ATTACHMENT G

Instructions on NAMCS Physician Induction Interview for Field Representatives

CHAPTER B3
NATIONAL AMBULATORY MEDICAL CARE SURVEY QUESTIONNAIRE, NAMCS-1

Introduction

The NAMCS-1 Questionnaire is used to determine therespondent's eligibility for the survey, collect certain information on his/her practice, and establish a sampling pattern to yield approximately thirty completed NAMCS-30 Patient Record forms. What follows is a detailed review of each item.

Continuing in the 2009 Panel, an accompanying NAMCS-1(CC) Control Card will be used to keep personal identifiable information about the respondent separate from the detailed information about his/her practice collected on the NAMCS-1 questionnaire. Personal identifiable information is information that directly identifies the respondent like his/her name, address, or telephone number. The two forms will be used together with the NAMCS-1 questionnaire indicating the personal identifiable information items to be recoded on the control card. When returning completed materials to your regional office, you will ship the control card in a separate box from that used for the NAMCS1 questionnaire.

If a duplicate control card is used an explanation needs to be given and headquarters notified. With out an explanation headquarters will treat it asa lost/missing form.

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1 Physician's address 1

Displays the two digit Regional Office Code (e.g., 21 for Boston), three digit Reporting Week (e.g., 018), the start and ending dates of that reporting week (e.g., December 31, 2007– January 6, 2008), and the four digit physician/provider identification number (e.g., 0001). You will use this number to match to the accompanying NAMCS-1(CC) control card where you will find thename and address of the respondent to be interviewed.

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2 Physician's telephone number 2

Physician's telephone number

Look up the doctor's telephone number(s) in the classified telephone directory (or "Business White Pages") or on the Internet.Check for a listing of office hours (e.g., Monday, Tuesday, and Thursday 9 AM- 5 PM) at the same time.

Enter the telephone number in Item 2 on the cover of the NAMCS1(CC) control card.

Enter the days and hours of the office schedule, if found, in the space provided on page 5 of the NAMCS-1 questionnaire.

You will need the doctor's office schedule to perform the following activites:

1) complete the table on page 5 in the NAMCS-1

2) plan your contacts (telephone screening, reminder, midweek, and follow-up calls) with the office

3) schedule appointments

4) verify when you edit the physician's/provider's reported patient visits when patients are scheduled to be seen during the survey week

Movers

If you cannot find any listing for the doctor either in the telephone directory or from Directory Assistance, you might have a doctor who has moved from the area. Call the local medical society and try to determine if the doctor is still in practice, and if so, where he/she is located. If you have Internet access, you can use web sites such as Fast Data, www.google.com, or www.ama-assn.org to locate a doctor. ***If you find that the doctor has moved out of the PSU, telephone your supervisor immediately*** so that the case can be reassigned to another field representative without loss of time. Before calling, obtain as much information as possible about the doctor's new location. Your supervisor may give you the name and address of the field representative to whom the case is reassigned. If so, you will mail the case directly to that person.

If, while trying to locate the physician's telephone number, you determine that he/she is no longer in practice, complete Check Item A on page 6 and Section III - Noninterview Report of the questionnaire. Before taking this step make every effort to verify your information, to be sure that there is no doubt that the doctor is no longer practicing.

Fax Number

Upon meeting with the physician and his or her staff, obtain and enter the office fax number in Item 2 on the NAMCS-1 Control Card. A fax number will make future correspondence easier.

Fill out the Progress Record as you complete each of the listed sections in the NAMCS-1 questionnaire. List the date the section was completed, your FR code and any notes that will help understand any irregularities. Completing this record will help both Census and NCHS track the length of time cases take from start to finish.

Section I - Telephone Screener

1. Purpose

Section I of the questionnaire is the Telephone Screener. As in 2008 this information will be recorded on the control card. This represents your first and **MOST IMPORTANT** contact with the physician's office. These items are included to perform the following:

1) determine if physician sees any ambulatory patients in a non-federal, non-institutional setting

2) verify the address of the office where the physician sees ambulatory patients

3) arrange an appointment for you to show the doctor and/or office staff the NAMCS forms and explain their participation in the survey

When you make your call to the office, introduce yourself and ask to speak to the physician. If he/she accepts your call, go directly to the Telephone Screener section on page 2 of the NAMCS1.

Frequently the doctor will not be in the office or the office staff will explain that he/she is busy and cannot come to the phone. In such cases, ***ask when it would be convenient for you to call back.***

Remember that your goal is primarily to obtain an appointment to visit the doctor and explain the study.

2. Explanation of Section I Items

Instructions for each of the Telephone Screener items are provided in numeric sequence on the following pages.

4 Record of telephone calls (Record on NAMCS-1 Control Card) 4

In item 4, enter the date, time, and results of***each call*** you make to the doctor's office to complete the Telephone Screener. Please complete this section on the NAMCS1 Control Card.

Record your entries immediately.	Do not trust this information to memory.
Be specific about the results.	For example, "Dr. on vacation. Call back this Thursday 3/15," is more helpful than, "Call back Thursday."
Write legibly.	Your entries will be read by another field representative or NCHS.

5a-b a. Has the physician moved out of the United States? 5a-b
b. Is the physician retired or deceased?

These questions are appropriately placed early in the NAMCS1 to help determine if the physician is in-scope or out-of-scope for the survey. Ask item 5a and mark the appropriate response box. If "Yes", skip to Check Item A. If "No", ask 5b and mark the appropriate response box. If "Yes" to Item 5b, skip to Check Item A. If "No", move to item6.

Community Health Center (CHS): If this interview is with a provider at a CHC, then follow these instructions:

- skip items 5 through 12 on pages 2 though 4
- complete the Office Schedule on page 5
- proceed to page 7 and begin the interview at the**Section II Induction** (If the CHC provider refuses, then return to page 6 and complete items 13a through 13g and CHECK ITEM A)

6 Introduction 6

A sample introduction is provided on the questionnaire. However, it is very important for you to be comfortable in speaking with the physician. Use words appropriate to each situation.

If the doctor indicates unfamiliarity with the letter sent from NCHS, take a few minutes to go over some of the information contained in that letter. **DO NOT READ THE LETTER DIRECTLY TO THE PHYSICIAN.** Simply cover the main points that are included on page 2 of the questionnaire

(below the regular introduction).

Use your own words to explain the concepts. This will be more natural and will have better results. Also, record in the notes at the bottom of page 3 that the physician did not receive the letter.

7a-b Specialty **7a-b**

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a. Your specialty is (...), is that right?
b. What is your specialty (including general practice)?

Item 7a verifies the information that was obtained by NCHS from the AMA or AOA. Specialty is used extensively when NCHS or other data users analyze the data collected. If the listed specialty in 7a is correct, mark "Yes" and skip to item 8. If the listed specialty is not correct, mark "No," obtain the correct specialty from the physician and enter in space provided in item 7b.

Many physicians have a secondary specialty, do not record it in item 7. Only record the physician/providers primary specialty.

Note that general practice is a recognized specialty. Do not take time during the interview to look up and mark the specialty code in item 7b, please enter it after leaving the office. Do not classify cases as in-scope or out-of-scope solely on the basis of specialty.

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8 Which of the following categories best describes your professional activity - patient care, research, teaching, administration, or something else? **8**

The purpose of item 8 is to verify that the assigned physician is eligible for the survey. If you determined this information during your earlier contacts with the office, mark the appropriate box after verifying with the physician.

9a-d a. Do you directly care for any ambulatory patients in your work? **9a-d**

b. PROBE: We include as ambulatory patients any patients coming to see you for personal health services who are not currently on the premises. Does your work include any such individuals?

c. **Are you employed by the Federal Government or do you work in a hospital emergency or outpatient department?**

d. **In addition to working in any of these settings, do you also see any ambulatory patients?**

The purpose of item 9a is to verify that the assigned physician is eligible for the survey. If you determined this information during your earlier contacts with the office, mark the appropriate box without asking. Make sure to follow the skip patterns when given.

NOTE: "Ambulatory patients" are patients who are not being seen as inpatients in a hospital, nursing home or other institution. However, patients who leave the institution and go to a doctor's office for care *are* considered to be ambulatory patients and therefore included in the NAMCS.

10a-b a. **We have your address as** (Read address shown in Item 1). **Is that the correct address for your office?** **10a-b**

b. **What is the (correct) address and telephone number of your office? (Record on NAMCS-1 Control Card)**

Item 10a is to verify information given to NCHS by the AMA and the AOA. In some cases, the physician may have changed the location of his/her practice and you will need the new address.

If the address on the item 1 control card label is incorrect, do the following:

- mark box 2 in item 10a
- ask item 10b
- enter the correct information on the NAMCS1 Control Card

(If the physician offers more than one office location, enter other locations on control card.)

If you determine that the physician moved from the PSU, do the following:

- mark the third box on page 6, Check Item A
- complete Section III– Noninterview starting on page 19
- call your office immediately with the information so that the case can be transferred

Do not complete Item 40 (Final Disposition) or Item 41 (Case Summary) at this time. This information should be completed by the new field representative reassigned to the case (after the editing process).

11 **Thank you, Dr...., but I believe that since you do not (see any ambulatory patients/practice any longer) our questions would not be appropriate for you. I appreciate your time and interest.** 11

This statement is read to end the interview.

IF	THEN
Box 3 in item 9a, indicating that the physician is no longer in practice.	Terminate the telephone callby reading item 11 on page 4. Complete Check Item A on page 6 and Section III - Noninterview on page 19.
Box 2 in items 9b, or box 2 in 9d is marked indicating the physician does not give direct care to ambulatory patients.	Terminate the telephone call by reading item 11 on page 4. Complete Check Item A on page 6 and Section III - Noninterview on page 19.

12 **I would like to arrange an appointment with you within the next week or so to discuss the study. It will take about 30 minutes. What would be a good time for you, before Friday, _____** (last Friday before the assigned reporting week)**?** 12

Before you call, you should review the reporting week displayed on item 1 of the questionnaire and control card.

Read item 12 and attempt to set up an appointment in the doctor's office no later than Thursday of the week before the doctor's reporting week. (The date of the Friday prior to the reporting week is displayed to help in this task. Try to make all appointments ***before*** that Friday, to allow for rescheduling.)

