

***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 Institution Level of Practice.**

**(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#

1. **(PB\_INSTI\_SIZE)** How many practice locations?

 |\_\_\_|\_\_\_|

TOTAL LOCATIONS

1. **(PB\_PROV\_TOTAL)** How many total providers?

 |\_\_\_|\_\_\_|

 TOTAL PROVIDERS

1. **(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 |
| 1. Pharmaceutical **(PB\_RES\_PHARM)**
 | 1 | 2 |
| 1. Practice-based research networks **(PB\_RES\_NETWORK)**
 | 1 | 2 |
| 1. Other **(PB\_RES\_OTH)** IF YES, GO TO **(PB\_PRAC\_RES \_OTH)**
 | 1 | 2 |
| 1. **(PB\_PRAC\_RES \_OTH)** SPECIFY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

1. **(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 |
| 1. **(PB\_SPEC\_MOU)** Memorandum of understanding or other written partnership agreement
 | 1 | 2 |
| 1. **(PB\_SPEC\_LSE)** Lease agreement
 | 1 | 2 |
| 1. **(PB\_SPEC\_PMT)** Payment for staff time
 | 1 | 2 |
| 1. **(PB\_SPEC\_IRB)** IRB
 | 1 | 2 |
| 1. **(PB\_SPEC\_CE)** Continuing Education
 | 1 | 2 |
| 1. **(PB\_SP\_OTHINC)** Other incentive type of activities. IF YES, GO TO **(PB\_INC\_OTH)**
 | 1  | 2 |
| 1. **(PB\_INC\_OTH)** SPECIFY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**INDIVIDUAL PRACTICE LOCATION**

**Part B. Questions 1 through 24 are to be gathered for the Individual Practice location.**

**(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

1. 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)**

1. **(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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **(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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Primary Hospitals (Hospital numbers –PSU#, specific hospital #) used for deliveries:
2. Hospital #1 **(INST\_NAME1) (INSTITUTE\_ID1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| H |\_\_\_|\_\_\_|\_\_\_| Hospital name

 PSU# Hospital#

1. Hospital #2 **(INST\_NAME2) (INSTITUTE\_ID2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| H |\_\_\_|\_\_\_|\_\_\_| Hospital name

 PSU# Hospital #

1. Hospital #3 **(INST\_NAME3) (INSTITUTE\_ID3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| H |\_\_\_|\_\_\_|\_\_\_| Hospital name

 PSU# Hospital #

1. Hospital #4 **(INST\_NAME4) (INSTITUTE\_ID4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| H |\_\_\_|\_\_\_|\_\_\_| Hospital name

 PSU# Hospital #

1. Hospital #5 **(INST\_NAME5) (INSTITUTE\_ID5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| H |\_\_\_|\_\_\_|\_\_\_| Hospital name

 PSU# Hospital #

**Characteristics of Patients in Medical Practice**

1. **(NUM\_BIRTHS)** Number of births per month:

 |\_\_\_|\_\_\_|

 TOTAL BIRTHS

1. **(NUM\_NEW\_PTS)** Number of **new** prenatal patients per month:

 |\_\_\_|\_\_\_|

 TOTAL PATIENTS

1. 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

1. 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 |
| 1. **(PROVIDER\_NCS\_TRN)** Allows NCS staff to provide training for office staff regarding the study?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_INFOWT)** Allows NCS information to be displayed in waiting room?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_INFOEX)** Allows NCS information to be displayed in exam rooms?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_ACC)** Allows NCS staff to access patient records for eligibility determination?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_ALT)** Office staff utilizes the Address Lookup Tool for eligibility determination?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_LTR)** Allows us to send letter to patients to introduce NCS?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_PNLTR)** Allows providers’ names to be used in the letter sent by NCS to introduce study?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_INFO)** Provides patient information on NCS during the appointment?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_STF)** Allows an NCS staff person to speak with a patient during her appointment?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_RFR)** Refers patients to NCS with no on-site contact?
 | 1 | 2 |
| 1. **(PROVIDER\_NCS\_PARTIC)** Other participation in NCS. IF YES, GO TO **(PROVIDER\_NCS\_OTH)**
 | 1 | 2 |
| 1. (**PROVIDER\_NCS\_OTH),** SPECIFY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |