2024 NATIONAL AMBULATORY MEDICAL CARE SURVEY (NAMCS) PROVIDER SURVEY COMPONENT TECHNICAL DOCUMENTATION

For Physician and Physician Associate Restricted Use Data Files

Division of Health Care Statistics
National Center for Health Statistics
December 2025

Overview

This document provides detailed information and guidance for users of the 2024 National Ambulatory Medical Care Survey (NAMCS) Provider Survey Component restricted use data files. Restricted use files may only be accessed in the National Center for Health Statistics (NCHS) Research Data Center (RDC) and other federal data centers. The RDC is responsible for protecting the confidentiality of survey respondents, study subjects, and institutions while providing access to restricted use data for statistical purposes. For information on how to access the restricted versions of the 2024 NAMCS Provider Survey Component data files through the RDC, please see: https://www.cdc.gov/rdc/restricted-nchs-variables/namcs-nhamcs.html.

There are two separate data files available in the NAMCS Provider Survey Component: one for physicians and one for physician associates, formerly known as physician assistants (PAs). The NAMCS Provider Survey Component collects provider-level data through a self-administered, mixed-mode survey (web and mail modes) from two nationally representative samples, the first being office-based physicians and the second being office-based PAs. The 2024 NAMCS Provider Survey Component is conducted by NCHS and is a member of the National Health Care Surveys – a family of surveys which measure health care utilization across a variety of health care providers and settings.

Section 1 of this document includes information on the scope of the survey, the data sources, and the confidentiality protections related to the data. Section 2 contains details on the sampling process and data collection procedures. Section 3 provides information on sampling, eligibility, and response rates.

It is important to note that, because of low survey response potentially resulting in systematic differences between respondents and nonrespondents, these data are unweighted and reflect sample counts only. An inflation factor typically assigned to each record to produce national estimates has not been included on either file. Unweighted sample data should not be presumed to be nationally representative.

Section 4 details the contents of the 2024 NAMCS Provider Survey Component restricted use data files and the edits used in the creation of the files. Because the data are unweighted, no information is provided on producing variance estimates, or on NCHS presentation standards for proportions, counts, and rates, or their relation to NAMCS Provider Survey Component data. Section 5 provides information on item missingness, and Section 6 provides a list of preferred reporting items for complex sample survey analysis.

Suggested Citation

Technical Documentation: National Center for Health Statistics. Division of Health Care Statistics. *2024 National Ambulatory Medical Care Survey (NAMCS) Provider Survey Component Technical Documentation for Physician and Physician Associate Restricted Use Data Files,* December 2025. Hyattsville, Maryland.

Physician Data File: National Center for Health Statistics. Division of Health Care Statistics. 2024 National Ambulatory Medical Care Survey (NAMCS) Provider Survey Component: Physician restricted use data file. 2025. Hyattsville, Maryland.

Physician Associate Data File: National Center for Health Statistics. Division of Health Care Statistics. 2024 National Ambulatory Medical Care Survey (NAMCS) Provider Survey Component: Physician Associate restricted use data file. 2025. Hyattsville, Maryland.

Contact Information

Data users can find the latest information about the NAMCS Provider Survey Component on our website, at: https://www.cdc.gov/nchs/namcs/about/index.html. If data users have queries about the data files, they may send their question through email to ambcare@cdc.gov, or call us at 301-458-4600. A response to data user inquiries is generally provided in 1-2 business days.

NCHS also has an ambulatory health care data listserv, where updates and information about the most recent ambulatory care data (including the NAMCS Provider Survey Component) are sent out. Details on how to subscribe to the NCHS Listserv for ambulatory health care data can be found at: https://www.cdc.gov/nchs/products/nchs_listservs.htm.

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Section 1 About the National Ambulatory Medical Care Survey Provider Survey Component

Section 1.1 Background

The National Ambulatory Medical Care Survey (NAMCS) Provider Survey Component was first piloted in 2023 as a provider survey that collects data on two types of U.S. health care providers: physicians and physician associates (PAs). The 2024 survey year marks the second time that NAMCS has collected data from PAs.