If the physician hesitates, or is unable to set a specific time, have several suggestions ready. Some may include:

"Which hours are better--in the morning or afternoon?"

"Is Wednesday or Thursday better for you?"

Keeping specific blocks of time and days of the week open on your calendar, and suggesting these times if the need arises will aid you in obtaining the appointment. If the screening call resulted in an

appointment, enter the day, date, time, in the boxes provided on the NAMCS-1. Record the office location on the NAMCS-1 Control Card.

If the physician refuses to participate perform the following:

1) mark the check box series
2) complete the item 13 series and Check Item A on page 6 of the questionnaire
3) notify your supervisor **IMMEDIATELY**

Since a follow-up attempt will be made to gain the doctor's cooperation, timeliness is very important.

Provider's Office Schedule

The office schedule should reflect the days and hours the provider will see patients during his/her reporting period. It may be completed ***at any time.*** Its purpose is to assist you in your contact with the office and with your edit of the case.

Obtaining More Information During the Telephone Screener	Occasionally, it may be appropriate or necessary to obtain part or all of the Induction Interview information (Section II, pages 7-18 of the NAMCS-1) during the Telephone Screener call. If a physician refuses to set up a personal interview and agrees to participate only if you send the forms by mail, you will need to obtain the induction information and explain the forms by telephone. If a particular doctor or office manager clearly indicates an interest in participating in the NAMCS, you might find it useful to continue with the induction questions.

PROCEED WITH CAUTION. Experience has shown that there is less likelihood of a refusal occurring if the initial call is limited to the basic screener items and the effort to obtain an appointment for a personal interview.

13a-g **Physician Practice Data for In-scope Refusing Physicians** **13a-g**

I appreciate that you choose not to participate in the study, but I would like to ask a few short questions about your practice so we can make sure responding physicians do not differ from non-responding physicians.

a. At how many different locations do you see ambulatory patients?

b. In a typical year, about how many weeks do you not see patients (e.g., conferences, vacations, etc.)?

c. You typically see patients fewer than half the weeks in each year. Is that correct?

d. You typically see patients all 52 weeks of the year. Is that correct?

e. During your last normal week of practice how many patient visits did you have at all office locations?

f. During your last normal week of practice how many hours of direct patient care did you provide?

g. At the office location where you see the most ambulatory patients:

(1) How many physicians are associated with you?

(2) Is this a single- or multi-specialty group practice

(3) Are you a full- or part-owner, employee, or an independent contactor

(4) Who owns the practice?

When providers do not participate in the survey, the questions in item 13 are the minimum NCHS needs to have answered so that analyses can be performed to make sure the survey is not biased between those participating and those that do not participate. Pay special attention to collecting the number of total visits in a normal week, item 13e.

It is preferable for refusing providers who will not complete RFs to complete the entire NAMCS-1, as would a participating provider. Item 13 is for those cases when the provider will not complete the entire NAMCS-1 with you.

Check Item A **Final outcome of screening** **Check Item A**

This is a MUST ENTRY item. Mark (x) the appropriate box describing the outcome of the Telephone Screener.

IF	THEN
"Appointment MADE..." has been marked	Go to Section II, page 7.
"In-Scope, but REFUSED" has been marked	Complete the Item 13 series, then go to Section III – Noninterview, on page 19.
"Out-of-Scope/Other" has been marked	Go to Section III - Noninterview, on page 19

◆ CHECK ITEM A MUST BE COMPLETED BEFORE CONTINUING ◆

Section II - Induction Interview

1. General

After completing the Telephone Screener (Section I) and getting an appointment with the physician, your next step is to keep the appointment and conduct the Induction Interview (Section II).

CHC: The NAMCS-1 Induction Interview should also be completed for CHC providers selected for sample. All CHC sampled respondents will have a Provider ID Number above 6000. Refer to Chapter E for more detailed information on the CHC procedures.

Before visiting the office, make sure the following preprinted entries on the questionnaire are correct and that they match the information in item 1, of the NAMCS-1 Control Card. If there is a mistake, please contact your supervisor. (The NAMCS1 Control Card for CHC providers will not have name or address information preprinted.)

- The date(s) of the provider's reporting week can be found in the following NAMCS-1 Locations:
    1) item 15a (page 7)
    2) item 16a (page 8)
    3) item 17a (page 9)
    4) item 17c (page 9)
    5) item 33a (page 15)

When you arrive at the office, take a few minutes to explain to the doctor the background and purpose of NAMCS. A summary of appropriate information is provided in the paragraphs on page 7 of the questionnaire, above the beginning of the Induction Interview items. It is preferable that you ***do not read*** this information word-for-word, but that you master its contents and convey it to the provider conversationally.

The basic facts, as displayed below, are simple:

- ambulatory care accounts for a large part of medical care
- without this study, little would be known about it
- medical educators, researchers, and others requested and need this information
- the study has been developed in close consultation with the medical profession
- the provider's own task is very simple

BE SURE THAT THE PHYSICIAN UNDERSTANDS

THAT PARTICIPATION IS VOLUNTARY AND ALL INFORMATION COLLECTED IS CONFIDENTIAL.

2. Explanation of Section II Items

Instructions for each item of the Induction Interview follow in numeric sequence.

14a-d **a. Overall, at how many different office locations do you see ambulatory patients?** **14a-d**

b. In a typical year, about how many weeks do you NOT see any ambulatory patients (e.g., conferences, vacations, etc.)?

c. You typically see patients fewer than half the weeks in each year. Is that correct?

d. You typically see patients all 52 weeks of the year. Is that correct?

The purpose of these questions are to determine the number of different locations at which the physician/provider sees ambulatory patients as well as the number of weeks in a typical year the physician/provider does not see ambulatory patients. Examples for not seeing ambulatory patients include illness, being away on vacation, or attending a conference.

15a-c **a. This study will be concerned with the AMBULATORY patients you will see in your office(s) during the week of Monday, _____ through Sunday,_____. Are you likely to see any ambulatory patients in your office(s) during that week?** **15a-c**

(For allergists, family practitioners, etc.- if routine care such as allergy shots, blood pressure checks, and so forth will be provided by staff in physician's absence, mark "Yes.")

b. Why is that?

c. Since it's very important that we include any ambulatory patients that you might see in your office during that week, I'll leave forms with you– just in case your plans change. I'll check back with your office justbefore (Starting date) **to make sure, and if necessary I can explain them in detail then.**

Read the introduction to item 15a establishing the dates of the reporting period and then ask, "Are you likely to see ***any*** ambulatory patients in your office during that week?"

The answer will usually be "Yes," in which case go on to item 16a. If there is any doubt, however,

define what we mean by "ambulatory patient" and "office." Then probe to make sure the doctor is in-scope. Use the definitions provided in your Information & Flashcard Booklet. If the doctor will not be seeing patients in the office during the survey week, but the office staff will be providing routine care such as allergy shots or blood pressure checks, mark the "Yes" box in item 15a. Explain that such visits represent a part of the overall picture of ambulatory care, and thus should be represented in the study.

Note that if the doctor expects to see ***any*** ambulatory patients, he/she is ***in-scope and must be included in the survey.*** Thus, a psychiatrist who expects to see only two or three patients during the week, or a physician who plans to be in the office only on Friday of that reporting week, are nevertheless included. If the doctor should remark that the assigned week is not "typical" and volunteers to participate in some other week instead, please explain the importance of the random assignment of the reporting week. These non-typical weeks are just as important as normal weeks when collecting statistics on the utilization of ambulatory care.

On the other hand, if the doctor immediately tells you that it will be a bad week because of one thing or another (this doctor will be seeing another doctor's cases as well as his/her own, will be without office help, etc.), express your sympathy but explain that this is part of the picture of any given week in the care of ambulatory patients and the estimates derived from the survey will not be valid if unusually busy physicians are excluded. Go on to say, however, that we will do all we can to make the job as easy as possible and that we have arranged it so that ***very busy physicians need report on only a fraction of their patients.*** (Note: The doctor will, however, have to ***log in*** ALL the patients he/she sees that are in-scope, even if they are usually his/her partner's.)

IF	THEN
The physician's response to item 15a is "Yes," the physician does expect to see ambulatory patients.	Go to item 16a.
The physician's (or staff's) response to item 15a is that the physician does not expect to see any ambulatory patients during the reporting week.	Ask why (item 15b), and record the reason. If the reason in item 15b indicates that there is no probability of the physician seeing patients during the reporting week, then skip to item 16a. If the reason indicates he/she may see patients, explain that it is important to capture all ambulatory visits, even when they are few.

IF	THEN
The physician's response to item 15b indicates that he/she might be seeing some patients that week.	Read item 15c and then proceed with item 16a. Provide the physician with a patient record folio and enter the folio number on page 17. It is important that you telephone the office of all such physicians just before the reporting week starts to make sure their plans have not changed. Make a note of this on your calendar. If their plans are still in question after that call, telephone once more in the middle of the reporting week.

16a-b		16a-b
	a. At what office locations will you see ambulatory patients during your practice's 7-day reporting period Monday, _____ through Sunday, _____?	
	PROBE: Are there any other office locations at which you will see ambulatory patients during that 7-day reporting period?	
	b. Give FLASH CARD A (p. 15 Flashcard Booklet) and ask "Looking at this list, choose ALL of the type(s) of settings that describe each location where you work."	

Ask item 16a to obtain the office locations where the doctor will see any ambulatory patients during his/her reporting period. If the provider has already indicated where he/she will be seeing patients, verify the location. For example, "You said that you will be seeing ambulatory patients at..."

Always ask, "Are there any ***other*** office locations where you will see ambulatory patients during your 7-day reporting period" to be sure you have all the provider's offices listed.

Enter the "street address" for each office location reported on the lines provided on the back of the NAMCS-1(CC) Control Card. Show Flashcard A and for each location ask the physician which setting types apply. You may circle up to three settings per location. Based on those answers, mark the appropriate "scope" status in item 16b. If ANY even numbered settings are marked, then mark the location as out-of-scope. Otherwise, the location is in-scope.

If a provider is unavailable or refuses to participate, you should still record locations where ambulatory patients are normally seen during their assigned 7-day reporting week.

