Supporting Statement A for Request for Clearance:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0278
(Expires 06/30/2021)

Contact Information:

Brian W. Ward, Ph.D.
Branch Chief
Ambulatory and Hospital Care Statistics Branch
Division of Health Care Statistics
National Center for Health Statistics/CDC
3311 Toledo Road, Room 3482
Hyattsville, MD 20782
301-458-4568
301-458-4693 (fax)
ijz8@cdc.gov

September 3, 2020

Table of Contents

Supporting Statement A – Justification Pages

List of Attachments

Att A - PHSA authorization
Att B - FRN 60 Notice (published)
Att C1 - Hospital Induction questionnaire (2020)
Att C2 - Ambulatory Unit Induction questionnaire (2020)
Att C3 - Hospital Induction questionnaire (2021)
Att C4 - Ambulatory Unit Induction questionnaire (2021)
Att D1 - ED PRF sample card (2020)
Att D2 - ED PRF sample card (2021)
Att E - List of publications
Att F - List of Consultants
Att G1 - IRB letter (signed)
Att G2 - Waiver of Informed Consent
Att H1 - NHAMCS Introductory letter (2020)
Att H2 - NHAMCS Introductory letter (2021)
Att I - Endorsement letters
Att J - Informed Consent flowchart
Att K1 - Retrieving medical records (2020)
Att K2 - Retrieving medical records (2021)
Att L1 - Reinterview questionnaire (2020)
Att L2 - Reinterview questionnaire (2021)

Supporting Statement
National Hospital Ambulatory Medical Care Survey (NHAMCS)

Goal of study: To assess health care service utilization through patient visits to hospital emergency departments (EDs) in the United States. This survey will be incorporated into the National Hospital Care Survey (NHCS) once there are enough hospitals participating in NHCS to ensure reliable national estimates can be made.

Intended use of the resulting data: These data are widely used by all agencies of the Public Health Service and other government, academic and private research organizations in tracking changes in hospital-based ambulatory health care in the emergency department.

Methods to be used to collect: NHAMCS is a multi-stage, probability survey and sampling begins with the selection of certain primary sampling units (PSU). The next level is selection of certain representative hospitals within those PSUs, and then the selection of the EDs, and finally selection of patient visits within the ED. Data collection is done retrospectively after each sampled hospital's designated, 4-week reporting period has passed, using a computerized instrument on a secure laptop.

The subpopulation to be studied: Non-federal, non-institutional, short stay (<30 days) general and children's general hospitals that have an ED and at least 6 beds assigned for inpatient use.

How the data will be analyzed: NHAMCS data are derived by using a multistage estimation procedure. Public-use files will be made available for visit level data. Facility or provider level data are only accessible through the Research Data Center (RDC).

The National Center for Health Statistics (NCHS) requests an approval for a revision of 3 years for data collection through the National Hospital Ambulatory Medical Care Survey (NHAMCS) (OMB No. 0920-0278, Exp. 06/30/2021). We are requesting approval to complete the 2020 data collection which is currently underway and collect data over the following three years (2021-2023) without change to the current survey activities. In addition to the requested approval, we also request to submit non-substantive change packages, as needed, for form modifications occurring throughout the approval period.

Starting with the 2021 data collection, NHAMCS will include a few questions to improve the quality of data obtained from eligible emergency service areas as well as COVID-19-related questions (with a few of these containing sub-questions) that will be used to assess whether EDs: (1) encountered shortages in personal protective equipment (PPE); (2) created areas outside ED entrances to screen for COVID-19; (3) turned away or referred elsewhere presumptive positive COVID-19 patients; and (4) had any health care providers at their practice or center who tested positive for COVID-19.

It is possible that the survey may have to adapt its plans in response to COVID-19 or related concerns. Should changes due to COVID-19 or related concerns be necessary, the program may submit a non-substantive change request, a generic information collection request (GenICs), a full revision, or a new clearance request to conduct special studies, as appropriate.

A. Justification

1. Circumstances Making the Collection of Information Necessary

NHAMCS is a national survey of emergency medical care provided at hospitals conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). The survey is conducted under the authority of Section 306 of the Public Health Service Act (41 USC 242k) (**Attachment A**).