NAMCS originally began as a national survey of office-based physicians and their visits in 1973. To be eligible for the survey, physicians had to be non-federally employed and primarily engaged in direct office-based patient care. NAMCS was conducted annually through 1981, again in 1985, and continued annually from 1989 through 2019. Statistics were collected at both the physician and the visit level. Visit-level data collection was severely impacted by the COVID-19 pandemic, and only physician-level data files were released through the NCHS Research Data Center for 2020 and 2021. The survey was not fielded in 2022 but was reintroduced in 2023 as a pilot, beginning with the restructured provider-level survey. No visit data were collected with the NAMCS Provider Survey Component in 2023 and 2024. Because of low response rates, the decision was made to only release unweighted survey data in the NCHS Research Data Center for both years. The 2024 survey is similar to the 2023 survey, with some differences as described below.

The NAMCS Provider Survey Component collected data on general provider characteristics and areas of special interest. For 2024, these areas include:

- workforce, revenue, and compensation;
- electronic health records and telemedicine;
- health equity and language barriers;
- pain treatment and treatment with opioids (asked of physicians only); and
- provider autonomy (asked of PAs only).

In 2024, 10,000 health care providers were sampled; 5,000 of these were physicians and 5,000 were PAs. The Physician file contains data for the 422 eligible physicians who participated in the survey, while the PA file contains data for the 399 eligible PAs who participated. For more detailed information regarding the sampling methodology, see Sections 2.2 and 2.3.

Section 1.2 Data Sources

In 2024, the NAMCS Provider Survey Component was a primary data collection which used a self-administered, mixed-mode survey in both web and mail formats. For more information on data collection, see Section 2.4.

Section 1.3 Data Confidentiality

NCHS and its agents take the security and confidentiality of the NAMCS Provider Survey Component very seriously. Strict laws have been implemented to establish minimum Federal standards for safeguarding the privacy of individually identifiable health information. Assurance of confidentiality is provided to all survey participants according to Section 308(d) of the Public Health Services Act [42 United States Code 242m (d)]. Strict procedures according to Section 3572 of the Confidential Information Protection and Statistical Efficiency Act (44 U.S.C. 3561-3583) are utilized to prevent disclosure of personal identifiable information in NAMCS Provider Survey Component data. All information which could identify a participating physician or PA is confidential and seen only by persons associated with NAMCS Provider Survey Component and is not disclosed or released to others for any other purpose. Prior to the release of restricted use and public use data files, if any, NCHS conducts extensive disclosure risk analysis to minimize the chance of inadvertent disclosure. As a result, selected characteristics and/or data elements may be omitted or masked even on restricted files to minimize the potential risk of disclosure. Masking is typically performed in such a way to cause minimal impact on the data.

The protocol for the NAMCS Provider Survey Component has been approved by the NCHS Research Ethics Review Board since it was first piloted in 2023.

Section 2 Methodology

Section 2.1 Brief Overview

The 2024 NAMCS Provider Survey Component included two independent national probability samples, one for office-based physicians and another for office-based PAs, to produce estimates of provider characteristics. These samples included 5,000 physicians and 5,000 PAs, respectively. The samples were each designed to allow for nationally representative estimates for each of these provider groups in the United States. As previously stated, however, because of low survey response, the decision was made not to weight the data, and nationally representative estimates cannot be made. The data reflect sample counts only.

Section 2.2 Physician Frame and Sampling Design

The target population for the NAMCS Provider Survey Component physician survey included non-federally employed physicians (doctors of medicine [MDs] and doctors of osteopathy [DOs]) practicing in the United States and classified as engaging in office-based patient care. Those specializing in radiology and pathology were excluded as in previous years of NAMCS. Anesthesiologists (who had been out of scope in all previous years of NAMCS, with the exception of a test sample in the second half of the 2021 survey year) were included if they were also classified as office based. For the universe of physicians, NCHS obtained a file of MDs from the American Medical Association (AMA) and a file of DOs from the American Osteopathic Association (AOA). These were used to construct the lists that were later used as the sampling frame. To be included in this sampling frame, NCHS created the following list of eligibility criteria:

- self-designated primary specialty that was within the list of eligible specialties provided by NCHS;
- practicing in nonfederal settings;
- having an age younger than 71 years;
- practicing within any of the 50 U.S. states or the District of Columbia;
- engaged in office-based patient care defined by primary type of practice and primary present employment code;
- may be hospital employed (as a proxy for physicians working in practices owned by hospitals; those selected in this group who were determined during data collection not to be working in a hospital-owned practice were screened out as ineligible); and

- may have an undetermined primary employment status that placed them in a “no classification” stratum.

