MASSACHUSETTS GENERAL HOSPITAL
HARVARD MEDICAL SCHOOL

Internal Medicine Associates
15 Parkman Street, Suite E, WAC 625
Boston, Massachusetts 02114-3117
Tel: 617-724-3450, Fax 617-724-0929
Email: jgoodson1@partners.org

John D. Goodson, MD
Associate Professor of Medicine
Harvard Medical School
Physician, Internal Medicine Associates
Founder, Stoeckle Center for Primary Care Innovation
Massachusetts General Hospital

June 30, 2021

Sonja Williams, Acting Team Lead
Ambulatory Care Team, Ambulatory and Hospital Care Statistics Branch
Division of Health Care Statistics
National Center for Health Statistics
Center for Disease Control

Re: National Ambulatory Medical Care Survey (NAMCS) -- NCHS invites comments to OMB on 2021-23 revision (by 7/1)

Dear Ms. Williams,

We appreciate the opportunity to comment on the proposed revisions to National Ambulatory Medical Care Survey (NAMCS). We believe that the NAMCS is an invaluable source of clinician-based descriptive ambulatory medical care service data. With our comments below, we will not only address specific questions about health center (HC) data collection but also share the concerns we have about the current sampling and information collection strategies.

We believe that events of the last 10 years call for a very substantial upgrade in the NAMCS. We offer our thoughts to the NCHS and the CDC with the best interests of our country, its residents, and the health care workforce foremost. In many ways, the NAMCS complements other national data sources such as NANES and the MEPS, providing data on ambulatory care delivery from the perspective of clinicians per se. The foundational goals for the NAMCS remain relevant, if not more relevant than ever.

The Affordable Care Act (ACA), the value-based payment paradigm incentives and reporting expectations, the consolidation of small and independent practices into larger and larger enterprises, the rapid adoption of EHRs, the emergence of advance practice clinicians (NPs, PAs, APRNs), the transition from ICD-9 to ICD-10 have all changed the landscape of healthcare delivery this last decade. In addition, the shifting composition of the total workforce, bundled payments, the ever-expanding therapeutic choices, the broader health promotion expectations for all ages, and the aging population have profoundly impacted ambulatory care delivery in the US. And then came COVID-19 and the concurrent national interest in addressing longstanding health care disparities. This last decade has witnessed more change in outpatient care than any previous similar decade.

Those of us in the health policy community assessing the impacts, good and bad, intended and unintended, on the day-to-day care of individuals, need robust, reliable, and representative data. As a country, we expect active surveillance of our borders but as a country we do not have the same

commitment to vigorous internal surveillance of our healthcare delivery, especially in the office and in the community. We see the NAMCS as a critical element of these internal healthcare surveillance tools. This is appropriately purview of the CDC. The detection and tracking of the nation's health depend on data collection and response capabilities. The ambulatory workforce, especially the cohort of primary care clinicians, is central to an effective response to any acute crisis (natural disasters as well as pandemics) as well as the longstanding chronic health crises of any number of chronic conditions such as diabetes, heart disease, hypertension, personal safety, and addiction.

We will use this comment opportunity to raise several questions about how the NAMCS should be configured for the future.

Specific comments

1. We agree with the focus on community HCs and the expanded sampling. We would emphasize the need to oversimple rural community health centers so as to ensure data reliability. Most CHCs are in urban or near urban sites with overlapping options for access. Many rural areas have only HC access

2. We are concerned about the clinician data bases available for sampling and how they are used. AMA and AOA data, though inclusive of MDs and DOs, may not provide accurate site of care data. Furthermore, this data may not include advanced practice clinicians (NPs, PAs, etc.). Roughly 50% of the non-MD/DO clinicians are working in specialty practices. In addition, there are more now working autonomously or nearly autonomously.

3. There are several new practice models that need to be adequately represented in data collection. There are traditional independent and small practices, there are single specialty and multispecialty practices, there are salaried practices, there are RVU-based compensation practices, there are large enterprise practices, there are direct primary care practices, there are concierge practices, there are acute care practices (Minute Clinics, etc.), and others. The range of non-primary care is not as broad but there is a range. We would favor an explicit commitment by the Bureau to defining this landscape, calibrating the importance of each type of practice, and then sampling and surveying the "80-90% case," the practice options that are used by 80-90% of the population.

4. The use of EHRs for data is problematic. Patient demographic data is the most reliable. However, the medications and medical problems addressed are not. Medication list validity depends on the willingness of the clinician or his/her staff to curate. This is time consuming and frequently neglected in the rush of clinical care. As an active primary care internist (JG) I have seen many inaccuracies. Some are related to the mistakes of other staff members (active medications that are deleted) or neglect (inactive medications are not removed). Medical problems used for billing purposes are not inclusive of all the issues addressed at a visit unless the clinician is scrupulous and thorough. Important problems, such as longstanding physical disabilities, are just not listed, though they may be fundamental to a patient's health.

5. Response rates for the NAMCS have fallen. In our review of the last decade, the response rates have fallen from the mid 60% to the mid 30% range. This speaks for itself. With this low level of participation, the data becomes more and more unstable despite statistical efforts to compensate.

Suggestions for the future of the NAMCS

1. We fear that existing tools as described will not provide the needed data. EHRs are not the solution. Big data does not necessarily equate to better or more reliable data.

2. The clinician community must be brought into the planning process. Importantly, the AMA cannot be the default options. Only 20-30% of participating MDs are members.[1] Other professional organizations such as ACP, AAFP, SGIM in primary care and ASCO, ACC, ADA, TES, and more should be recruited in support of a new national commitment to a self-assessment of ambulatory care.

3. Direct observation will be needed. EHR data can be complementary but having survey workers at practice sites to guarantee complete and accurate data remains the gold standard.

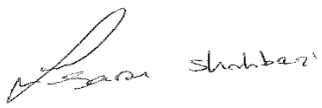
4. New instruments will be needed that capture the work delivered. We have used existing NAMCS data[2] to compare work completed among specialties but with this we have only come to know how much more needs to be known. For example, more accurate diagnostic coding is needed, and medication lists need to be accurate and validated.

5. Sampling needs to be reconfigured to capture the full range of practice sites, as noted above.

There is much more to be considered. We encourage the Bureau to expand it commitment over the years ahead so that we and others can have the data we need to assess the impacts of policy changes, changes in practice economics, and the unmet needs of the population. We remain fully supportive of the Bureau and the Center and are available to assist in any way that might be helpful.

Most sincerely,

John D. Goodson, MD
Physician, Massachusetts General Hospital
Division of General Internal Medicine
Department of Medicine
Associate Professor of Medicine
Harvard Medical School
Boston, MA 02114
JGoodson1@MGH.Harvard.edu



Sara Shahbazi, PhD
Research Scientist
Division of General Internal Medicine
Department of Medicine
Massachusetts General Hospital
Boston, MA 02114

References

1. Laugesen, M. *Journal of health politics, policy, and law*. 2019; 44: 67-85.

2. Goodson JD, Shahbazi S, Rao K, and Song Z. *Differences in the Complexity of Office Visits by Physician Specialty: NAMCS 2013-2016*. J Gen Intern Med. 2020 Jun;35(6):1715-1720. PMID: 32157646.