The mission of NCHS is to provide statistical information that will guide actions and policies to improve the health of the American people, and NHAMCS continues to support this mission by collecting data on patient visits to emergency departments (EDs) at non-federal, non-institutional, general and children's general short-stay hospitals in the United States. NHAMCS provides data that are needed to track health care trends, and to evaluate the performance of the U.S. health care system in terms of the way in which emergency health care is organized, financed, and delivered. Additional justifications for conducting NHAMCS include the need for more complete data to study the effects of: (1) hospital consolidation, (2) increasing efforts to contain health care costs and improve access and quality, and (3) the introduction of new medical technologies and use of electronic health records. The currently approved 2020 NHAMCS Hospital Induction questionnaire (**Attachment C1**), NHAMCS Ambulatory Unit Induction questionnaire (**Attachment C2**), and ED Patient Record Form (**Attachment D1**) will be used to complete the 2020 data collection. The 2021 NHAMCS hospital induction questionnaire (**Attachment C3**), the 2021 NHAMCS Ambulatory Unit Induction questionnaire (**Attachment C4**), and the 2021 ED Patient Record Form (**Attachment D2**) will be used, without changes, for data collection for the next three years, from 2021 to 2023.

2. Purpose and Use of Information Collection

The purpose of this study is to assess health care service utilization through patient visits to hospital emergency departments (EDs) in the United States. NHAMCS data are widely used by all agencies of the Public Health Service, other government agencies, academic, and research organizations in tracking changes in hospital-based ambulatory health care. These data complement those from the National Ambulatory Medical Care Survey (NAMCS), a physician survey, to provide a description of ambulatory health care in the United States. A negative consequence of not having information collected in the NHAMCS is that there would be a paucity of hospital-based ambulatory health care data from emergency departments (EDs) to monitor hospital consolidation, increasing efforts to contain health care costs and improve access and quality, and the introduction of new medical technologies and use of electronic health records.

Ambulatory medical care is predominantly how most Americans get the care they need, with emergency ambulatory care used more so by the uninsured. In 2017, there were 138,977,000 estimated visits to hospital EDs in the United States. Emergency medicine is an important aspect of healthcare that should be monitored not only because it serves as a safety net to underserved populations, but because it provides an indication of the emergent status of the country. NHAMCS is designed to obtain information on how such care is provided in the hospital setting at both the sampled patient encounter level and administrative data level. Valid data concerning hospital emergency medical care are needed to inform decisions on the allocation of resources and training of health professionals to aid in efforts to control health care costs, monitor quality of care, and to plan for the provision of ambulatory medical care.

Users of NHAMCS data other than the CDC include Congress and federal government agencies such as the Government Accountability Office, DHHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA). These data are also used by state and local governments, medical schools, schools of public health, colleges and universities, private businesses, non-profit foundations and corporations, professional associations, and health maintenance organizations. Through datasets available on the web and through the NCHS Research Data Center, NHAMCS is also used by individual practitioners, researchers, administrators, and health planners.

NHAMCS data are cited frequently to describe patterns and trends in ambulatory health care in hospital EDs. This may include the citation of recent NCHS reports, or journal articles using NHAMCS data. Some recent topics include: opioid use among pediatric patients, pediatric asthma care, antibiotic prescribing, outpatient benzodiazepine prescribing, and psychiatric emergency department visits, among others. A list of recent publications using NHAMCS data are provided (**Attachment E)**.

3. Use of Improved Information Technology and Burden Reduction

Respondent burden in the current NHAMCS data collection is held to a minimum using computerized sampling procedures at the patient level in the ED. In addition, the computerized induction interview allows field representatives (FR) to skip non-applicable questions and quickly populate write-in fields using pre-programed drop-down menus. Consequently, the time a hospital respondent spends during the induction interview has been significantly reduced over the years.

When collecting data for ED visits, the use of computerized data entry into the electronic patient record form (PRF) has also greatly simplified 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 and medications. Overall, the current computerized data entry system used by NHAMCS has significantly reduced both FR and respondent burden, and ultimately improved field operations and overall data quality. This computerized data collection has also sped-up data transmission and processing.

