THE NATIONAL
CHILDREN'S
STUDY

HEALTH   GROWTH   ENVIRONMENT

Recruitment Strategy Substudy

Event Name(s):
Provider-Based Recruitment Schema Questionnaire (PB)

Instrument Name(s) and Versions:
Provider-Based Recruitment Schema Questionnaire (PB) – 1.0

Recruitment Groups:
Provider-Based

Provider-Based Recruitment Schema Questionnaire (PB)

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Provider-Based Recruitment Schema Questionnaire (PB)

INTERVIEWER COMPLETED

Part A. Questions 1 through 6 are to be answered at the <u>Institution Level of Practice</u>.

(PB_INSTI_INFO_DATE) Date Questionnaire is Completed:

month_____   day_____   year _____
MM   DD   YYYY

(PB_INSTI_INFO_SOURCE) Interviewer: Circle information sources used to complete instrument.
SELECT ALL THAT APPLY.

      OBSERVATION……………………………………………………… 1
      WEBSITE/PRINTED INFORMATION………………………………… 2
      INTERVIEW WITH PROVIDER………………………………………… 3
      INTERVIEW WITH PROVIDER STAFF……………………………… 4

Medical Practice Institution

1. **(PB_INSTI_FULLNAME)** Name of practice :_____

2. **(PB_INSTI_ID)** Practice number (PSU#, Practice #)

      |___|___|___|___|___|___|___|___| P |___|___|___|
      PSU#   PRACTICE#

3. **(PB_INSTI_SIZE)** How many practice locations?

      |___|___|
      TOTAL LOCATIONS

4. **(PB_PROV_TOTAL)** How many total providers?

      |___|___|
      TOTAL PROVIDERS

5. **(PB_PRACT_RES)** Does practice participate in research studies?

        Yes………………………………………………………… 1
        No……………………………………………………. 2 **(PB_PRAC_SPEC)**

If 5, **(PB_PRACT_RES)** = Yes, what type of research does practice participate in?

	YES	NO
a. Pharmaceutical **(PB_RES_PHARM)**	1	2
b. Practice-based research networks **(PB_RES_NETWORK)**	1	2
c. Other **(PB_RES_OTH)** IF YES, GO TO **(PB_PRAC_RES _OTH)**	1	2
d. **(PB_PRAC_RES _OTH)** SPECIFY _____		

6. **(PB_PRAC_SPEC)** Were there special requirements for the medical practice to participate in NCS?

        Yes………………………………………………………… 1
        No……………………………………………………… 2
        (PROVIDER_COMPLETE_DATE)

If 6, **(PB_PRAC_SPEC)** = Yes, what was required?

	YES	NO
a. **(PB_SPEC_MOU)** Memorandum of understanding or other written partnership agreement	1	2
b. **(PB_SPEC_LSE)** Lease agreement	1	2
c. **(PB_SPEC_PMT)** Payment for staff time	1	2
d. **(PB_SPEC_IRB)** IRB	1	2
e. **(PB_SPEC_CE)** Continuing Education	1	2
f. **(PB_SP_OTHINC)** Other incentive type of activities. IF YES, GO TO **(PB_INC_OTH)**	1	2
g. **(PB_INC_OTH)** SPECIFY _____		

INDIVIDUAL PRACTICE LOCATION

Part B. Questions 1 through 24 are to be gathered for the <u>Individual Practice location</u>.

(PROVIDER_COMPLETE_DATE) Date Questionnaire is Completed:

month_____   day_____   year _____
MM   DD   YYYY

(PB_PROV_ SOURCE) Interviewer: Circle information sources used to complete instrument. SELECT ALL THAT APPLY.

       OBSERVATION………………………………………………… 1
       INTERVIEW WITH PROVIDER……………………………… 2
       INTERVIEW WITH PROVIDER STAFF……………………… 3

Medical Practice Characteristics

1. Practice location address.

      _____

      Street address **(ADDRESS_1)/(ADDRESS_2)**

      _____   _____

      Suite/Apt/Unit# **(UNIT)………………**City **(CITY)**

      |___|___| |___|___|___|___|___| |___|___|___|___|
      State   Zip code   Zip code+4
      (STATE)   (ZIPCODE)   (ZIP4)

2. **(PB_PROV_ID)** Practice location number (PSU#, practice #,location #)

      |___|___|___|___|___|___|___|___| P |___|___|___| L |___|___|
      PSU#   Practice#   Location#

3. **(PB_PROV_SIZE)** Practice location size (number of providers)

       |___|___|___|
       Total providers

4. Practice location provider mix (number of each provider type):

|___|___|
(**NUM_OBGYN**) Obstetrics/Gynecology (OB/GYN)

|___|___|
(**NUM_FP**) Family practice

|___|___|
(**NUM_MIDWIVES**) Midwives

|___|___|
(**NUM_OTHER**) Other

INTERVIEWER INSTRUCTION: VERIFY NUMBER OF OBGYNs, FPs, MIDWIVES AND OTHERS SUCH THAT **(PB_PROV_SIZE)** = **(NUM_OBGYN)** + **(NUM_FP)** + **(NUM_ MIDWIVES)** + **(NUM_OTHER)**

5. **(PB_PRAC_TYPE)** What type of practice?

