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

OMB No. 0920-0234
(Expires 12/31/2017)

Contact Information:

Carol DeFrances, Ph.D.
Chief, Ambulatory and Hospital Care Statistics Branch
Division of Health Care Statistics
National Center for Health Statistics/CDC
3311 Toledo Road
Hyattsville, MD 20782
301-458-4440
301-458-4032 (fax)
csd0@cdc.gov

January 27, 2016

Table of Contents

Supporting Statement

National Center for Health Statistics
National Ambulatory Medical Care Survey

- Goal of the study: NAMCS data are used to statistically describe patient visits to physician offices and community health centers (CHCs), including the conditions most often treated, and the diagnostic and therapeutic services rendered, and medications prescribed.

- Intended use of the resulting data: These data are widely used by health care researchers, medical schools, policy analysts, congressional staff, the news media, and many others to improve our knowledge of medical practice patterns.

- Methods to be used to collect: A randomized list of sampled providers is generated from a universe of physicians. Basic practice characteristics are collected and these sampled providers are then assigned a pre-determined 7-day reporting period to collect cross-sectional patient medical record data.

- The subpopulation to be studied: Data are collected on the practicing physicians who are selected to participate in NAMCS. Data are also abstracted from a fraction of their patient visits during the assigned reporting week.

- How data will be analyzed: NAMCS data are weighted to be nationally-representative. Weighted data will be analyzed using frequencies and cross tabulations. 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.

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: Expires 12/31/2017), for the purpose of

- Continuing previously approved survey activities for the 3 years 2016, 2017, and 2018
- Discontinuing the provision of state-based estimates, due to decreased funding
- Modifying existing questions for clarification and to keep up-to-date with current medical practice and terminology (see Attachment D3)
- Adding new questions on emerging health topics to regular data collection activities (see Attachments C2 and C4)
- Adding new questions to the physician interview that pertain to policies, services, and experiences related to the prevention and treatment of sexually transmitted infections (STIs) and HIV prevention (STD/PrEP) (see Attachments C2 and C3)
- Include a small number of physicians who will prepare and transmit Electronic Health Records (EHRs) to fulfill Meaningful Use requirements (Onboarding)

NAMCS is a national survey of both provider characteristics and patient visits to office-based

physicians conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. In 2016, NAMCS will produce estimates for four Census regions and nine Census divisions. The annualized 2016-2018 NAMCS sample size is projected to be 3,934 combined office-based physicians and CHC providers. 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.

New/modified activities planned for the 2016-2018 survey period:

- Physician Induction Interview (NAMCS-1): In addition to the sexually transmitted infections (STI) questions discussed above, modify question text for clarity, modify physician workforce questions, modify EHR questions, and tailor wording for questions directed to CHC settings. (see Attachments C2 and C3)
- Physician Induction Interview, CHC service delivery site (NAMCS-201): Move facility-level questions from the CHC provider-level questionnaire path to the more appropriate CHC facility-level questionnaire. (see Attachment C4)
- NAMCS Patient Record form (PRF): Add 3 new chronic condition checkboxes, make slight wording changes to existing diagnostic services, make slight text modifications to the disposition answer list, and clarify the header text for date of blood draw. These clarifications were done to aid Census Field Representatives when abstracting data from patient medical records. (see Attachment D3)
- NAMCS Patient Record form (PRF): Include a small number of physicians who will prepare and transmit Electronic Health Records (EHRs) to fulfill Meaningful Use requirements (Onboarding).

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 a re-abstraction of patient visits from 72 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 2016-2018 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) non-federal office-based physicians; and (2) providers 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.

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 104 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 2016-2018.

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, expires 04/30/2016), 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 2015 is 12,085 total office-based and CHC providers.

In 2016, allocated funds will cover a sample size of 3,934 combined office-based physicians and CHC providers. The same levels are anticipated for 2017 and 2018.

- Office-based Physicians

In each NAMCS survey year, since the survey's inception, there has been a 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. ACA funds may return in future years, but were not provided in 2015 or 2016. In the absence of ACA funding in 2015, CDC provided the funding for an expansion sample of 16 states. No expansion funds were made available for 2016, and state-level estimates are halted. Approved funding levels allow for Census region and division estimates instead. The same level of funding is anticipated for 2017 and 2018. The proposed annual number of office-based physicians during 2016-2018 is 3,700, and this is a reduction from 8,080 office-based physicians sampled in 2015.