In-Scope	Out-Of-Scope
1. Private solo or group practice	2. Hospital emergency department
3. Freestanding clinic/urgicenter (not part of a hospital outpatient department)	4. Hospital outpatient department
5. Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or 'Look Alike' Clinics)	6. Ambulatory surgicenter
7. Mental health center	8. Institutional setting (school infirmary, nursing home, prison)
9. Non-federal Government clinic (e.g., state, county, city, maternal, and child health, etc.)	10. Industrial outpatient facility
11. Family planning clinic (including Planned Parenthood)	12. Federal government operated clinic (e.g., VA, military, etc.)
13. Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente)	14. Laser vision surgery
15. Faculty Practice Plan	

If #3 or #11 are marked then probe as needed

If flashcard number 3 (free-standing clinic/urgicenter) is marked, ask
Is this/that clinic .....
in an institutional setting (#8), in an industrial outpatient facility (#10) or operated by the Federal Government (#12) ?

If "Yes" to any of the three, then mark (X) the out-of-scope box.

If flashcard number 11 (family planning clinic) is marked, ask
Is this/that clinic operated by the Federal Government (#12) ? If "Yes," mark (X) the out-of-scope box.

If in doubt about any (clinic/facility/institution), PROBE
(1) Is this/that (clinic/facility/institution) part of a hospital ED or OPD (#2, #4)?
(2) Is this/that (clinic/facility/institution) operated by the Federal Govenment (#12)?

If "Yes" to either, then mark (X) the out-of-scope box.

In most cases this will be obvious from the answer. For example, the response, "I have a private practice at 410 West Elm Street" would classify an office as in-scope. However, "Mt. Sinai Hospital Emergency Room" is out-of-scope. If there is any doubt, ask the probe in 16b, and code accordingly.

Remember that a physician/provider or a group of physicians can rent ***private*** office space located within a hospital without working for the hospital. Such locations are generally in-scope. When still in doubt after probing, call your supervisor for clarification.

Occasionally, you may find that ***all*** of the locations at which the doctor expects to see patients during the week are out-of-scope. Mark box 1 in Check Item B, follow the skip pattern and end the interview. After you have left the office, complete Section III of the questionnaire.

NOTE: There is a national trend in which hospitals are buying physician practices and hiring the physicians as employees of the hospital. That is, what was once an office-based physician practice is now an office-based hospital practice. These practices are freestanding offices and are in-scope for NAMCS.

16c-d	**c.**	**Are there other locations where you NORMALLY would see patients even though you will not see any during your 7-day reporting period?**	**16c-d**
	d.	**Of these locations where you will not be seeing patients during you 7-day reporting period, how many total <u>office visits</u> did you have during your last week of practice at these locations?**	

The purpose of item 16c is to determine if there are office locations that the sampled provider would normally see patients, but for some reason will not be during the reporting period. Examples of such reasons may be the office is closed for renovation or the provider will be at a conference during the day(s) he or she would work at that location. This question is NOT asking about other locations the provider may work at only a few times a month, and just did not happen to fall into the reporting period.

Item 16d quantifies the number of visits from those locations mentioned in item 16c, if there are any.

Items 16c and 16d are different from 16a and 16b because the later two questions ONLY include those locations where the provider will see patients during the reporting period. No office location reported in item 16a should have an estimated number of visits of zero (reported in item 17d) unless the physician is unavailable during reporting period (Final = 4).

As a reminder, if the provider will not see any patients during his or her reporting period or refuses to participate, mark item 16 accordingly and follow the skip instructions as indicated.

Check Item B

Check Item B will determine how you will proceed with the interview for each physician.

IF	Then
"Out-of-scope" has been marked in item 16b for ***all*** locations	Mark box 1 in Check Item B, read the closing statement, and end the interview. The physician will be out-of-scope for NAMCS. After you have left the physician's office, complete Section III on page 19 of the NAMCS-1. Mark box 10 "Other out-of-scope" in item 35, and enter "All locations out-of-scope" on the "Other-Specify" line provided in item 36. Then mark box 2, "Out-of-scope" for item 40 on page 21.
"In-scope" has been marked in item 16b for ***all/some*** locations	Mark box 2 in Check Item B. Continue with item 17a on page 9.
For physicians who will not be seeing patients during the reporting week (15a - No)	Although some doctors will not be completing Patient Record forms during the reporting week, you will proceed with the interview by completing items 16-31 to obtain general information about their office practice for a normal week. Make the following entries on pages 19, 20, and 21: 1) Item 35 - mark box 6 or box 11 based on the response to item 15b, 2) Item 38 - enter the explanation, and 3) Item 40 - mark box 2 or 4 (as appropriate).

Items 17a-18h on pages 9 and 10 are a series of related items which will obtain basic information about the type and size of each location where the provider will see patients during the reporting period. Record responses to these items on the chart directly to the right of each question.

Each of the four columns represents an office location. It is very important to answer these items for each location in the same order they were written in Item 16a. Only include In-Scope locations for these items.

17a-e

a. **During the week of Monday, _____ through Sunday, _____ How many days do you expect to see any ambulatory patients?** (Only include days at in-scope locations.) 17a-e

Note - Non-Participating Physicians: If refusal (Final=3) or unavailable (Final = 4), enter the number of days in a normal week.

b. **During your last normal week of practice, approximately how many office visit encounters did you have at each office location?**

Note: If physician is in group practice, only include the visits to sampled physician.

c. **During the week of Monday, ____ through Sunday _____, do you expect to have about the same number of visits as you saw during your last normal week in each office taking into account time off, holidays, and conferences?**

Note: Mark (X) response. If answer is "Yes", transcribe the number in 17b to 17d for that office location. If answer is "No", then ASK item 17d for that office location.

d. **Approximately how many ambulatory visits do you expect to have at this office location?**

e. **Tally of estimated number of visits**

NOTE: To obtain the total number of estimated visits, add the estimate for each office location in 17d.

These questions determine the expected size of the physician's practice at in-scope locations during the reporting week. The information obtained for items 17a through 17e is important as it will be used to determine the sampling interval during the reporting period. Some doctors with a limited private practice may see only a few patients per week. Others may be busy in their office five or six days a week seeing a steady stream of patients who are lined up in the waiting room. It would be a severe burden to ask the latter type of physician to complete a form on every patient; it is also unnecessary, since a sample of visits can produce reliable data.

Physicians with small practices may be asked to report on every patient seen, while others will report on every second, third, or fifth patient. The formula for determining which patient is sampled is arranged so that in most cases the physician will not have to report on more than 30 patient visits per week. For example, the physician who expects to see about 45 patients in two days of practice will receive a Start With (SW) number and Take Every (TE) number where she or he will complete 22 Patient Record forms and report on every second patient. The physician who expects to see 125 patients in five days of practice will receive a Start With (SW) number and Take Every (TE) number where she or he will complete a patient record for every 3rd patient for a total of 41 completed Patient Record forms.

Ask 17a only once for ***all*** in-scope offices to determine the ***total*** days in practice.

Item 17b asks the physician, "During your last normal week of practice, approximately how many office visits encounters did you have at each office location?" We anticipate the physician being able to answer this question without the FR having to define "normal" but if they press on this, a normal week would be one with a normal case load, no holidays, vacations, or conferences.

Item 17c asks, during the sample week (dates provided), does the physician expect to see about the same number of visits as he/she saw during his/her last normal week of practice. If the answer is No, then ask 17d for this office. If the answer is Yes, transcribe the number in 17b to 17d.

Based on the instructions in the above paragraph, each office location should have an entry in item 17d.

Item 17e is nothing more than a total of the estimated number of visits for all offices in 17d.

For example, a physician has two offices, for the first office they tell the FR that they see about 50 visits in a normal week (item 17b) and further estimates that they will see about the same number in their sampled week. The FR should mark yes for item 17c and transcribe 50 in item 17d. For the second office, the physician reports that they normally have 25 visits (item 17b), but after asking 17c the FR finds out that for the sampled week, the physician does not expect to have the same number of visits. In response to this, the FR marks "No" in item 17c and asks 17d and determines that the physician expects to see only 10 patients. For item 17e, the total would be 60 (item 17d for office # 1=50 and 17d for office #2=10).

Remember, if the physician is part of a group practice we are only interested in collecting the estimated number of visits to the sampled physician, NOT the entire practice.

Again, remind the physician that we ***include*** all of his/her patients ***receiving medical attention*** from any member of his/her staff even if the patient does not see the doctor. This would include patients

seen by a nurse, nurse practitioner, and physician's assistant but ***not*** by another physician.

18a-h **18a-h**

a. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way (at this/that in-scope location)?

If solo, skip to item 18d.

b. How many physicians are associated with you (at this/that in-scope location)?

c. Is this a single- or multi-specialty (group) **practice** (at this/that in-scope location)?

d. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with you (at this/that in-scope location)?

e. Are you a full- or part-owner, employee, or an independent contractor (at this/that in-scope location)?

If "Owner" is marked then automatically mark "Physician or physician group" in item 18f.

f. Who owns the practice (at this/that in-scope location)?

REFER TO FLASHCARD B (p. 16 Flashcard Booklet)

g. Do you see patients in the office during the evening or on weekends?

h. What is your Federal Tax ID at each office location? (Record on Control Card)

For each in-scope location, ask items 18a-h and remember to keep offices in the same order they were recorded in item 16a.

Some physicians have a solo practice at one location and share a practice at a different location. If the doctor has a solo practice, mark box 1 in item 18a and skip to item 18d. If the doctor does not have a solo practice, mark box 2 and continue with item 18b.

Record in item 18b the number of ***other*** physicians associated with the sample physician on the line provided.

Item 18c asks, "Is this a single or multi-specialty (group) practice?" The answer is based on the number of specialties practiced by the physicians in the group. If all the physicians practice the same specialty (e.g., general medicine), then mark "Single" specialty. If the physicians in the group practice different specialties (e.g., general medicine, pediatrics, ophthalmology), then mark "Multi" specialty.

Record in item 18d the number of mid-level providers associated with the sampled physician on the line provided. Mid-level providers may include nurse practitioners, physician assistants, and nurse midwives.