Similar criteria were used for both the AMA and the AOA sampling frames which were later combined for the sample selection.

Sampling stratification variables were region and a recode of self-designated specialty into broader physician specialty groups which included general/family medicine, osteopathy, internal medicine, pediatrics, general surgery, obstetrics and gynecology, orthopedic surgery, cardiovascular diseases, dermatology, urology, psychiatry, neurology, ophthalmology, otolaryngology, anesthesiology, an “other” group for all other eligible specialties, and those in an eligible specialty but whose primary employment status was unclassified at the time of sampling (eligibility for this group was determined during the data collection process). The sample was then selected using stratified systematic sampling based on the cross-classification of region and physician specialty group.

The design for the physician sample in 2024 NAMCS was essentially the same as 2023 NAMCS. Differences between the 2023 NAMCS sampling design compared with 2021 NAMCS are described in the 2023 NAMCS Provider Survey Component Technical Documentation.

Section 2.3 Physician Associate Sampling Design

The NAMCS Provider Survey Component target population for the PA survey included non-federally employed PAs practicing in the United States and classified as engaging in office-based patient care. Some PA specialty groups were identified as ineligible, using similar guidelines to those used with the 2023 and 2024 NAMCS Provider Survey Component physician sample (see Section 2.2) and previous years of NAMCS. Ineligible specialty groups included PAs specializing in radiology and pathology. PAs with a specialty of anesthesiology were included if they were also classified as office based in both 2023 and 2024. Previously, providers in this specialty had been out of scope in NAMCS with the exception of a test sample in the second half of the 2021 NAMCS.

For the universe of PAs, NCHS obtained a file from the American Academy of Physician Associates (AAPA). This was used to construct the initial provider list that was later used as the sampling frame. The 2024 PA sample had the following characteristics:

- A sample size of 5,000 PAs;
- The sample size allocation of a minimum sample size of PAs to smaller strata and allocation of

the remaining sample proportionally to the larger strata;

- PA age was younger than 71 years; and
- PAs with a specialty of anesthesiology were included in a separate sampling strata; PAs unclassified as to type of employment and PAs without a listed specialty were included in additional sampling strata.

As in 2023, some important differences between PA sampling and physician sampling are the following:

a. Physicians must have had a primary specialty indicated by the physician to be included in that sample. However, PAs were not required to have a primary specialty listed in the universe file. For this reason, PAs with a missing primary specialty were included in the survey.

b. The AAPA file did not include osteopathic providers. This stratum was only used in the physician sample.

c. NAMCS sampling includes hospital-employed physicians and PAs with the intent to include physicians and PAs who work in practices owned by hospitals. In the physician sampling, there was an indicator that was used as a proxy indicating such cases. However, this information was not available for PAs, so this criterion was not applicable in PA sampling. Hospital-employed PAs therefore may or may not be present in the sample.

d. The original design called for PAs practicing in community health centers (CHCs) to be included in the sampling design. However, the AAPA file did not contain information that could identify PAs practicing in a CHC. Therefore, they were unable to be included systematically, and it was not known at the time of sampling if there were CHC-employed PAs in the sample.

e. The physician universe file identified those presumed dead, retired, or inactive, so these cases could be excluded from the universe. However, this information was not available for PAs, so these exclusion criteria were not applicable for PA sampling. The sample therefore could include PAs who were in these categories.

Sampling stratification variables were region and a recode of self-designated individual specialty to broader PA specialty groups for sampling. These included general/family medicine, internal medicine, pediatrics, general surgery, obstetrics and gynecology, orthopedic surgery, cardiovascular diseases, dermatology, urology, psychiatry, neurology, ophthalmology, otolaryngology, anesthesiology, an “other” group for all other eligible specialties, those whose primary employment status was unclassified at the time of sampling but would be confirmed during data collection, and those who primary specialty was

unclassified at the time of sampling. The sample of PAs was selected using stratified systematic sampling based on the cross-classification of region and PA specialty group. Similar to sample size allocation for the physician sample, a hybrid sample size allocation (between equal allocation and proportional allocation) was implemented to ensure sufficient cases for analysis in the smaller strata and at the same time larger strata did not have too many cases.