Private with no health system or university affiliation   1
Private with health system or university affiliation ……   2
Health system with no university affiliation ………………   3
Academic medical center …………………….………………4
Federally qualified health center ……………………………. 5
Public health department clinic …………………………….. 6
Other,……………………………………………..……………. -5 **(PB_PRAC_TYPE_OTH)**

   (PB_PRAC_TYPE_OTH), SPECIFY _____

6.   **(PB_PROV_SVC**) Services provided:
          SELECT ALL THAT APPLY.

Pregnancy screening only………………………………….… 1
Prenatal care only ………………….………………………..… 2
Full OB with birthing …………….……………………………. 3
GYN only/no OB ……………………………………………….. 4
Other. …………………………………………………………… -5 **(PB_PROV_SVC_OTH)**

   (PB_PROV_SVC_OTH), SPECIFY _____

7. Primary Hospitals (Hospital numbers –PSU#, specific hospital #) used for deliveries:

   a. Hospital #1 **(INST_NAME1) (INSTITUTE_ID1)** _____

     |___|___|___|___|___|___|___|___| H |___|___|___| … Hospital name
       PSU#   Hospital#

   b. Hospital #2 **(INST_NAME2) (INSTITUTE_ID2)** _____

     |___|___|___|___|___|___|___|___| H |___|___|___| … Hospital name
       PSU#   Hospital #

   c. Hospital #3 **(INST_NAME3) (INSTITUTE_ID3)** _____

     |___|___|___|___|___|___|___|___| H |___|___|___| … Hospital name
       PSU#   Hospital #

   d. Hospital #4 **(INST_NAME4) (INSTITUTE_ID4)** _____

     |___|___|___|___|___|___|___|___| H |___|___|___| … Hospital name
       PSU#   Hospital #

   e. Hospital #5 **(INST_NAME5) (INSTITUTE_ID5)** _____

     |___|___|___|___|___|___|___|___| H |___|___|___| … Hospital name
       PSU#   Hospital #

Characteristics of Patients in Medical Practice

8. **(NUM_BIRTHS)** Number of births per month:

     |___|___|
     TOTAL BIRTHS

9. **(NUM_NEW_PTS)** Number of **new** prenatal patients per month:

     |___|___|
     TOTAL PATIENTS

10.   Observed or reported primary race of patients:

(PT_RACE_AIAN) American Indian or Alaska Native:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(**PT_RACE_ASIAN**) Asian:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(PT_RACE_BLACK) Black or African American:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(PT_RACE_HISP) Hispanic or Latino:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(PT_RACE_NHPI) Native Hawaiian or Other Pacific Islander:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(PT_RACE_WHITE) White:
0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

11.   Observed or reported primary language preferred by patients?

(PT_LANG_ENG) English:

0-33%...1
34-66%.. 2
67-100% ……………………………………………………. 3

(PT_LANG_SPAN) Spanish:

0-33%... 1
34-66%.. 2
67-100% …….. 3

(PT_LANG_OTH) Other:

0-33%... 1 **(PT_LANG_SPEC)**
34-66%.. 2 **(PT_LANG_SPEC)**
67-100% …….. 3 **(PT_LANG_SPEC)**

(PT_LANG_SPEC), SPECIFY LANGUAGE(S)

_____

12. Approximate payer mix :

(PAY_INS_TRICARE) Tricare:

0-33%... 1
34-66%.. 2
67-100% …….. 3

(PAY_INS_MEDICAID) Medicaid:

0-33%... 1
34-66%.. 2
67-100% …….. 3

(PAY_INS_COMM) Commercial:

0-33%... 1
34-66%.. 2
67-100% …….. 3

(PAY_INS_HMO) HMO:

0-33%... 1
34-66%.. 2
67-100% …….. 3

(PAY_SELF) Self Pay:

0-33%... 1
34-66%.. 2
67-100% …….. 3

Description of Practice Location's Participation in NCS

	YES	NO
13. **(PROVIDER_NCS_TRN)** Allows NCS staff to provide training for office staff regarding the study?	1	2
14. **(PROVIDER_NCS_INFOWT)** Allows NCS information to be displayed in waiting room?	1	2
15. **(PROVIDER_NCS_INFOEX)** Allows NCS information to be displayed in exam rooms?	1	2
16. **(PROVIDER_NCS_ACC)** Allows NCS staff to access patient records for eligibility determination?	1	2
17. **(PROVIDER_NCS_ALT)** Office staff utilizes the Address Lookup Tool for eligibility determination?	1	2
18. **(PROVIDER_NCS_LTR)** Allows us to send letter to patients to introduce NCS?	1	2
19. **(PROVIDER_NCS_PNLTR)** Allows providers' names to be used in the letter sent by NCS to introduce study?	1	2
20. **(PROVIDER_NCS_INFO)** Provides patient information on NCS during the appointment?	1	2
21. **(PROVIDER_NCS_STF)** Allows an NCS staff person to speak with a patient during her appointment?	1	2
22. **(PROVIDER_NCS_RFR)** Refers patients to NCS with no on-site contact?	1	2
23. **(PROVIDER_NCS_PARTIC)** Other participation in NCS. IF YES, GO TO **(PROVIDER_NCS_OTH)**	1	2
24. (**PROVIDER_NCS_OTH),** SPECIFY _____		