Item 18e asks "Are you a full or part-owner, employee, or an independent contractor?" Mark the appropriate box. If the physician is an owner, then automatically mark "Physician or physician group" in item 18f.

Item 18f asks "Who owns the practice?" This question asks about the ownership of the medical practice and not the physical building or real estate where the practice is located. As stated above, if "Owner" was marked in item 18e, then mark "Physician or group practice" without asking the question, otherwise show Flashcard B and mark the appropriate box.

Item 18g asks if the patients are seen in the office in the evening or on weekends. Mark the appropriate box.

Item 18h asks for the Federal Tax ID at each office location. A Federal Tax Identification Number is a nine-digit number that the IRS assigns to business entities. The IRS uses this number to identify taxpayers that are required to file various business tax returns. This number is used by many entities including physician practices or CHCs. Please record all 9 digits. Starting in the 2009 panel this information will be recorded on the NAMCS1 Control Card.

19a-b **a. During your last normal week of practice, how many hours of direct Patient care id you provide?** **19a-b**

b. During your last normal week of practice, about how many encounters of the following type did you make with patients:

(1) Nursing home visits
(2) Other home visits
(3) Hospital visits
(4) Telephone consults
(5) Internet/e-mail consults

Item 19a is asking for the providers "best guess" of the weekly hours spent providing direct patient care.

For item 19b, an encounter is a session/visit with an individual patient. For example, if a physician/provider goes to a hospital and visits four patients, the number of patient encounters equals four. If the physician/provider visits the hospital twice to see the same patient, the number of patient encounters is two.

20 **Does your practice submit claims electronically (Electronic billing)?** **20**

The purpose of item 20 is to determine the extent to which the practice uses electronic files stored on a computer for medical and billing records.

Item 20 is concerned with billing records which represent the documentation kept on the charges rendered for medical care provided as well as the financial and insurance arrangements under which bills are paid by individual patients.

21a-b **a. Does your practice use ELECTRONIC MEDICAL OR HEALTH**
21a-b RECORDS (EMR/EHR)(not including billing records)?
FR Note – Complete question 21b regardless of answer to 21a.

b. Does your practice have a computerized system for -

(1) Patient demographic information?
If yes, ask -- **(a)** Does this include patient problem lists?

(2) Orders for prescriptions?
If yes, ask -- **(a)** Are there warnings of drug interactions or contraindications provided?
(b) Are the prescriptions sent electronically to the pharmacy?

(3) Orders for tests?
If yes, ask -- **(a)** Are orders sent electronically?

(4) Viewing Lab results?
If yes, ask -- **(a)** Are out of range levels highlighted?

(5) Viewing Imaging results?
If yes, ask -- **(a)** Are electronic images returned?

(6) Clinical notes?
If yes, ask -- **(a)** Do they include medical history and follow-up notes?

(7) Reminders for guideline-based interventions and/or screening tests?

(8) Public health reporting?
If yes, ask -- **(a)** Are notifiable diseases sent electronically?

The purpose of item 21a is to determine if the practice uses partial or all electronic medical records (EMR).

Regardless of the extent the practice has electronic medical records, item 21b asks about the kinds of electronic information available. Note thesub questions when the answer is "Yes" and the four answer categories for each. The "Turned Off" category should be checkd when the electronic medical record system has the capability, but the office or practice has turned off that option.

As electronic medical record systems are used by a greater proportion of practices, researchers are interested in the features that areeither used or not used by physicians and how their use varies by different characteristics.

22 Are there any of the above features of your system that you do NOT use or have turned off? 22

The purpose of item 22 is to probe the physician/provider to make sure they had not forgotten to mention any feature of the EMR system they do not use or have turned off.

If the provider does list any feature of the EMR that is tuned off, make sure you have checked box #4 for the corresponding feature in item 21b.

23 Are there plans for installing a new EMR/EHR system or replacing the current system within the next 3 years? 23

Due to the increasing pressure on physician practices to have an EMR system, item 23 is to determine future demand for EMR systems.

If practice does not use electronic medical records, SKIP item 24 and 25.

24 What year did you last buy or upgrade your EMR system? 24

We are interested in how old the EMR system the practice is using

25 Are you using a "Certification Commission for Healthcare Information Technology" (CCHIT) Certified EMR system? 25

We are interested in how many physicians' offices are using this certified EMR system.

Ask items 26 through 29 ONCE for ALL in-scope locations.

26a-c I would like to ask a few questions about your practice revenue and contracts with managed care plans. 26a-c

a. Roughly, what percent of your patient care revenue comes from-

(1) **Medicare?**
(2) **Medicaid?**
(3) **Private insurance?**
(4) **Patient payments?**
(5) **Other?** - (including charity, research, CHAMPUS, VA, etc.)

REFER TO FLASCHARD C (p. 17 Flashcard Booklet)

b. **Roughly, how many managed care contracts does this practice have such as HMOs, PPOs, IPAs, and point-of-service plans?**

c. **Roughly, what percentage of the patient care revenue received by this practice comes from (these) managed care contracts?**

In **item 26a**, work with the physician and his/her staff to approximate the percent of the practice's revenue obtained from the contracts above. The categories should sum close to 100 percent. The physician may not have this information readily available and may have to consult others in the office to obtain the information. Do not leave blank or use a dash to indicate 0 percent. The only acceptable response for a null answer is the number 0.

In **item 26b**, enter the approximate number of managed care contracts. Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Include Medicare managed care and Medicaid managed care, but not traditional Medicare and Medicaid. Include all the different plans an insurance provider may have and for which the physician has a contract. For example, the physician may have a separate contract for each of the plans an insurance company may offer: a PPO, IPA, and point-of-service plan. In this example, the answer to 24b would equal 3 contracts, not 1 contract. It may be necessary to obtain information from the billing office of the practice. Definitions of the different plans cited in the question are as follows:

- **HMO:** Stands for Health Maintenance Organization. An HMO is an organized system for providing comprehensive health care to large groups of voluntarily enrolled members in a specific geographic area. HMO's provide comprehensive care with no deductibles, limited out-of-pocket costs (usually $5-$10 co-pay), and no claims to file. Members must use the doctors, hospitals, and drug stores that belong to the HMO's network, and choose a primary care physician (PCP) who oversees their care and provides referrals to specialists when needed. The HMO ensures the quality and appropriateness of services through formal quality assurance programs.

- **PPO:** Stands for Preferred Provider Option. The PPO is the least integrated health insurance option and offers the most flexibility for members. Enrollees do not have to select a Primary Care Physician (PCP), and no referrals are needed. They are encouraged to use providers contracted with the PPO. They may choose to use providers who are not part of the PPO, in which case, the PPO covers less of the cost and the patient is charged a higher co-payment.

- **IPA:** Stands for Independent Practice Association. In this model, the managed care plan contracts with individual physicians in independent practice or with associations of

independent physicians to provide services to plan members at a negotiated rate per capita, or flat retainer, or negotiation fee-for-service basis while contracting with one or more plans. Participating physicians are usually paid on a capitated or modified fee-for-service basis and may also continue care for patients not covered by the insurers with whom the IPA contracts.

- **POS:** Stands for Point-Of-Service option. In a POS, enrollees select a Primary Care Physician (PCP) who directs their care. The enrollee has the option of seeking care outside the network, but receives more coverage if they use providers in the network. Members seeking care outside of the network will incur higher out-of-pocket costs. Referrals are required for specialty care within the network to be fully covered.

Item 26c seeks an approximate percent of the practice's revenue from managed care contracts. If the physician and/or office staff have trouble answering, please probe by asking "would you say 10, 40, or 70 percent."

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27 **Roughly, what percent of your patient care revenue comes from each of the following methods of payment?** 27

(1) Usual, customary and reasonable fee-for-service?
(2) Discounted fee-for-service?
(3) Capitation?
(4) Case rates (e.g., package pricing/episode of care)?
(5) Other?

REFER TO FLASHCARD D (p. 18 Flashcard Booklet)
FR Note – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value.

Showing flashcard D, have the physician/provider estimate the percent of patient care revenue that comes from each form of payment listed. The categories should sum close to 100 percent. As in question 24a please include a value for all patient care revenue categories. Do not leave blank or use dash to indicate 0 percent. The only acceptable response for a null answer is the number 0.

28a-b **a. Are you currently accepting "new" patients into your practice(s)** (at in-scope locations)? 28a-b

b. From those "new" patients, which of the following types of payment do you accept (at in-scope locations)?

(1) Private insurance -
(a) Capitated?

(b) Non-capitated?

(2) Medicare?

(3) Medicaid?

(4) Workers compensation?

(5) Self-pay?

(6) No charge?

Ask the items once for all in-scope locations. If item 28a is "Yes," then ask about each payment type separately recording an answer for each one in question 28b.

Type of Payment		Definition
1	Private insurance	Charges paid in-part or in-full by a private insurer (e.g., Blue Cross or Blue Shield) either directly to the physician or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan.
	(a) Capitated	An arrangement where the physician receives a fixed fee for patient care over a set time. More specifically, capitation is a method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations (HMOs). Examples of the practice's revenue are income dollars from direct services to patients and dollars from contracts for patient care services. Do not include investments as part of the practice's revenue from patient care.
	(b) Non-capitated	No arrangement for the physician to receive a fixed fee over a specified period of time. The insurer does not restrict the fee paid to the physician or institutional provider by service, time, or the number of patients for who care is provided.
2	Medicare	Charges paid in-part or in-full by a Medicare plan. Includes payments directly to the physician as well as payments reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan.
3	Medicaid	Charges paid in-part or in-full by a Medicaid plan. Includes payments made directly to the physician as well as payments reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan or the State Children's Health Insurance Program.
4	Worker's Compensation	Designed to enable employees injured on the job to receive financial compensation regardless of fault.
5	Self-pay	Charges paid by the patient or patient's family, which will not be reimbursed by a third party. "Self-pay" is perhaps a poor choice of wording since we really have no interest in whether the patient actually pays the bill. This category is intended to include visits for which the patient is expected to be ultimately responsible for most of the bill. DO NOT check this box for a co-payment or deductible.
6	No charge	Visits for which no fee is charged (e.g., charity, special research or teaching). Do not include visits paid for as part of a total package (e.g., prepaid plan visits, post-operative visits included in a surgical fee, and pregnancy visits included in a flat fee charge for the entire pregnancy).

29a-c **(a) Roughly, what percent of your daily visits are same day appointments?** **29a-c**

(b) Does your practice set time aside for same day appointments?

(c) On average, about how long does it take to get an appointment for a routine medical exam?

The questions in item 29 are intended to answer how accessible the provider is in terms of same day appointments.

Item 29a asks the provider to estimate what percent of all visits are same day appointments. It is fine for this number to be a "best guess" or "back of the envelope" estimate.

Item 29b is self-explanatory and asks if the practice sets time aside each day for same day appointments.

Item 29c asks the average time it would take a patient to get a routine medical exam. For this question, routine medical exam will mean different things to different specialists. For example, it may mean "Well baby check" to pediatricians; a "general medical exam" to a family practitioner or internist; a "pap test" to an obstetrician/gynecologist; or a routine eye exam to an ophthalmologist.

30a-e **Item 30 should only be asked of GFP, IM, PD, OB/GYN physicians and all providers at community health centers. Otherwise, skip to Item 31.** **30a-e**

(a) Does your practice currently recommend the Human Papillomavirus (HPV) Vaccine?

(b) Does your practice plan on recommending the HPV vaccine?

(c) Which HPV vaccine does your practice recommend using?

(d) What age group(s) does your practice recommend patients get the HPV vaccine? (Mark (x) all that apply.)

(e) Please indicate the reason(s) why your practice does NOT plan on recommending the HPV vaccine. (Mark (x) all that apply.)

REFER TO FLASHCARD E (p. 19 Flashcard Booklet)

Items 30a through 30e ask about the provider's intention in using the newly approved Human Papillomavirus (HPV) vaccine. **These questions should only be asked of the following specialties and subspecialties (as detailed on page 3 of the NAMCS 21 Information and Flashcard Booklet).**

- **General/Family Practitioners (GFP)**
- **Internists (IM)**
- **Pediatricians (PD)**
- **Obstetrician/gynecologists (OB/GYN)**
- **All physicians and mid-level providers at community health centers.**

Item 30a asks if the provider's practice recommends the HPV vaccine. If they report yes, you should skip to item 30c, but if they report no, you are to ask item 30b.

Item 30b asks if the provider's practice plans on recommending the HPV vaccine in the future. If they report yes, ask item 30c. If they report no, skip to item 30e.

Item 30c asks which HPV vaccine the practice recommends using. Mark (X) only one answer choice but note that choice 3 is "Both."

Item 30d asks the provider what age group(s) the practice recommends patients receive the HPV vaccine. Mark (X) all that apply.

If the provider does not currently and has no plans to recommend the HPV vaccine, item 30e asks the provider what reason(s)are preventing their recommendation. Show Flashcard E to the provider for reference as you ask this question. Mark (X) all that apply.

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31 Do you offer any type of cervical cancer screening? 31

Item 31 allows us to measure the proportion of providers that perform any type of cervical cancer screening. **Ask item 31 of all providers.**

This item is also a screening question to determine if the provider should be given the NAMCSCCS or Cervical Cancer Screening Supplement. **The supplement should only be given ONLY to the following specialties and subspecialties (as detailed on page 3 of the NAMCS21 Information and Flashcard Booklet) who answered "Yes" they do offer any type of cervical cancer screening.**

- **General/Family Practitioners (GFP)**
- **Internists (IM)**
- **Obstetrician/gynecologists (OB/GYN)**
- **All providers at community health centers**

If you have any questions as to who should be given the NAMCSCCS, speak with your supervisor. The NAMCS-CCS is self administered paper questionnaire.

CHECK ITEM C Is provider part of the community health center sample?

Check Item C provides a skip pattern for item 32 based on whether the respondent is part of the CHC sample. Do NOT give item 32 series questions to "traditional" NAMCS physicians (i.e., physician ID's less than 6000).

32 Provider demographics **32**

a. **What is your year of birth?**
b. **What is your sex?**
c. **What is your ethnicity?**
d. **What is your race?**
e. **What is your highest medical degree?** ***REFER TO FLASHCARD F (p. 20 Flashcard Booklet)***
f. **What is your primary specialty?**
g. **What is your secondary specialty?**
h. **What is your primary board certification?**
i. **What is your secondary board certification?**
j. **What year did you graduate medical school?**
k. **Did you graduate from a foreign medical school?**

Item 32 obtains the same information from the providers in the community health centers that we have for the physicians in the traditional sample. Gathering this information will allow analysis for all physicians and providers from whom we collected data. Please follow item 32e skip pattern correctly; that is, only physicians (MDs and DOs) receive questions 32f-32k. We are not interested in the specialty, board certification, and medical school information for midevel providers.

33a-b a. **During the period Monday, _____ through Sunday, _____ will ANYONE be available to help you fill out the patient record forms for this study?** **33a-b**

b. **Who will be helping you at each location? (Complete on NAMCS-1 Control Card)**

The purpose of these items is to determine if other office staff will be assisting the physician/provider. If "Yes," record the name(s) of who will be assisting by location number in the table on the NAMCS 1 Control Card, and if "No", go to visit sampling.

Visit Sampling

Background

The sampling plan of visits made to individual physician practices or providers at community health centers is constructed using the Take Every and Start With numbers. The **Take Every** number is a predetermined number which defines a sampling interval. For example, if the Take Every number is 5, the office staff would select every 5th patient visit to that office during the 7-day reporting period.

The **Start With** number is between 1 and the Take Every number. It is used only **once** to begin the sampling process (i.e., select the first patient visit during the reporting period). At the start of each day thereafter, the sampling should continue from where it left off the day before—sampling those visits based on the Take Every number. Thus, if the Start With number is 4, the office staff would select the 4th patient visit to the office at the beginning of the data collection period. Assuming the Take Every and Start With numbers are 5 and 4, respectively, the office staff would select the 4th, 9th, 14th, 19th, ... patient visits. The Start With number is used only once on the first day of the reporting period. At the start of each day thereafter, the sampling should continue from where they left off the day before, filling out a Patient Record form for each visit equal to the Take Every number.

Determining the TAKE EVERY number

To determine the Take Every number for a physician's practice or physician/provider at a CHC you will need the following items:

1) estimated number of practice days from item 17a on page 9 of the NAMCS1

2) tally of estimated number of total patient visits from item 17e on page 9 of the NAMCS1

3) the Take Every table on page 16 of the NAMCS1

Follow these steps to determine the office's Take Every number:

1) Find the column that corresponds to the answer the physician gave to 17a - the number of days the physician will see patients that week.

2) Find the row that includes the total estimated number of patient visits given in 17e.

3) Look across the row (line) containing the total number of expected patient visits and find

where it intersects the column containing the number of days the physician will see patients. The number at the intersection is the Take Every number.

Circle the appropriate Take Every number and transcribe it in the box beneath the table on page 16 of the NAMCS-1.

Determining the START WITH number

Using the Start With number table on page 17 of the NAMCS1, follow these steps to determine the Start With number:

1) Find the Take Every number, determined above, in the left column.

2) Look across to the corresponding number in the right column, this is your Start With Number. Circle and enter the Start With number in the blank box to the right of the table.

The entries in the Start With column will most likely vary for each NAMCS1 in your assignment. For statistical purposes, a separate set of Start With entries is generated for each NAMCS1 questionnaire before printing.

Enter the Start With and Take Every sampling pattern on the front and inside cover of the NAMCS-30 Patient Record folios given to the physician's office as well as the cover of the NAMCS-26 instruction booklets left at the office.

Folio Number Table

Complete The Folio Number Table

Before discussing the folio instructions with the provider, complete the Folio Number Table. Please refer to the Folio Number Table in the middle of page 17 in the NAMCS1. The table is a record of the folio pad sequence numbers left with the provider's office. Below are some items to keep in mind.

1) Folio Number: Transcribe the 7-digit folio identification number from the first Patient Record form inside the Folio to the NAMCS1 Folio number table. This number is ***printed in black*** at the top of the Patient Record forms. Accurate transcription is crucial, since there is no identification of the provider on the Log or Patient Record forms. Without this number there is no way of connecting the provider to the completed forms.

2) Number of PRFs Completed: After collecting the edited Patient Record forms, enter the number of Patient Record forms completed for each folio pad left with the provider's office or offices. Do not include voids.

Providing Folios to the Physician/Provider **(READ CAREFULLY VERY IMPORTANT)**

You will have ascertained and recorded in item 16a, all the office locations at which the physician/provider expects to see ambulatory patients during the assigned reporting week, and will have coded them as either in-scope or out-of-scope. Many physicians will confine their ambulatory practice to a single office, but some will divide their time between two or more offices or locations.

If the provider practices in more than one location, each location should be assigned **separate folio**. Inform the provider that you will deliver a Folio to the other locations.

You will then have to make arrangements with the provider to visit the other office(s) to drop off the Folios preferably in advance of the day he/she practices there, but no later than that morning.

There are a number of reasons for this procedure.

1) There is likely to be a different assistant at the other office(s), and it will be important for you to brief them personally on the tasks involved.

2) If we rely on the doctor/provider or his/her assistant to carry the NAMCS forms to the other location(s), they may forget them.

3) It will be helpful for you to actually see the other practice location(s) and take note of any possible problems that might arise there.

If the same assistant accompanies the physician/provider to the other location(s), and if you are convinced that he or she is sufficiently motivated to bring the forms along to each office, instruct them that it is ok to use one folio (and check later to be sure there has been no slip-up).

If the same folio is used at different locations, if possible, please try to separate folio numbers by the specific office where they were collected. For example if PRFs 0000001-0000010 were from office #1, and 0000011-0000020 were from office #2, record 0000001 in office #1 and 0000011 in office #2. If separating folio numbers by office is too difficult, make remarks in the note section of the NAMCS-1 specifying which PRF numbers came from which office.