- Community Health Centers (CHCs)

In each NAMCS survey year since 2006, there has been a sample of 104 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. There are a proposed 104 CHC service delivery sites annually for 2016-2018. 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 234 total CHC providers.

Annualized NAMCS Sample Counts for 2016-2018	
Total traditional Office-based Physicians	3,700
CHC service delivery sites	104
Total CHC Providers = CHC sites * 2.25 CHC providers	234

Combined (traditional + CHC providers) Sample Size	3,934

New/modified activities planned for the 2016-2018 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 2015 Physician Induction Interview (NAMCS-1). **Attachment C2** provides the full list of 2016 questions in the order that it would appear in the instrument for office-based physicians and highlights in red the changes from 2015 to 2016. **Attachment C3** provides the full list of 2016 questions for CHC providers and highlights in red the changes from 2015 to 2016. As in 2015, the 2016 NAMCS-1 questions will be collected on a computer-assisted interviewing instrument.

The Physician Induction Interview (NAMCS-1) has undergone a re-structuring in 2016. There are now three distinct question tracks: traditional physicians, CHC providers, and CHC facility sites. In the past, induction questions were worded exactly the same, regardless of type of provider or health care setting. But, as we have witnessed a rapidly evolving health care delivery system, we acknowledge the increasing importance of Community Health Centers in the provision of health care and the need for NAMCS to also evolve in capturing the unique characteristics of CHCs. Survey year 2015 served as the interim year where we tailored questions for the CHC setting with the ultimate goal of creating three distinct paths, which we achieved in 2016. CHC providers use the same instrument as the one used for office-based physicians, but the wording is tailored for questions directed to CHC providers. 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. The question path for traditional office-based physicians remains intact and is not re-structured. Facility-level questions were moved from the CHC provider-level questionnaire path to the more appropriate CHC facility-level questionnaire (NAMCS-201 found in **Attachment C4**). This change was made in direct response to field reports that CHC facilities are best equipped to answer questions about workforce, EHR capabilities, and payments. CHC providers often do not know the answers to administrative questions, so this move will reduce the number of blank responses and improve efficiency. **Attachment C3** indicates in blue font the questions that were moved to the NAMCS-201 CHC service delivery site questionnaire in **Attachment C4**.

DHCS collaborated with CDC's Division of STD Prevention (DSTDP) to add a new module of questions to the Physician Induction Interview about policies, services, and experiences related to the prevention and treatment of sexually transmitted infections (STIs) and HIV prevention. Issues include confidentiality for adolescent patients as well as current treatment methods for diagnosing and treating STIs in the same venue. The physicians are also asked whether they undertake a HIV risk assessment with patients and whether their practice includes high-risk patients. There are several reasons to justify the inclusion of these questions, which are described

in three major themes. First, youth are less financially stable and experience a significant health burden of certain conditions, such as sexually transmitted diseases (STDs, including HIV) and unintended pregnancies. While cost is often cited as a barrier to accessing care, data show that perceptions of confidentiality also impact access to services. For adolescents, confidentiality issues typically involve concerns about parents. A question about the availability of a written policy to ask parents to leave the exam room was adapted from the Medical Expenditure Panel Survey (MEPS). This question and a companion item from the National Survey of Family Growth (NSFG) will help CDC's Division of STD Prevention (DSTDP) assess missed opportunities for services because of confidentiality concerns. Delays in or avoidance of care contributes to disease transmission; thus, this question on privacy will be useful to examine chlamydia testing and risk assessment. Second, questions asking about the availability of on-site tests are valuable because STDs are diagnosed in widespread settings and it is important to know if appropriate treatments are available in the same venues as diagnosis. In particular, current treatment guidelines for gonorrhea recommends an injection of 250g ceftriaxone over oral medication (cefixime). These questions were drawn from a panel of experts familiar with the CDC STD Treatment Guidelines. Third, appropriate STD screening relies on a health care provider taking an adequate sexual risk assessment. This item was developed from several previous studies including NSFG and included the sexual behaviors that are most commonly recommended by these studies. A risk assessment is important for all persons, which is why this question asks about a wide range of sexual and drug-use behaviors. These new questions (labelled STD-PrEP) have been inserted before questions on CLAS standards in the induction instrument for both traditional physicians and CHC providers **(Attachment C2 on pages 8-10, Attachment C3 on pages 9-11)**.