4. Efforts to Identify Duplication and Use of Similar Information

Based on previous work at NCHS, and discussions with other government and professional organizations, five sources of data related to NHAMCS were identified:

Table 1. Sources of Data Related to NHAMCS

Data Source	Agency	OMB No.	OMB Exp. Date
National Hospital Care Survey (NHCS)	National Center for Health Statistics (NCHS)	0920-0212	03/31/2022
National Electronic Injury Surveillance System, All Injury Program (NEISS AIP)	Consumer Product Safety Commission (CPSC) and CDC	3041-0029	01/31/2020
National Health Interview Survey (NHIS)	National Center for Health Statistics (NCHS)	0920-0214	12/31/2020
Medical Expenditure Panel Survey (MEPS)	Agency for Healthcare Research and Quality (AHRQ)	0935-0118	11/30/2021
State Emergency Department Databases (SEDD)	Agency for Healthcare Research and Quality (AHRQ)	N/A	N/A

The National Hospital Care Survey (NHCS), conducted by NCHS, is designed to integrate the data collected by the National Hospital Discharge Survey (NHDS) (Discontinued) and NHAMCS. The target universe of NHCS is inpatient discharges and ambulatory visits to non-institutional, non-federal hospitals in the 50 states and the District of Columbia. NHCS utilizes electronic data collection capabilities, including EHRs. Hospital level information is collected using a facility questionnaire, with visit level data collected from UB-04 claims or EHR data. Efforts are in place to ensure that estimates generated using NHCS data are nationally-representative. However, until that time NHAMCS will continue to serve as NCHS' source for nationally-representative ED data.

The National Electronic Injury Surveillance System (NEISS) is operated by the Consumer Product Safety Commission (CPSC) in 100 sampled U.S. hospital EDs and has an agreement with CDC to conduct the NEISS All Injury Program (NEISS AIP). The NEISS AIP is designed to provide national incidence estimates of all types and external causes of nonfatal injuries, adverse events, and poisonings treated in hospital EDs. Illness-related ED visits are not covered by the NEISS AIP, and its use in assessing medical care provided in hospital EDs is limited. NHAMCS data are used by the NEISS AIP to benchmark their statistics.

The National Health Interview Survey (NHIS), conducted by NCHS, is a population-based survey in which information is obtained through household interviews. Recall problems are expected with household respondents and can prevent them from providing the detailed medical information about diagnoses, diagnostic/therapeutic procedures, and medications all of which are collected in NHAMCS by abstracting from patients' medical records.

The Medical Expenditure Panel Survey (MEPS) Household Component, conducted by the Agency for Healthcare Research and Quality (AHRQ), is based on a subsample of households that participated in the previous year's NHIS. This survey provides-nationally representative data on health care utilization, expenditures, insurance coverage, sources of payment, and access to care measures at the individual and family level. MEPS has a linked Medical Provider Survey that acquires more detailed information on the sources of payment and the associated medical procedures and medical diagnoses that characterize the medical events that the household respondents have experienced. Like NHIS, MEPS is a household survey of the civilian, noninstitutionalized population and health care use data are reported by household respondents. The design of NHAMCS differs in that it is a provider-based survey with a slightly broader population (e.g., includes homeless populations). Health care utilization estimates will therefore differ between MEPS and NHAMCS due to different survey methodologies and sources of error.

The State Emergency Department Databases (SEDD), conducted by AHRQ, are databases from data organizations in 39 participating U.S. states that capture discharge information on all ED visits that do not result in an admission. SEDD contain clinical and resource use information included in a typical discharge abstract, such as diagnoses, procedures, patient demographics, and expected payment sources; however, NHAMCS collects data on reason for visit, external cause of injury, and medications that are not included in SEDD. Furthermore, data collected from SEDD varies from state-to-state, whereas NHAMCS data collection procedures are standardized nationwide.

The purposes of all these data collection systems and the contents and utility of the resulting data are distinctly different from the proposed NHAMCS data collection. Consequently, the information available from these systems is not adequate as a robust picture of the current state of the U.S. health care system in EDs as provided by NHAMCS data and cannot be used as an alternative.