INSTRUCTIONS

Explain Patient Record Folio

At this point, hand the provider the Folio and a copy of the sample Patient Record form (NAMCS73) and explain, ***in your own words,*** how to complete the forms. Cover the following points in your explanation of the Folio:

Topics To Cover With Provider/Office Staff When Explaining Patient Record Folio	
Topic	**Background Information**
Define what is meant by in-scope and who should be listed on the Patient Visit Log	All patients who see the doctor or ***who receive care only from an assistant*** (e.g., a test, shot or examination administered by a nurse, etc.) ***should be listed.*** Patients who should not be listed include the following: 1) patients who do not seek care or services (e.g., they come to pay a bill or leave a specimen) 2) telephone contacts with patients should not be listed
Review Patient Visit Log	Review what can be used for the patient visit log. Provide the Patient Visit Worksheet found in Exhibit 2 of the Instruction Booklet as an example. Basically, any form where patients are listed sequentially and the sampling pattern can be applied is acceptable.

Topics To Cover With Provider/Office Staff When Explaining Patient Record Folio	
Topic	**Background Information**
Explain how to apply the sampling pattern to select patient visits	Emphasize that sampling is designed to ease the physician's task. A Patient Record form needs to be completed only for the beginning patient in the sampling (Start With) and all patients selected based on the Take Every number. Two points meriting special attention: 1) Extending the Take Every across days: If the office uses a new Patient Visit Worksheet/Sign-In Sheet each day, it is important that they extend the Take Every pattern from one sheet to the next. 2) Multi-Locations: If possible, arrange for the usage of a single Patient Visit Sign-In/Worksheet across offices for sampling. Apply the Start With number once, and extend the Take Every number across the Patient Visit Worksheet throughout the reporting period. This is the preferred approach. If this is impractical or impossible and it is necessary to maintain a separate Patient Worksheet at each location, then apply the Start With number once at each location and extend the Take Every number appropriately throughout the reporting period. Use the same Start With and Take Every numbers at each location.
Point out the Overlay on the front cover of the PRF	Explain that the exact number of patients seen and the exact number of Patient Records completed should be entered in the appropriate box at the end of each day. **THIS IS EXTREMELY IMPORTANT.** Space is also available on the Overlay to indicate: 1) reporting week dates 2) sampling pattern (Start With/Take Every) 3) instructions on returning the completed Folio

Example of Folio Cover Overlay:

WEEK OF -		FROM Month Day				TO Month Day			
SURVEY WEEK		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	**Total**
Complete a Patient Record for patient **SW** ____ and Every **TE** ____ nth ***patient thereafter.***	Number of patient visits								
	Number of records completed								
*Please return the entire Folio with **both the completed and blank forms** at the completion of the survey week. Thank You!*									

Go over the ***Patient Record form*** with the doctor/provider, item byitem. Concepts meriting SPECIAL attention include:

Item 2, Injury/Poisoning/ Adverse Effect	If any part of this visit was related to an injury, poisoning, adverse effect of medical or surgical care, or an adverse effet of medicinal drug, then mark the appropriate box. If this visit was not related to any of these, then mark the last option, "None of the above."
Item 3, Reason for Visit	Record the patient's own words. We want the patient's own complaint here, not the physician's/provider's diagnosis. If the patient has no complaint, the physician/provider should enter the reason for the visit.
Item 5a(1), Provider's Primary Diagnosis for this Visit	Can be tentative or provisional or expressed as a problem. Physician/provider should not record "Rule Out" diagnosis (R.O.). Enter any other diagnosis related to the visit (e.g., depression, obesity, asthma, etc.) in items 5a(2) and 5a(3).

Item 5b, Chronic Disease Checklist	Mark all chronic diseases that the patient has, regardless of entry in item 5a. This item supplements the diagnoses reported in item 5a. If the patient has cancer, indicate stage. If none of the conditions listed apply, then mark "None of the above".
Item 6, Vital Signs	Record specific values for the 4 vital signs. For height and weight, enter the value on the line next to the type or measurement system used. If height was not measured at this visit and patient is 21 years of ageand over, enter the most recent height recorded, up to 1 year ago. If you see fractions for pounds and inches on the medical record, please round to a while number. If you cannot determine the unit of measurement, as a default, the value for weight should be recorded in the "pound" box; and for height, record the value in the "feet" and "inches" box.
Item 8, Health Education	Mark all services ordered or provided at this visit.
Item 9, Non-Medication Treatment	Mark and/or list all non-medical treatment including surgical or non-surgical procedures ordered or provided at this visit.
Item 10, List medication/ immunization names	Record up to 8 medications that were ordered, supplied, administered or told to continue at the visit. Include Rx and OTC Medications, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements. Use SPECIFIC BRAND OR GENERIC DRUG NAMES as entered on prescription or medical records. Do NOT enter broad drug classes such as "pain medication." Record if the medication/immunization was new or continued.
Item 13, Time Spent with Provider	Best estimate of time spent in face-to-face contact with the patient. The answer may be zero (0), if the patient was attended entirely by a nurse or technician and did not see the sampled physician/CHC provider.

URGE BOTH PROVIDER AND ASSISTANT TO COMPLETE THE PATIENT RECORD FORMS DURING OR IMMEDIATELY AFTER THE PATIENT'S VISIT, IF POSSIBLE.

Experience has shown that the task takes less time if completed at this point and the information is more accurate. If this is not possible, the forms should be completed during any break in the office day, or no later than the end of the day.

If there is an assistant,he/she can use the following steps to ensure that the PRFs are completed in a timely fashion.

- Enter the patient names onto the Patient Visit Worksheet as patients check into the office (or similar form maintained by the office).
- Apply the Start With number and extend the Take Every number on a reoccurring basis to identify patients falling into sample for whom Patient Record forms need to be completed. It is important to keep this listing current. If a patient has to leave before receiving medical attention, line through the patient's name and do not include him/her on the sampling worksheet.

- Complete items 1a to 1h for those patients who fall into sample and a Patient Record form is required.

- Give the partially completed Patient Record form to the physician/provider so he/she can complete it during the patient's visit.

When the physician/provider has completed the Patient Record form, he/she should return it to the assistant. The assistant should edit it quickly for any missing information, and either ask the doctor to provide this or obtain it from the records. The assistant should then file the Patient Record form in the pocket of the Folio. If the completed forms are filed in numerical order the assistant can, (1) verify at the end of the day that a form was completed for every patient required, and (2) identify any that are missing.

Before returning the completed Patient Record forms to you, the provider or staff should be certain that all pages of the Patient Log containing patient names have been removed. The physician or assistant should ***keep*** the detached Log Forms for 3 or 4 weeks in case you telephone with any questions. The Patient Record forms can still be matched to the Log Forms by number. When you edit the completed forms you can still telephone the assistant and say, "We are missing forms 1501227 and 1501228. Can you check that for me?" The assistant can then identify the appropriate patient from the Log Forms by number and provide you with the missing data.

If the physician mails the Patient Record forms to you with the names still attached, then return the names to the physician/provider.

At the end of the assigned reporting week, place the completed Patient Record forms and remaining blank materials in the Folio. Place thefolio in the envelope addressed to you and mail. (Log Forms showing patient names should ***not*** be included.)

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34 CLOSING STATEMENT 34

a. **Thank you for your time and cooperation Dr.... I will call you on Monday, _____ to see if (everything is all right/your plans have changed). If you have any questions** (Hand doctor your business card),**please feel free to call me. My telephone number is also written in the folio.**

b. **Thank you for your time and cooperation Dr.... The information you provided will improve the accuracy of the NAMCS in describing office-based patient care in the United States.**

End the interview with one of the appropriate the statements provided. Remember to be brief, and to maintain a professional approach. Remind the doctor that you will call on Monday of the Reporting Week to answer any questions that might arise.

Section III- Noninterview

1) Purpose of Section III	Noninterview questions are completed for many reasons. When completing the noninterview report, keep in mind that the information you enter may be used by the Regional Office for follow-up or verification. Therefore, be as specific as possible when recording explanations. Read over all entries for legibility and content.
2) Explanation of Section III items	Instructions for each of the Section III items are provided in numeric sequence on the following pages.

35 What is the reason the provider did not participate in this study? 35

Item 35 lists the reasons that a physician/provider might not participate in NAMCS.

Code 1 - Refused/Breakoff

A refusal may come at the time of the Telephone Screener or in the course of the Introduction Interview. Also, any refusal to participate which comes during the assigned reporting week should be coded as Refused/Breakoff. If you mark code 1 in item 35, you will need to complete items 37a-e, to provide specific information about the refusal or breakoff. Be sure to report refusals to your supervisor immediately.

Code 2 - Non-office based

Be especially careful if classifying a physician as "non-office based." If the physician sees ambulatory patients, check with your supervisor before making them a code 2.
Physicians are non-office based **IF** they are employed full-time by the following agencies:

1) the federal government (including physicians in the military service) and have no private practice
2) an institution or organization thatserves its own population, with no separate private practice
3) a hospital, with no private practice and works exclusively with inpatients or in EDs or OPDs

Examples:

1) Government employment	VA hospitals Military hospitals and clinics
2) Institutions	Clinics run by private companies, (e.g., Ford Motor Co.) and universities, (e.g., University of Michigan Nursing homes)

Excluded from this category are HMOs and/or Kaiser plans. **DO NOT** classify physicians practicing in HMOs or Kaiser plans as non-office based. These physicians are in-scope for NAMCS.

Code 3 - Sees no ambulatory patients

Refers to physicians/providers who treat patients only indirectly, including the following specialists:

1) anesthesiology
2) pathology and forensic pathology
3) radiology, therapeutic radiology, and diagnostic radiology

This also includes physicians/providers who teach, are engaged in research or administration full-time.

Refer to NAMCS DEFINITIONS in your Information and Flashcard Booklet for a full list of out-of-scope reasons. If you are not sure whether the physician is in or out-of-scope, ***call your supervisor immediately.***

If the physician/provider is out-of-scope, we need to know why. If you mark "non-office based" or "sees no ambulatory patients" for item 35, ***be sure to answer item 36 giving the full details.*** For example, "the doctor is doing cancer research and has no private practice" or "sees only patients admitted to an institution."

Code 4 - Retired & Code 5 - Deceased

If you determine that the physician/provider is retired or deceased, mark the appropriate box and skip to item 40. No other items on the Noninterview Report need to be completed.