Additional proposed changes to the NAMCS-1 Induction include additions, deletions, and modifications to the Physician Workforce questions (see **Attachment C2 on pages 12-16 and Attachment C3 on pages 13-18**). Physician workforce questions were greatly streamlined, which involved deleting duplicative questions on EHR utilization, deleting questions on certain services provided, deleting questions on tasks performed, paring down the questions on autonomy of non-physician clinicians, and adding staffing categories for clinical nurse specialist (CNS) and nurse anesthetist (NA). For 2016, the physician workforce module was pared down to include only the most essential questions. This streamlining was necessitated by the ending of funding from the sponsor, the Assistant Secretary for Planning and Evaluation (ASPE). Despite the lack of funding for this module, there still remains a great need to collect data on workforce capability.

Additions, deletions, and modifications are also proposed for the electronic health records (EHR) section (see **Attachment C2, pages 16-21 and Attachment C3. pages 18-24**). NAMCS uses the same EHR questions as those used for the self-administered mailed survey, National Electronic Health Record Survey (NEHRS) OMB No. 0920-1015 (Expires 04/30/2017), which provides a valuable opportunity for reliability and validity checks. The Office of the National Coordinator for Health Information Technology (ONC) sponsors NEHRS, which was previously included as a part of this NAMCS package before it was approved as a separate information collection request. We propose to modify the currently approved NAMCS EHR section by deleting several questions relating to consults and computerized capabilities, as these topics were no longer a priority for the sponsor. For 2016, ONC has proposed expanding the currently approved content

to obtain data about the constantly evolving health information exchanges (HIE), particularly with respect to sending, receiving, and integrating patient health information. Content on the survey contains items that collect necessary trend and practice data in order to evaluate the HIE-expanded content and meaningful use incentive program goals.

Community Health Center Induction Interview (NAMCS-201)

The community health center induction interview (NAMCS-201) is expanded to include a block of facility-level questions that were previously in the CHC provider-level questionnaire. By moving these facility-level questions to the CHC induction, we can limit the burden on CHC providers and reduce redundancy in our data. See **Attachment C3** (CHC provider path) for the block of facility-level questions, indicated in blue text, that were moved to the CHC facility path in **Attachment C4**.

Patient Record form (**Attachments D2 and D3**)

Minor modifications were made to clarify data collection and improve data quality. A review committee of staff scientists, physicians, and researchers convenes every year to ensure that NAMCS keeps current with the most relevant health issues. For 2016, three chronic conditions were added to the checkbox list of the patient's underlying chronic conditions: Attention deficit disorder (ADD)/Attention deficit hyperactivity disorder (ADHD), Hepatitis B, and Hepatitis C.

Slight modifications for greater clarity were made to the already existing checkbox list of diagnostic services ordered or provided. For the disposition question, the word "provider" was added to the answer list whenever the word "physician" appears. This was done to be inclusive of non-physician clinicians sampled in the CHC provider path. Finally, in the laboratory testing section, "Date of test" was changed to the more exact "Date of blood draw". Blood draws are typically conducted in-house with an exact date, but the blood samples are typically sent away to private companies for testing with varying completion time. Currently we collect the values for the serum creatinine laboratory test as mg/dL; however, we have found that this laboratory test can also be recorded in µmol/L units. To improve data quality, we have provided FRs with the option of entering serum creatinine in either md/dL or µmol/L units.

Starting in the 2016 NAMCS survey cycle, physicians may also submit data to NCHS electronically, in order to meet Meaningful Use requirements (See more details in Section A.3). Only a small proportion of sampled NAMCS physicians are anticipated to transmit PRF data through their EHR system. The bulk of PRF abstractions will continue to be abstracted by field representatives (FRs). It is estimated that FRs will abstract data at least 85 percent of the time. Field data has shown that FRs conduct nearly all of the patient record abstractions.

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, and (5) determination of policies, services, and experiences related to the prevention and treatment of sexually transmitted infections (STIs) and HIV prevention.

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

Journal articles using NAMCS data

- Farhangian ME, McMichael AJ, Huang KE, Feldman SR.Treatment of Alopecia Areata in the United States: A Retrospective Cross-Sectional Study. J Drugs Dermatol. 2015 Sep 1;14(9):1012-4.