Section 2.4 Data Collection Procedures

The 2024 NAMCS Provider Survey Component physician and PA surveys shared a single survey instrument, which was administered in a mixed-mode format, with the two separate modes being web and mail. A minority of participating providers (35.6% of physicians and 40.1% of PAs, unweighted) completed the survey using the mailed paper questionnaire, while the remainder completed it using the web instrument. Most survey questions were asked of both physicians and PAs. One section of questions on pain treatment and treatment with opioids was asked only of physicians, while another section of questions on provider autonomy was asked only of PAs. The sampled provider was the preferred respondent, but knowledgeable office staff or other proxies were also allowed to respond. For most respondents, the sampled provider responded, with 85.6% (unweighted) of physicians and 92.7% (unweighted) of PAs completing the survey themselves.

Data collection was conducted by RTI International, Research Triangle Park, NC and occurred over a 5-month period in 2024-2025. Similar fielding strategies and procedures were used for both physicians and PAs. NCHS and RTI invited sampled providers to participate in the survey by using up to five mail contacts and up to seven email contacts. For all questionnaires received, data keying and initial processing was carried out by RTI. NCHS developed and performed comprehensive edits and data quality checks on the files received from RTI.

Section 2.5 Weighting

Weighting was initially conducted to produce physician-level estimates for the physician survey and PA-level estimates for the PA survey. Weighting methods were designed to account for sampling probabilities and nonresponse. However, due to low survey response and concerns raised during a comparison of the 2023 respondents and non-respondents, the decision was made not to weight these data and to release them only as unweighted files in the RDC. That is, the files only reflect sample counts, not national estimates.

Section 3 Sample Size, Eligibility, and Response Rate

Section 3.1 Physician Survey

The 2024 NAMCS Provider Survey Component physician sample included 5,000 physicians: 4,780 MDs and 220 DOs. A total of 183 physicians did not meet all of the criteria and were determined to be ineligible for the survey. The most frequent reasons for being ineligible were that the physician was retired or deceased, did not provide ambulatory care, or was not office-based. A majority of the sampled physicians (90.4%) did not respond to the survey and their eligibility could not be determined (n=4,356). Of the 422 physicians who responded to the survey, 413 were full respondents and 9 were partial respondents. The unweighted response rate was 11.8%, based on the number of full and partial responders. See Table 3.1 below for more details.

Table 3.1 Final disposition of the 2024 NAMCS Provider Survey Component physician sample

Final Disposition	Unweighted
Total number of physicians sampled	5,000
Final=1, Eligible respondent, completed survey	413
Final=2, Eligible respondent, refused survey	39
Final=3, Ineligible (out of scope) physician	183
Final=4, Unknown eligibility (made no response to survey)	4,337
Final=5, Unknown eligibility (refused or partial response)	19
Final=6, Eligible respondent, partial response	9
Factor used to estimate eligibility for physicians with unknown eligibility (Eligible physicians divided by all those with known eligibility)	0.72
Physician response rate	11.79

NOTE: Physician response rate was calculated based on AAPOR Response Rate 4, described here: Standards-Definitions-10th-edition.pdf

Section 3.2 Physician Associate Survey

The 2024 NAMCS Provider Survey Component PA sample included 5,000 PAs. A total of 185 PAs did not meet all the criteria and were determined to be ineligible for the survey. The most frequent reasons for being ineligible were that the PA did not provide ambulatory care, was retired or deceased, or was not office-based. Twenty-six PAs responded with a refusal. More than three-quarters of the sampled PAs (87.8%) did not respond to the survey and their eligibility could not be determined (n=4,390). Of the 399 PAs who responded to the survey, 390 were full respondents and 9 were partial respondents. The unweighted response rate was 11.5% based on the number of full and partial responders. See Table 3.2 below for more details.