Code 6 - Temporarily not practicing

Mark code 6 for physicians who are unavailable for a period of ***three months or more,*** but who are not retired from practice. Examples might be:

- back in school for six months
- out of the country for an extended period
- seriously ill
- writing a book, etc.

If you mark code 6, skip to item 38 and enter a clear explanation.

Code 7 - Can't locate

If you have tried all possible sources of information including:

- directory assistance
- the U.S. postal service
- county and state medical societies
- the Internet (AMA Website)

but are still unable to determine the provider's location, mark code 7, and skip to item 40. Call your office with this information immediately.

Code 8 - Not licensed

If the provider indicates that he/she is not licensed, mark code 8 and skip to item 40. Also, call your supervisor with this information.

Code 9 - Moved out of U.S.A.

If you determine that the provider no longer practices in the United States, mark code 9, and skip to item 40.

Code 10 - Other out-of-scope

If you determine that the provider is outof-scope for a reason not covered by one of the codes listed above, mark code 10, then enter a detailed explanation in item 36.

Code 11 - Unavailable during reporting period

Mark code 11 for providers who will not be seeing patients during the reporting week. Reasons will vary but many times include vacation, conference, or illness. The absence must be for a duration of ***less than three months.*** Sometimes you will ascertain this fact from your Telephone Screening call ("I'm sorry, the doctor is out of town until May 15" or "The doctor will not be in his office for at least three weeks"). Sometimes you will not know until you inform the provider of the Assigned Reporting Week during the Induction Interview.

In all such cases, enter the reason for unavailability in item 38 and ***hold the questionnaire.*** Telephone the doctor's office again just before the Assigned Reporting Week to make sure his/her plans have not changed. If a return in midweek is at all likely, telephone once more at that time to see whether he/she might see any patients during the reporting week. If the doctor does change plans and returns to practice during the week, you will have to visit the office, explain the use of the Patient Record forms, and convince him/her to begin the study.

In every case of unavailability, whether the physician ultimately sees any patients or not, ***obtain all the information in the Induction Interview.*** The provider's assistant or colleague will be able to

supply this information by phone. Return the questionnaire to the office ***at the end of the provider's reporting week.***

Please note that a provider who says, "I'm too busy next week" or "I can't do it because my assistant will be off next week" is ***not unavailable.*** If the provider persists in this response, he/she must be counted as a ***refusal.***

Code 12 - Moved out of PSU

Occasionally, a provider may have moved out of the PSU. These providers are ***still in the sample*** and must be followed. In such cases, you will have to move as quickly as possible to discover the ***provider's present address*** and report this to your supervisor.

Usually, the best source of this information will be the County or State medical society. They will often have a new address or will at least know what community the provider moved. If they have no information on the present address, you will have to try other sources. For example; appropriate sources include:

- the present occupant of the provider's former office
- the U.S. postal service
- a hospital where the provider was formerly affiliated (the medical society may be able to give you the hospital name)
- the Internet (AMA Website)

Any such moves must be reported ***immediately*** because your office must then alert a field representative in the new PSU to make contact with the provider in advance of the Assigned Reporting Week. Your supervisor may give you the name and address of the field representative to whom the assignment is to be transferred.

Enter the provider's new address in item 39a on the NAMCS-1 Control Card and the transfer information provided by your supervisor in item 39b on the NAMCS1 Control Card.

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36 **Check all that apply to describe provider's practice or medical activities which define him/her as ineligible or out-of-scope.** **36**

Record this information immediately while the details are fresh in your mind. Check all that apply to describe provider's practice or medical activities which define him/her as ineligible or out-of-scope. If you have any questions about the provider's eligibility, discuss the situation with your supervisor immediately. After completing item 36, skip to item 40.

37a-e **a. At what point in the interview did the refusal/break-off occur?** **37a-e**

b. By whom?

c. What reason was given?

d. Date refusal/break-off was reported to supervisor

e. Conversion attempt result

It is very important that you complete this series of items ***accurately and completely,*** since we intend to follow-up every refusal and break-off vigorously and promptly. It is also essential ***to immediately telephone your supervisor.*** Enter the date you reported the refusal/breakoff in item 37d.

When reporting (via telephone) refusals and/or breakoffs to your supervisor, give the full details and the days and hours the provider and staff are in the office. This is a great help. Also provide estimated times when you would be available to visit the provider's office for the Induction Interview. In this way, the office may be able to arrange an appointment if the doctor agrees to participate.

If you get a refusal in spite of your persuasive efforts, accept it graciously to leave the way open for further attempts. Do NOT mention to the provider or staff that they may be contacted by telephone or receive another letter. If you mention this, you could close the door on a conversion attempt. For example, if the field representative says, "Someone from my office will call you," the provider may respond emphatically "I don't want any more phone calls or letters."

As most of the refusals happen during the telephone screening, your main job is to get the provider to agree to see you to discuss participation in the survey.

Your office will phone you directly when a doctor agrees to participate or agrees to give you an appointment to discuss the survey materials. ***Do not assume*** that because the provider was converted that he/she was thoroughly convinced that NAMCS is a worthwhile endeavor. The long distance telephone call (person-to-person) may have influenced the provider to reconsider our request and to give the caller the time to discuss any problem or objection(s) about participating. The field representative must ***be prepared to reinforce*** the conversion specialist's work.

The office will brief you on what commitment was obtained from the provider and what arrangements were made with the provider or nurse for participation in the survey.

If the conversion specialist is not successful in getting the provider to agree to participate in the survey, your supervisor will notify you that the refusal is final.

Item 37e refers to the outcome of the attempt to convert a refusal or breakoff. As soon as your supervisor learns of the refusal or breakoff, a conversion specialist from the office will telephone the doctor. The results of this conversion attempt will then be reported to you, and you should mark the appropriate box in item 37e.

If the conversion attempt was successful you will follow-up by phoning the doctor again for an appointment or by keeping the appointment the office may have made, or by taking whatever other action is suggested. If the conversion attempt was not successful or was not made, you will return the questionnaire and other material related to the case to the office.

38 Why is the provider unavailable or not in practice? 38

If code 6 - Temporarily not practicing, or code 11 Unavailable during reporting period, are marked in item 35, enter a full explanation of the reason in item 38. Use another sheet of paper if there is not enough space, and attach it to the questionnaire. Enter "see attached sheet" on the lines provided.

39a-b a. What is the provider's new address? 39a-b
b. Name of Field Representative
Record information on NAMCS-1 Control Card

If the doctor has moved out of the PSU (code 12 marked in item 35), you will enter the new address and telephone number in item 39a on the NAMCS-1 Control Card. Be sure that this information is recorded clearly and accurately.

After you notify your office with this new location information, the office may provide you with the new regional office (if applicable), name of the person who will be assigned to follow up on the case, and the new PSU number to which the case will be assigned. Complete item 39b on the NAMCS-1 (CC) with this information.

If the office gives you an address for the field representative who will take the case, mail all case materials directly to his/her address. Please remember to mail the NAMCS-1, NAMCS-30, and NAMCS-CCS separate from the NAMCS-201 and NAMCS-1(CC). Remember to include copies of the NCHS advance letter and the endorsement letters.

Section IV - Disposition and Summary

1) When to complete	Complete items 40 - 42 (on page 21 of the questionnaire) AFTER all edits of the Patient Record forms and NAMCS-1 items have been completed; and the final edit call (if needed) has been made. (See Section 2, Final Edit Call, on page B6-10).
2) Explanation of Section IV items	Instructions for each item are provided in numeric sequence on the following pages.

40a-c **Final Disposition** **40a-c**
(a) Eligible physician/provider
(b) Unused CHC NAMCS-1
(c) Transfer cases

This item reflects the FINAL STATUS of the case.

Section (a) is a CRITICAL item that must be completed for all private practice physicians in the regular NAMCS sample and all physicians/providers selected to the CHC sample.

Box 1 "Completed Patient Record forms," if you have received any completed forms from the provider.

Box 2 "Out-of-scope," if you determined that the provider is out-of-scope for this study. (Refer to item 35, codes 2, 3, 4, 5, 6, 8, 9, or 10).

Box 3 "Refused-Breakoff," should be used if AFTER ALL CONVERSION EFFORTS, the provider still has not completed and returned any Patient Record forms.

Box 4 "Unavailable during reporting period" is used for providers who are in-scope for this study, but who did not practice during the assigned reporting week (Item 35, code 11). The total time not practicing should be for less than three months.

Box 5 "Moved out of PSU" should be marked rarely since the majority of movers are followed. If you determine that the provider is no longer living within your PSU, contact your supervisor immediately. ***NOTE*** - If the provider's new address is in another NAMCS PSU you may be instructed to send the materials to a field representative in the new PSU. Always seek approval from the Regional Office before marking the case code 5, "Moved Out Of PSU." (See paragraph on Movers in Section 2, Provider's telephone number, on page B3-2.)

Box 6 If you have not been able to locate the provider, mark "Can't locate."

Section (b) is solely for those community health centers with less than three physians/providers selected to sample. The Field Representative and Regional Office are still responsible for returning three original NAMCS-1 questionnaires. This section provides thefinal dispositions for the blank questionnaires that could not be completed. For example, if you sample a CHC and there are only two providers working at that location, for the 3rd provider you would mark checkbox 7 "Less than 3 providers sampled." Likewise, if the Director of the CHC refuses each of the 3 NAMCS1s you turn in, you would select a disposition of "Parent CHC Refused to Participate." The other disposition is for CHCs that are out-of-scope and therefore there are no providers to sample.

Section (c) has only one checkbox, "Moved out of PSU." This is NOT a valid FINAL disposition, but rather a "holding" disposition for those cases for which the provider has moved from their sampled location and the FR is transferring the case to the new RO. The new RO should determine the final disposition and mark the correct checkbox in either section 40 (a) or (b.)

CASE SUMMARY IS THE MOST IMPORTANT ITEM ON THE NAMCS-1. IT PROVIDES THE BASIS FOR ACCURATE STATISTICAL ESTIMATES USING NAMCS DATA.

