(2) Introductory Letter to Freestanding ASCs

H. NHAMCS Endorsing Letters

I. Hospital Induction Form

J. Hospital Induction Form for New Sample of Hospitals

K. Freestanding Ambulatory Surgery Center Induction Form

L. Ambulatory Unit Induction Form

M. Emergency Department Patient Record form

N. Outpatient Department Patient Record form

O. Ambulatory Surgery Patient Record form

P. Pulling and Refiling Medical Records

Q. Colonoscopy Supplement Pilot Questions