- Jolles MP, Haynes-Maslow L, Roberts MC, Dusetzina SB. Mental Health Service Use for Adult Patients With Co-occurring Depression and Physical Chronic Health Care Needs, 2007-2010. Med Care. 2015 Aug; 53(8):708-712.
- McMorrow S, Long SK, Fogel A. Primary Care Providers Ordered Fewer Preventive Services For Women With Medicaid Than For Women With Private Coverage. Health Aff (Millwood). 2015 Jun 1;34(6):1001-9. doi: 10.1377/hlthaff.2014.0907.

- Petterson SM, Liaw WR, Tran C, Bazemore AW. Estimating the residency expansion required to avoid projected primary care physician shortages by 2035. Ann Fam Med. 2015 Mar;13(2):107-14. doi: 10.1370/afm.1760.

- Taheri A, Davis SA, Huang KE, Feldman SR. Onychomycosis treatment in the United States. Cutis. 2015 May;95(5):E15-21.

Conferences

- Hing E, Myrick K, Park M. Basic and Advanced Hands-On Learning Institutes on Understanding and Analyzing Ambulatory Health Care Data. Presentation at the 2015 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.

Other Publications

- 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 pieces of sensitive information being collected are the medical record number and date of birth. Medical record number will only be used for internal survey operations purposes, and will be eliminated from the dataset prior to transmittal to NCHS. Birth date is converted to patient's age in the public use file. No information in identifiable form (IIF) data are shared with researchers.
Likewise, the impact on the privacy of the provider is negligible. Section 10.1 "Privacy Impact Assessment Information" lists the items collected about providers that are considered IIF and describes the measures taken to ensure confidentiality. 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.

Starting in 2016, physicians may electronically submit patient data to NCHS. This new data submission method is referred to as "Onboarding". To encourage use of EHRs, the government provides financial incentives to physicians and hospitals (providers) who adopt certified EHRs and meet specific reporting objectives (termed Meaningful Use (MU)) through the Medicare and Medicaid Incentive Program. Providers may submit electronic health data to the National Health Care Surveys, including NAMCS, and receive MU credit. The ability to receive MU credit is a major incentive and recruitment tool for NAMCS. Any physician may register with NCHS to receive MU credit and must demonstrate the ability to electronically submit EHR data. After a physician registers, a determination will be made by NCHS staff as to whether the physician is part of the NAMCS sample or not. After such determination, the same data elements will be requested and the same protocol followed for both sampled and non-sampled physicians. All physicians will be invited to the testing and validation stage and ultimately to submit EHR data. All physicians will be asked to provide all patient visits for a designated reporting week. From these data, a sample of visits will be drawn as done in abstracted NAMCS data collection. Data

received from **sampled** physicians will be evaluated, and if acceptable, will be added to the NAMCS data set. For eligible **non-sampled** physicians, receiving their EHR data will be dependent on NCHS data storage capabilities; however, it is anticipated that over time NCHS will accept data from all eligible non-sampled physicians who register with NCHS for MU credit. Collectively, NAMCS will have two data sets: 1) one file with abstracted and EHR data from sampled physicians, which will be used to make national estimates; 2) another file with data from sampled (abstracted and EHR data) and non-sampled physicians (EHR data only), which will be used for research purposes.

While sampled and non-sampled physicians are asked to participate in NAMCS, they will be informed about HIPAA research disclosure requirements. Physicians or medical groups expressing interest in submitting data will be provided with guidance on how to submit the data. The guidance will include explicit statements that the data submitted to NCHS will be used for research purposes and they will need to include NAMCS in the list of research disclosures provided to their patients if requested. Physicians or medical groups submitting data will be asked to remove all direct Personal Identification Information (PII) (patient name, address, cell phone, work phone, home phone and e-mail) prior to transmitting the data to NCHS. If removal of the direct PII is too burdensome for the physicians, NCHS will remove it upon receipt.

It is anticipated that 5% of sampled NAMCS physicians will participate in this new program.

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, expires 12/31/2017) 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. 0935-0118) 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 October 8, 2015 (**Attachment B1**). One comment was received (see Attachment B2) and 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.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsors the Physician Workforce component of the core NAMCS Physician Induction Interview (NAMCS-1). These questions have been fielded since 2013. NCHS has maintained close contact with

ASPE during discussions of modifications to the 2016-2018 workforce questions.

CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention sponsors the 10 new questions on policies, services, and experiences related to the prevention and treatment of sexually transmitted infections (STIs) and HIV prevention (STD/PrEP) that are proposed for the 2016 NAMCS Physician Induction Interview (NAMCS-1).