5. Impact on Small Businesses or Other Small Entities

Some NHAMCS respondents are small hospitals. In order to reduce respondent burden for these and all responding hospitals, patient visit sampling is used to minimize data collection workload. The data collected on each patient visit are limited to a minimum number of key items which adequately describe the utilization of hospital emergency services at a given location. FRs are responsible for data collection using computerized PRFs. If the facility refuses to allow FRs to access their medical records, the FRs can work with the hospital staff in data collection.

6. Consequences of Collecting the Information Less Frequently

Collecting ambulatory care information less frequently would make it difficult to track the rapidly changing environment in hospital ambulatory health care delivery. An annual NHAMCS data collection ensures that there is timely data to inform decision making, describe current ED practices, monitor trends, and inform policy changes. It also enables the continued study of well-established issues such as ED crowding, antibiotic use, preventive services, or any of the other analytic examples presented in the package.

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

A 60-day notice was published in the Federal Register on January 28, 2020, volume 85, number 18, page numbers 4990-4991 (**Attachment B1**). No public comments were received.

b. Efforts to Consult Outside the Agency

NHAMCS is an ongoing survey, and experts are consulted by NCHS on survey advice as needed. NCHS will continue to work closely with these outside individuals and agencies as the need for consultation arises. Currently, there are no unresolved issues with the survey. A list containing the names of the consultants is provided in **Attachment F**.

9. Explanation of Any Payment or Gift to Respondents

NHAMCS will not offer a payment or gift to respondents for participation.

10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This submission has been reviewed by the Information Collection Review Office (ICRO), who determined that the Privacy Act does apply. The applicable System of Records Notice is 09-20-0167 Health Resources Utilization Statistics. The NCHS Privacy Act Coordinator and the NCHS Confidentiality Officer have also reviewed this package and have determined that the Privacy Act is applicable.

An assurance of confidentiality is provided to all respondents according to section 308(d) of the Public Health Service Act (42 U.S.C. 242m(d)) 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 (Title III of the Foundations for Evidence-Based Policymaking Act of 2018 (Pub. L. No. 115-435, 132 Stat. 5529 § 302)) 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 this section, 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 subchapter, 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."

The computerization of NHAMCS has eliminated the need to record potentially identifiable information on paper. Although medical record numbers are entered into computerized instruments, they are only used for survey operations purposes to assist FRs in abstracting data from the various record systems in the facility. Once the NHAMCS case is complete and data are ready to be transmitted to NCHS, the medical record numbers are erased from the dataset and no longer retained.

A routine set of measures are in place to safeguard the confidentiality of NHAMCS participants. Confidential data are treated in a secure manner and are not disclosed. All staff with access to confidential information are given instruction by NCHS staff on the requirement to protect confidentiality and are required annually to sign a pledge to maintain confidentiality. Only 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 on a secure server, the Consolidated Statistical Platform (CSP), on the NCHS network. Any records that are held by U.S. Census Bureau or other NCHS agents are deleted permanently from their networks after the data has been released to the public, pursuant with the requirements of the latest IRB approval. Computerization of the survey has decreased the risk of losing confidential information; NHAMCS data are collected on a secure laptop with limited network connectivity and encrypted before transmittal.

NHAMCS visits level and some provider level data are made available to the public on our NCHS website, but the provider level data are only available through the NCHS Research Data Center (RDC). Confidential data are never released to the public. Personal identifiers, such as hospital name, address, and patients date of birth are always removed from the publicly-released data. All publicly-released data are reviewed by the NCHS Disclosure Review Board to avoid data breaches.

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

The NHAMCS data collection plan has been approved by NCHS's Ethics Review Board (ERB) (Protocol #2016-04, **Attachment G1**) based on 45 CFR 46. In addition, the ERB has granted a waiver of the documentation of informed consent by hospitals (**Attachment G2**).