Table 3.2 Final disposition of the 2024 NAMCS Provider Survey Component physician associate sample

Final Disposition	Unweighted
Total number of PAs sampled	5,000
Final=1, Eligible respondent, completed survey	390
Final=2, Eligible respondent, refused survey	26
Final=3, Ineligible (out of scope) physician	185
Final=4, Unknown eligibility (made no response to survey)	4,372
Final=5, Unknown eligibility (refused or partial response)	18
Final=6, Eligible respondent, partial response	9
Factor used to estimate eligibility for PAs with unknown eligibility (Eligible PAs divided by all those with known eligibility)	0.70
PA response rate	11.45

NOTE: PA response rate was calculated based on AAPOR Response Rate 4, described here: Standards-Definitions-10th-edition.pdf

Section 4 Data Processing

Because of small sample sizes, the data included in the restricted use data files underwent additional processing to facilitate analysis. For some variables, response categories were collapsed into broader categories. These recoded variables are listed below along with their names on the restricted use files. Original data are also included on the files but may be subject to additional scrutiny before they can be released.

- During a typical week, approximately how many patient visits do you personally receive at your reporting location? (ESTTOTVIS_CAT)
    - Data were aggregated into the following categories: under 20 visits; 21-40 visits; 41-60 visits; 61-80 visits; 81-100 visits; more than 100 visits.

- At your reporting location, how many other providers are employed? (NUMPROV_CAT)
    - Data were aggregated into the following categories: 1 provider; 2-3 providers; 4-10 providers; 11-50 providers; 51-100 providers; more than 100 providers.
- At your reporting location, are you a full- or part-owner, employee, independent contractor, or a volunteer? (OWNERSHR)
    - Data were aggregated into the following categories: full owner; part owner; employee; and "other".
- At your reporting location, who owns the practice? (OWNS_RLR)
    - Data were aggregated into the following categories: physician/physician group; health center; academic medical center or teaching hospital; other hospital; other health care corporation; and "other".

Section 5 Survey Content

For the 2024 NAMCS Provider Survey Component restricted use data files, 151 variables were included on the Physician file and 155 variables were included on the PA file. Many of these questions were the same for both types of providers, but certain questions were only asked of physicians while others were only asked of PAs.

The questions asked of both types of providers include general questions about the provider's reporting location, defined as the setting where most patient visits were received. These included number of patient visits received in a typical week, number of providers at the reporting location, single or multi-specialty status, employment status of provider, and ownership of practice. Other items asked of both types of providers included types of payment accepted, acceptance of new patients, electronic health records and telemedicine, and language barriers. Provider demographics (sex, race, ethnicity) were also collected for both types of providers. The COVID-19 questions asked in 2023 were removed for 2024.

A section on pain treatment and treatment with opioids was asked of physicians only. Questions included for physicians only in 2023 on how billing was accomplished for various categories of advanced practice providers (PAs, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists) were not asked in 2024.

PAs were asked to respond to a special section on provider autonomy, which included questions on number of years practicing in current specialty, number of years working clinically as a PA,

supervision/collaboration guidelines, patient panel, billing, and a checklist of 16 tasks which the PA might personally perform.

The files also contain information on whether the survey was submitted on paper or online.

Codebooks for the NAMCS Provider Survey Component were produced separately for each file. Please refer to the 2024 NAMCS Provider Survey Component Physician Restricted Use Data File Codebook and the 2024 NAMCS Provider Survey Component PA Restricted Use Data File Codebook for detailed information on the variables, including variable names, variable type, variable descriptions, and variable values.

Section 5.1 Item Missingness Rates

Unweighted item nonresponse rates for survey items that exceeded 5% are shown in Table 5.1 (for physicians) and Table 5.2 (for PAs). Item nonresponse rates were calculated to include blank entries and responses of "Unknown" or "Don't know" and have been adjusted to account for skip patterns in the data. Imputation was not conducted for any data elements with missing values.