The National Center on Birth Defects and Developmental Disabilities (NCBDDD) at the Centers for Disease Control and Prevention (CDC) sponsors the 6 questions on alcohol screening and brief intervention (SBI) that continue for a second year on the 2016 NAMCS Physician Induction Interview (NAMCS-1).

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 2016-2018 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. Any future plans to offer payment or gifts would be submitted to OMB for review and potential approval.

10. Assurance of Confidentiality Provided to Respondents

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 because this study includes the collection of information in identifiable form. The applicable System of Records Notice is 09-20-0167 Health Resources Utilization Statistics.

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

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

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

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

Information in Identifiable Form (IIF)

NAMCS 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.

11. Intuitional Review Board (IRB) and Justification for Sensitive Questions

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 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**.

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 2016-2018 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 FR's 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 2016-2018, 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, 2016-2018. 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 2016-2018 multiplied by the average time to complete each record (number of respondents * number of responses per respondent * hours per response).

We propose no change in the burden time for completing the NAMCS-1 for traditional physicians; however, we anticipate a decrease in burden time from 45 minutes to 30 minutes for CHC providers. This decrease is a result of moving numerous NAMCS-1 induction questions (CHC path) (Attachment C3) to the CHC induction interview (NAMCS-201) (Attachment C4). Conversely, we are proposing a slight increase in burden to complete the NAMCS-201 (Attachment C4), from the currently approved 20 minutes to a total of 30 minutes. This increase is the direct result of moving the aforementioned block of induction questions from the current NAMCS-1 (CHC path) to the current NAMCS-201.

Office-based physicians and CHCs comprise the two overarching components of the NAMCS. Within each component, there are 2 different instruments associated with each sampled provider: Provider Induction interview (NAMCS-1) and Patient Record forms (PRFs). As mentioned above, the CHC has an additional induction for administrators at the sampled 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 will complete the induction, 10% of those physicians will abstract patient records, 5% of physicians will participate in the new Meaningful Use program, which entails preparing and transmitting EHRs, and FRs will abstract patient records for the remaining 85% of those physicians. Census field data has shown that FRs abstract nearly all of patient record forms, but we have used a conservative 85% 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 can be selected per CHC service delivery site, but an average is used), 10% of those CHC providers abstract patient records, and FRs abstract patient records for the remaining 90% 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 90% FR abstraction estimate for the burden table below. Eligible physicians in private practice (N=2,590; 70% of 3,700) and CHC providers (N=234; 2.25 providers * 104) will be asked to complete induction items (NAMCS-1) (**Attachments C2-C3**). All sampled CHC providers are considered eligible. All community health center executive/medical directors from sampled CHCs (N=104) will be asked to complete the automated CHC facility-level induction items (NAMCS-201) (**Attachment C4**). Approximately 30 forms are expected from each sampled provider, and this estimate holds for both traditional office-based physicians and CHC providers. A minority of participants will complete electronic Patient Record forms (NAMCS-30) (**Attachments D2**) themselves (N=282; 259+23), while a majority will rely on Census abstractors to complete the forms. A projected 130 physicians are anticipated to prepare and transmit EHRs to fulfill Meaningful Use requirements **(Attachment O)**. In cases abstracted by Census FRs, the only responsibility for the sampled provider is that their office staff will pull and re-file the medical records (N=2,412; 2,201+211) (**Attachment H**). Since the procedure for the reabstractre-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=72) (**Attachment I**).

The estimated annual burden is 5,435 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% * 3,700 total office-based physicians = 2,590 (includes 130 Onboarding physicians)
- Assume only 10% of physicians choose to abstract data themselves = 10% * 2,590 = 259
- Assume only 5% of physicians prepare and transmit EHRs = 5% * 2,590 = 130
- Assume FRs abstract 85% of PRFs = 85% * 2,590 = 2,201

Community Health Centers (CHCs)

- Assume 100% response rate of all sampled CHC service delivery sites = 104
- Assume 2.25 CHC providers (out of 3 maximum) per CHC choose to participate = 2.25 * 104 = 234
- Assume only 10% of CHC providers choose to abstract data themselves = 10% * 234 = 23
- Assume FRs abstract 90% of PRFs = 90% * 234 = 211