12. Estimates of Annualized Burden Hours and Cost

a. Burden Hours

The NHAMCS is expected to sample about 410 hospitals each year. In previous requests for approval for NHAMCS, the response rates of the latest public available data were used to estimate the annualized burden hours. However, in this request we have calculated the annualized burden hours as though all sampled hospitals will respond and provide full participation during abstraction of ED visit data. While we recognize that, in reality, not all respondents will complete the survey or fully participate, this method of estimation of burden for NHAMCS is comparable to the approach used by many other surveys conducted by NCHS.

This submission requests OMB approval for the completion of the 2020 data collection and for the following three years of NHAMCS data collection. The estimated annualized burden is 1,500 hours and is summarized in the table below. With the addition of the COVID-19 questions and the new ESA eligibility questions starting with the 2021 data collection, we anticipate that the change in burden would be minimal enough to be absorbed in the estimated annualized burden above.

For the 2020 (**Attachment H1**) and 2021-2023 (**Attachment H2**) data collection, each sampled hospital receives an introductory letter, along with endorsement letters from professional organizations that support the survey (**Attachment I**). The letter provides an overview of the study and is the primary tool to obtain informed consent to participate in the study. An overview of the process of obtained informed consent is provided in **Attachment J**. The hospital is contacted by a U.S. Census field representative who determines the eligibility of the facility and asks the hospital liaison to complete a Hospital Induction questionnaire. A complete Induction takes approximately 30 minutes. For each year, approximately 410 sampled hospitals are sampled and asked to complete the Hospital Induction questionnaire. This survey instrument has questions on hospital characteristics and focuses on only the ED setting. The total expected response burden for the 2020 NHAMCS hospital induction is estimated at 69 hours annualized over the 3 years. The 2021 NHAMCS hospital induction questionnaire is expected to be 205 hours annually.

Ambulatory units within the ED are referred to as emergency service areas (ESAs), with most EDs having only 1-2 ESAs. Each ESA in the ED will be inducted using the Ambulatory Unit Induction questionnaire, which takes about 15 minutes to complete. For the 2020 data collection, assuming each ED has two ESAs for each year of data collection, we estimate a total response burden of 68 hours annualized across the three years. And, we expect the Ambulatory Unit Induction questionnaire for the following three years will be completed by no more than 820 respondents, with a total response burden of 205 hours annually.

Next, a set number of 100 ED visits will be targeted for abstraction from each sampled hospital using the PRF by U.S. Census Bureau staff. As this abstraction is performed by Census Bureau staff, and not hospital staff, burden for the completion of these PRFs does not exist. However, there is an anticipated 1 minute of response burden to be incurred by hospital staff when trying to orient the U.S. Census Bureau FR to their medical record system, or in certain cases where the hospital does not grant full access to the FR, to pull records from their system and relay that information. The annualized burden to complete this process is estimated at 228 hours for the 2020 data collection (**Attachment K1**), and 683 hours for the 2021-2023 data collection (**Attachment K2**).

The reabstraction study was discontinued beginning in the 2019 NHAMCS and was replaced with a reinterview to assess consistency of responses provided during the Hospital Induction Interview. This

quality control measure will be administered by U.S. Census Bureau staff to approximately 30% of sampled hospitals, or a total of 125 hospitals, and is initiated after the initial Hospital Induction is completed. The hospital administrator is provided a letter informing them they will likely be asked to participate in a reinterview by telephone, which takes approximately 15 minutes. It is estimated that the annualized burden to the respondents will total 31 hours for the 2020 data collection (**Attachment L1**), and 11 hours for the 2021-2023 data collection (**Attachment L2**).

Table 2a. Estimated Annualized Burden to Respondents by Year

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Response Burden (in hours)
Hospital Chief Executive Officer	Hospital Induction Data Collection (2020)	137	1	30/60	69
Hospital Chief Executive Officer	Hospital Induction Data Collection (2021-2023)	410	1	30/60	205
Ancillary Service Executive	Ambulatory Unit Induction Data Collection (2020)	273	1	15/60	68
Ancillary Service Executive	Ambulatory Unit Induction Data Collection (2021-2023)	820	1	15/60	205
Medical Record Clerk	Retrieving Patient Records (2020)	137	100	1/60	228
Medical Record Clerk	Retrieving Patient Records (2021-2023)	410	100	1/60	683
Ancillary Service Executive	Telephone Reinterview (2020)	42	1	15/60	11
Ancillary Service Executive	Telephone Reinterview (2021-2023)	125	1	15/60	31
Total					1,500

Note: The burden for the 2020 data collection using questionnaires without the revised CIPSEA language, and the 2021-2023 data collection using questionnaires that have the revised CIPSEA language are shown in the table above.