Table 5.1. Item missingness rates for the 2024 NAMCS Provider Survey Component Physician restricted use data file

Variable Name	Variable Description	Denominator	% Missing: Includes blank entries and responses of "Don't Know" and "Unknown"
OWNS_RL	At your reporting location, who owns the practice?	Physicians with OWNERSH ne 1 (n=312 physicians)	6.09
TELE_ISSUE1 - TELE_ISSUE6	At your reporting location, what, if any, issues affect your own use of telemedicine? - Limited Internet access and/or speed issues	All physicians	5.69 (Entire item blank)
SASDAPPT	Does your reporting location set time aside for same day appointments?	All physicians	5.93
INTERPTY1	When you use interpreters at your reporting location, how often do you personally use each type? - Staff/contractor trained as a medical interpreter	Physicians with LIMITED_ENGLISH ne 1 (n=376)	5.86

INTERPTY2	When you use interpreters at your reporting location, how often do you personally use each type? - Bilingual Staff (not formerly trained as an interpreter)	Physicians with LIMITED_ENGLISH ne 1 (n=376)	5.32
INTERPTY4	When you use interpreters at your reporting location, how often do you personally use each type? - Language translation service (iPad/phone-based)	Physicians with LIMITED_ENGLISH ne 1 (n=376)	5.85
RECORD1-RECORD10	What information does your reporting location record on your patients' culture and language characteristics? - Nationality/Nativity, Primary language, sexual orientation, gender identity, race/ethnicity, religion, income, education, other, None	All physicians	5.69 (Entire item blank)
TREAT_PAIN	At your reporting location, do you personally currently treat any patients for pain?	All physicians	5.21
TRTGOAL	When managing your own pain patients at your reporting location, how often do you...Establish treatment goals with your recently diagnosed pain patients? (e.g., less pain, improved function, increased social activities, better sleep quality, etc.)	Physicians with TREAT_PAIN ne (4, 5) (n=240)	8.34
NONRX	When managing your own pain patients at your reporting location, how often do you...Recommend non-pharmacological approaches to your recently diagnosed pain patients before or instead of opioid therapy?	Physicians with TREAT_PAIN ne (4, 5) (n=240)	8.75
NONOPIOID_01-NONOPIOID_08	What types of non-opioid medications do you currently recommend to pain patients at your reporting location? SELECT ALL THAT APPLY.	Physicians with TREAT_PAIN ne (4, 5) (n=240)	6.67 (Entire item blank)
FOLWUP1	After you start opioid therapy on a pain patient at your reporting location, when do you personally re-evaluate him/her?	Physicians with TREAT_PAIN ne (4, 5) and NUMPTS2 ne 1 (n=169)	13.61
RSKSCRN	Prior to starting opioids for pain management at your reporting location, how often do you personally do the following? Screen patients for depression and other mental health disorders.	Physicians with TREAT_PAIN ne (4, 5) and NUMPTS2 ne 1 (n=169)	11.84
RSKBENFT	Prior to starting opioids for pain management at your reporting location, how often do you personally do the following? Discuss risks and benefits of using opioids for pain treatment.	Physicians with TREAT_PAIN ne (4, 5) and NUMPTS2 ne 1 (n=169)	11.24
TREAT_OPIOID	At your reporting location, how many of your own patients are you currently treating for opioid use disorder?	All physicians	9.95
OPIOID_PROG	Does your reporting location have an opioid treatment program where patients could be referred for opioid use disorder?	All physicians	21.33
PRVRACE	What is your race? - Recoded	All physicians	5.21

Table 5.2. Item missingness rates for the 2024 NAMCS Provider Survey Component Physician Associate restricted data file

Variable Name	Variable Description	Description	% Missing: Includes blank entries and responses of "Don't Know" and "Unknown"
ESDOH	Does your reporting location use an EHR to…? Record social determinants of health (e.g., employment, education, race/ethnicity, language and literacy skills)	All PAs with EMEDREC=1 (378)	10.06
TELE_ISSUE1 - TELE_ISSUE6	At your reporting location, what, if any, issues affect your own use of telemedicine? - Limited Internet access and/or speed issues	All PAs	7.02 (Entire item blank)
SASDAPPT	Does your reporting location set time aside for same day appointments?	All PAs	6.02
APPTTIME	On average, about how long does it take to get an appointment with you for a routine medical exam at your reporting location? By 'routine medical exam,' we mean any medical care considered 'routine' for your specialty.	All PAs	6.52
LIMITED_ENGLISH	At your reporting location, how many of your own patients have limited English proficiency?	All PAs	5.27
INTERPTY1	When you use interpreters at your reporting location, how often do you personally use each type? - Staff/contractor trained as a medical interpreter	PAs with LIMITED_ENGLISH ne 1 (n=372)	9.14
INTERPTY2	When you use interpreters at your reporting location, how often do you personally use each type? - Bilingual Staff not formerly trained as an interpreter)	PAs with LIMITED_ENGLISH ne 1 (n=372)	5.37
INTERPTY4	When you use interpreters at your reporting location, how often do you personally use each type? - Language translation service (iPad/phone-based)	PAs with LIMITED_ENGLISH ne 1 (n=372)	5.37
RECORD1-RECORD10	What information does your reporting location record on your patients' culture and language characteristics? - Nationality/Nativity, Primary language, sexual orientation, gender identity, race/ethnicity, religion, income, education, other, None	All PAs	5.01 (Entire item blank)
PRVRACE	What is your race? - Recoded	All PAs	5.01