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	Physician Induction Interview (NAMCS-1)	2,590	1	45/60	1,943
	Patient Record form (NAMCS-30) (Physician abstracts)	259	30	14/60	1,813
	Prepare and transmit EHR (MU Onboarding)	130	1	1	130
	Pulling, re-filing medical record forms (FR abstracts)	2,201	30	1/60	1,101
Community Health Centers	Induction Interview – service delivery site (NAMCS-201)	104	1	30/60	52
	Induction Interview – Providers (NAMCS-1)	234	1	30/60	117
	Patient Record form (NAMCS-30) (Provider abstracts)	23	30	14/60	161
	Pulling, re-filing medical record forms (FR abstracts)	211	30	1/60	106

Re-abstraction study	Pulling, re-filing medical record forms (FR abstracts)	72	10	1/60	12
				Total	5,435

B. Burden Cost

The cost to providers for each data collection cycle is estimated to be $429,214.
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 2014 National Occupational Employment and Wage Estimates" for (1) health care practitioners and technical occupations, (2) office and administrative support occupations, and (3) management occupations. Data were gathered on mean hourly wages in 2014 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 a 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 (NAMCS-201), PRF (NAMCS-30), and 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 $94.78 (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 ($88.78) 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 ($26.14) was based on office staff (reported from BLS categories) that might perform this activity: registered and licensed nurses; office supervisors and support staff; receptionists and information clerks; medical secretaries; and physician assistants. Finally, the estimate used for those individuals completing the CHC facility items ($83.72) included (1) medical and health services managers (as a proxy category 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	Physician Induction Interview (NAMCS-1)	1,943	$94.78	$184,158
	Patient Record form (NAMCS-30) (Physician abstracts)	1,813	$94.78	$171,836
	Prepare and transmit EHR (MU On-Boarding)	130	$94.78	$12,321
	Pulling, re-filing medical record forms (FR abstracts)	1,101	$26.14	$28,780
Community Health Centers	Induction Interview – service delivery site (NAMCS-201)	52	$83.72	$4,353
	Induction Interview – Providers (NAMCS-1)	117	$88.78	$10,387
	Patient Record form (NAMCS-30) (Provider abstracts)	161	$88.78	$14,294
	Pulling, re-filing medical record forms (FR abstracts)	106	$26.14	$2,771
Re-abstraction study	Pulling, re-filing medical record forms (FR abstracts)	12	$26.14	$314
			Total	$429,214

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 2016-2018 survey is $8,392,113.

Expense Description	Total Cost
Interagency Agreement for data collection with the Bureau of the Census	$5,904,000
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	$ 8,392,113

15. Explanation for Program Changes or Adjustments

The decrease in sample size will decrease the requested burden by 19,876 hours from the 25,311 total hours reported in the most previously approved package. The total NAMCS burden will now equal 5,435 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 2016 survey is as follows:

Steps	Timeline	Activity
1	Within one month of OMB approval	Begin data collection for 2016 survey
2	One year after OMB approval	Formally end reporting period
3	Three months after reporting period ends	Close out fieldwork
4	One year and five months after OMB approval	Begin cleaning and weighting
5	One year and six months after OMB approval	Begin data analysis
6	Two years after OMB approval	Public use data available on Internet Publish reports and on-line data summary tables

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 2012 Summary Tables are available at http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2012_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

Recently, changes to the NAMCS have occurred frequently, necessitating a yearly OMB package. Creating a yearly OMB package for NAMCS creates circumstances that potentially can delay the release of our data collection instruments. To mitigate the problems caused by a delayed OMB approval date, we are seeking approval to not display the expiration date for OMB approval of the information collection, which will eliminate the computer programming time it takes to add the expiration date to the computer data collection instrument and all printed survey aids.

The first NAMCS reporting period typically starts before the calendar year and it is ideal to start the initial contact and interviewing process in late December. If an outstanding OMB package has not been approved by early December, we are forced to suspend any and all survey operations until the actual OMB expiration date can be applied to the automated data collection instrument. If the expiration date is supplied any time after the end of December, the actual release of the automated instrument is delayed due to computer programming. If we are granted approval not to display the OMB expiration date, we could have the automated instrument programmed and finalized in advance of the provision of the expiration date, and we could release the instrument as soon as the expiration date is provided by OMB. In short, efforts can be focused on readying all survey instruments in advance of OMB approval and once approval is granted, data collection can start immediately.

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.