EXCEPT FOR RESPONDENT COOPERATION, RECORDING THE TOTAL COUNT OF ACTUAL VISITS FOR THE REPORTING PERIOD IS THE MOST IMPORTANT TASK IN THE SURVEY!

The total visit count for the reporting period is the basis for all analysis of survey data. The more accurate this count is, the more valid and useful the data from the survey becomes. Without this count, the patient visit data are virtually useless. Obtaining this count and knowing how accurate it is can sometimes be difficult. We rely on you, the FR, to obtain the best possible determination of the count for each respondent. The source of the best information will vary from respondent to respondent, but may be a count based on the overlay on the cover of the Patient Record Folio Log, the provider's appointment book, or some other record. In most instances, it will be easier for the respondent to help provide an accurate count if told in advance exactly what is needed and why. Having the respondent keep track of the count on a daily basis for NAMCS is generally helpful.

- **Item 41.1** -- Determine "Number of patient visits" after all edits have been completed and the Final Edit Call has been made. As mentioned above, refer to the PRF cover overlay or another reliable source provided by the respondent. Enter the total number of patient visits during the reporting week.

- **Item 41.2** -- Determine "Number of days during reporting week on which patients were seen" as follows:

  1) Refer to Edit Item 43d on page 22 of the NAMCS-1.
     a. ***If Item 43d is marked "Yes"*** - simply enter the total days in practice from the provider's office schedule (page 5 on the NAMCS-1).

     b. ***If Item 43d is marked "No"*** - check the entries made in Section VI, Part 2 "Missing Days or Blocks of Time" on page 23 of theNAMCS-1 to determine which days during the reporting week the provider actually saw patients. Please note, the NAMCS1 contains a typo and directs you to p.24.

  2) Office staff can also be consulted for a count of days. Enter this total number of days in the box provided in item 41.2 of the NAMCS-1.

- **Item 41.3** -- Enter the total number of Patient Record forms that you received from the physician in the boxes provided. In this count, do NOT include any Patient Record forms that were not completed due to no shows, left before being seen, etc. Do not include voids.

FR, PLEASE READ BEFORE CONTINUING.

These instructions are important for understanding cases that may need special attention at a later date.

Item 41(1) – Accurate determination of "Number of patient visits during reporting week" is **EXTREMELY IMPORTANT**! This count includes any days the physician may have skipped or not participated and may be obtained from either the office staff or from the PRF Flio cover. Only include visits to the sampled provider, and total visits to entire practice or clinic.

Item 41(3) – If the number of Patient Record forms completed is less than 20 or greater than 40, then explain why in the NOTES section below.

Item 17e and 41(1) - If applicable, record explanation of why items 17e and 41(1) differ significantly and any other information regarding this case which may help to understand it at a later date.

42a-b Final disposition for Cervical Cancer Screening Supplement (CCS) **42a-b**

a. Physician/Provider Eligible for the CCS
b. Other

This item must be completed for **all** providers in the survey.

(a) Physician/Provider Eligible for the CCS
If the provider was eligible for the supplement, complete part (a) of this item. Eligibility is defined as any and all physicians/providers with the following specialties:

- GFP
- IM
- OB/GYN
- any provider at a CHC

Refer to page 3 of your Information Flashcard Booklet for subspecialty clarifications that would allow physicians to also receive a CCS.

Even if the eligible provider reported that they did not perform screening, you should still complete part (a).

(b) Other
Record the CCS disposition for private practice physicians in the regular NAMCS sample whose specialty is NOT in the categories mentioned above in section (a).

If you have questions refer to the NAMCS1 Item 42 Decision Chart on Page 24 of the NAMCS21 Information Flashcard Booklet or speak with your supervisor.

Section V - Patient Record Form Check

Section V serves as a final check to insure that the sampling procedures were completed properly and the quality of information returned on the Patient Record forms is the best it can be. The baseline for the check is the Case Summary countsin item 41, page 21 of the NAMCS-1 Questionnaire and the Sample Provider's Office Schedule which is found on page 5 of the NAMCS1. The instructions will be discussed in more detail on page B5-6.

CHECK ITEM D

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1) Record who answered the questionsin the Physician Induction Interview. If the physician/provider or the office staff did not answer the Induction Interview, mark (x) in the "Other" category and specify in the adjacent blank box.

2) Record who completed the Patient Record forms in the appropriate space. If the mid-level provider/doctor, office staff, or FR did not complete the Patient Record forms, mark (X) in the "Other" category and specify in the adjacent blank box.

3) Record whether or not the sampled provider accepted the Data Use Agreement. If HIPAA was not an issue and/or not discussed then mark "Yes."

4) If the data was abstracted, then record if the Accounting Document was placed in the medical records of the patients whose visits fell into sample. If the Accounting Document was not placed in the medical records, please provide an explanation so a better understanding can be developed.

5) Record if the IRB approval was requested by the sampled provider/staff.

43a-d **Verify that all items on the patient Record form check have been answered. DO NOT call the sampled provider regarding missing information on Patient Record form unless instructed by your supervisor or the FR Manual.** **43a-d**

a. **Check for missing Patient Record forms (e.g., if the last completed Patient Record is number 1500051, do you have 1500001 through 1500050).** ***List missing Patient Record forms in Section VI, part I of chart.***

b. **Item 1a –** ***Date of visit recorded on each Patient Record form– If missing, complete 1 and 2 below.***

c. **Items 1-13 – Verify that each of these items has been answered on the Patient Record form. List missing information in Section VI, Part 3 of chart on page 24.**

d. **Check the sample provider's officeschedule against the dates on the Patient Record forms for survey week days with no completed Patient Record forms. Do the dates on the Patient Record forms include every day during the survey week that the sample provider's office scheduled appointments?**

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43 a – d are the Patient Record form quality verification questions. Follow these instructions to verify

that the patient record entries are complete and accurate. Remember, these checks should be completed by you (the FR) and your RO editors.

Section VI - Missing Information Chart

Section VI works in conjunction with Section V by providing an orderly process to record the mistakes or concerns encountered in the final review of the returned Patient Recordforms.

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46 For all Final =1 cases, transfer information from front of Patient Record Folio. 46

Starting in 2008, the FR will transcribe the Number of Patient Visits/Completed Patient Record entries from the cover of the NAMCS-30 PRF to item 46 in the NAMCS-1 Questionnaire. In addition, the SW and TE values should be recorded. Please pay special attention to the situations below.

1) Sampled Physician Seeing Patients At More Than One Office

Use a separate folio at each office location. Clearly distinguish between figures recorded on the folio covers as displayed in the example below where the physician saw patients at two office locations.

NAMCS-1, Item 46 Summary Where Separate Folio Used At Two Office Locations

WEEK OF –			**FROM** Month Day				**TO** Month Day			
SURVEY WEEK			Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
Complete a Patient Record for patient		Number of patient visits #1	8	8	0	15	15	0	0	46
SW		#2	7	7	15	0	0	15	0	44
	TE	Number of records completed #1	2	2	0	5	5	0	0	14
		#2	2	2	5	0	0	5	0	14
Notes										

2) Sampled Physician Seeing Patients At More Than One Office But Inadvertently Uses The Same Patient Record Folio At All Locations

This situation is the real reason item 46 was added to the NAMCS-1, so try to distinguish between the work completed at each office, in the exact manner as the above example. This is the preferred method and will greatly help in determining which visits should be assigned to a partidar office. If not possible, then make sure the entries correctly summarize the "Visits/Records Completed"

across all offices where patients were seen. In the NOTES space beneath item 46, enter the Starting and Ending Sequence numbers for the patient records completed at each office where patients were seen (e.g., Office 1 = 1000001 to 1000015 and Office 2 = 1000016 to 1000030) As a rule, we prefer that a separate folio be used at each office location.

Appendix A – Definition of Group Practice

Please pay special attention to the following definition and background information on group practices.

There has been some confusion about what constitutes a group practice as it relates to the staff and laboratory test information requested in the NAMCS-1. Confusion occurs more frequently in large groups with:

- *a very large staff*
- *facilities at more than one location*
- *more than one laboratory*
- *an off-site laboratory serving the group*

The following guidelines are intended to help define what constitutes the "group practice" for the sample physician. Once the group is defined, the staff and laboratory testing information should be collected for the group.

DEFINING THE GROUP

The variety of possible administrative arrangements for group practices in NAMCS makes it difficult to describe an arrangement that will apply to all cases. It is often impossible to separate the information for the sample physician from others in the group, it is necessary to consider the group as a whole for recording staff and laboratory information. In many groups, facilities are shared by members of the group and cannot be separated. Therefore, to be consistent, laboratory information should be reported for the whole group even if the information could be separated for the sample physician.

The sample physician usually will be able to define the content of the group practice, particularly when the entire group is practicing at the same location. It is generally safe to accept the word of the sample physician that he/she belongs to the group; let the physician define which physicians and staff make up the group.

However, when a group practice operates facilities that provide medical care at more than one location (the physicians and staff may work at one location or maywork part of their time at several locations), the group is defined as the physicians and staff at all locations where the sample physician sees patients.

LABORATORY DATA

Similarly, the laboratory testing information recorded in the NAMCS-1 should include the tests done by the sample physician and those done for the physician by staff of the group. The laboratory testing could be done in a variety of settings including the physician's immediate office, in a nearby room, or in an offsite laboratory operated by the group exclusively for the group. If a laboratory is used by other members of the group, the laboratory information for the NAMCS-1 should pertain to all activities of the laboratory, including tests ordered by others in the group. If a laboratory also serves physicians NOT in the group, then that laboratory will NOT be considered part of the group. Do NOT include testing done in that laboratory, or staff working in that laboratory, in the information recorded on the NAMCS-1. For example, a large HMO is made up of several "units" at a single location, including an OBG "department." The entire HMO constitutes the group. The sample OBG physician does a few routine tests in her immediate office. These tests will be included in the data recorded on the NAMCS-1. Also, the OBG department has a separate room(s) where other tests are performed by laboratory technicians for any of the OBG's in the HMO. All tests performed in this laboratory are also included in the laboratory data. In addition, the HMO operates a large laboratory facility for use by all of its physicians, (the laboratory may be either on or off site). These tests will also be included in the data IF the laboratory serves only the physicians in that group (here defined to be the single location of the HMO).