Table 2b. Summary Estimated Annualized Burden to Respondents – 2020, 2021-2023

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Response Burden (in hours)
Hospital Chief Executive Officer	Hospital Induction Data Collection (2020, 2021-2023)	547	1	30/60	274
Ancillary Service Executive	Ambulatory Unit Induction Data Collection (2020, 2021-2023)	1,093	1	15/60	273
Medical Record Clerk	Retrieving Patient Records (2020, 2021-2023)	547	100	1/60	911
Ancillary Service Executive	Telephone Reinterview (2020, 2021-2023)	167	1	15/60	42
Total					1,500

b. Burden Cost

The average cost for hospital staff to participate over the three data collections is estimated to be $70,836.56. The hourly wage estimate was based on the Bureau of Labor Statistics May 2018 National Occupational Employment and Wage Estimates, North American Industry Classification System (NAICS) code 622100 – General Medical and Surgical Hospitals (https://www.bls.gov/oes/current/naics4_622100.htm).

Table 3. Estimated Annualized Burden Cost

Type of Respondent	Form Name	Response Burden Hours	Hourly Wage Rate	Respondent Cost
Hospital Chief Executive Officer	Hospital Induction Data Collection (2020)	69	$117.37	$8,098.53
Hospital Chief Executive Officer	Hospital Induction Data Collection (2021-2023)	205	$117.37	$24,060.85
Ancillary Service Executive	Ambulatory Unit Induction Data Collection (2020)	68	$58.88	$4,003.84
Ancillary Service Executive	Ambulatory Unit Induction Data Collection (2021-2023)	205	$58.88	$12,070.40
Medical Record Clerk	Retrieving Patient Records (2020)	228	$19.40	$4,423.20
Medical Record Clerk	Retrieving Patient Records (2021-2023)	683	$19.40	$13,250.20
Ancillary Service Executive	Telephone Reinterview (2020)	11	$117.37	$1,291.07
Ancillary Service Executive	Telephone Reinterview (2021-2023)	31	$117.37	$3,638.47
Total				$70,836.56

13. Estimates of Other Total Annual Cost Burden to Respondents and Record keepers

There are no annual capital or maintenance costs to the respondent resulting from the collection of information for NHAMCS.

14. Annualized Cost to the Government

The estimate of average annual cost for the next three years of NHAMCS is given below.

Table 4. Annualized Cost to the Government

Cost	Item
Interagency agreement for data collection with U.S. Census Bureau	$4,200,000

Printing of public relations materials and reports	$55,000
Contract (medical coding, data entry, and keying/coding quality control)	$400,000
Sponsoring agency expenses (salaries, benefits, and other misc.)	$802,440
Average total costs for 12 months	$5,457,440

15. Explanation for Program Changes or Adjustments

The currently approved annual total burden is 788 hours and the proposed total burden is 1,500 hours. The adjusted increase of 712 burden hours is due to the new method of calculating burden to include all sampled hospitals.

16. Plans for Tabulation and Publication and Project Time Schedule

Plans for the tabulation and publication include the timely release of NHAMCS data files, in addition to NCHS web tables, and *NCHS Data Brief* and other reports. The annualized project timeline is provided in Table 5, where [year of study] represents one year over the next three years.

Table 5. Project Time Schedule

Activity	Time Schedule
Begin [year of study] data collection	Immediately after OMB approval
Begin internal data editing (conducted on a quarterly basis after delivery of data)	Within 4 months of OMB approval
Close out [year of study] field work	Within 18 months of OMB approval
End data processing and internal data editing	Within 19 months of OMB approval
Publish first NCHS Data Brief	Within 22 months of OMB approval
Public-use data available on Internet	Within 2 years of OMB approval

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

The display of the OMB expiration date is not inappropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.