PA_SUPCOLL	At your reporting location, are there supervision/collaboration guidelines describing the types of decisions you can make or activities you can perform without direct physician involvement in your own patients' care?	All PAs	9.02
PA_OWNPANEL	At your reporting location, do you have your own panel of patients?	All PAs	5.01
PA_CLAIMS	At your reporting location, how are claims submitted most of the time?	All PAs	38.09
PA_REFER	At your reporting location, are there any major activities that you are personally qualified to perform but must refer out to another provider to perform?	All PAs	25.56

Section 6 Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA) Checklist for the 2024 NAMCS Provider Survey Component Restricted Use Data Files

Table 6.1 below provides a Preferred Reporting Items for Complex Survey Analysis (PRICSSA) checklist (Seidenberg, Moser, & West, 2023) for users of the 2024 NAMCS Provider Survey Component Physician restricted use data file. This information may be helpful to users when analyzing data from the file.

6.1 Preferred Reporting Items for Complex Sample Survey Analysis – Physician Restricted Use Data File

Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA)	Description
Name of survey	National Ambulatory Medical Care Survey Provider Survey Component (Physician)
Data collection mode	Self-report by mail using a paper survey instrument or online using a web-based survey instrument
Target population	Office-based physicians primarily engaged in direct patient care in the 50 U.S. states and the District of Columbia
Populations excluded	Federally employed, not primarily engaged in office-based care, age 71 years or older at time of sampling, those specializing in radiology or pathology
Sample design	Stratified systematic sampling
Variance and standard error estimation	Not applicable (unweighted data file)
Weighting	Not applicable (unweighted data file)
Presentation standards	Not applicable (unweighted data file)
Unweighted total sample size	422 physicians
Weighted total sample size	Not applicable (unweighted data file)
Response rate (unweighted)	11.79%
Location of example code	Not applicable (unweighted data file)

Table 6.2 below provides a Preferred Reporting Items for Complex Survey Analysis (PRICSSA) checklist (Seidenberg, Moser, & West, 2023) for users of the 2024 NAMCS Provider Survey Component Physician Associate restricted use data file. This information may be helpful to users when analyzing data from the file.

6.2 Preferred Reporting Items for Complex Sample Survey Analysis – Physician Associate Restricted Use Data File

Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA)	Description
Name of survey	National Ambulatory Medical Care Survey Provider Survey Component (Physician Associate)
Data collection mode	Self-report by mail using a paper survey instrument or online using a web-based survey instrument
Target population	Office-based physician associates primarily engaged in direct patient care in the 50 U.S. states and the District of Columbia
Populations excluded	Federally employed, not primarily engaged in office-based care, age 71 years or older at time of sampling, those specializing in radiology or pathology
Sample design	Stratified systematic sampling
Variance and standard error estimation	Not applicable (unweighted data file)
Weighting	Not applicable (unweighted data file)
Presentation standards	Not applicable (unweighted data file)
Unweighted total sample size	399 physician associates
Weighted total sample size	Not applicable (unweighted data file)
Response rate (unweighted)	11.45%
Location of example code	Not applicable (unweighted data file)

Section 7 Reference

Seidenberg AB, Moser RP, West BT. Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA). J Surv Stat Methodol 11(4). 2023. https://doi.org/10.1093/jssam/smac040.