**Attachment 2: NAMCS: Medical Organizations Survey OMB No.: 0920-0222 Exp. Date xx/xx/20xx**

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| **NOTICE -** Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Information Collection Review Office; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).**Assurance of Confidentiality -** All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).  |

NAMCS: Medical Organizations Survey

The Medical Organizations Supplement is an expansion of the National Ambulatory Medical Care Survey (NAMCS). The purpose of the survey is to collect information about medical organizations where all physicians work across many settings. Your participation is greatly appreciated. Your answers are completely confidential. Participation in this survey is voluntary. If you have questions or comments about this survey, please call 866-966-1473.

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| 1. Which of the following best describes this medical organization? By medical organization we mean the organization that employs physicians who work together and may share staff, patient medical records, and income, and includes solo practices and groups owned by a hospital. If the medical organization has more than one location answer across all locations. CHECK ONE ONLY

□1 Independent solo or two physician practice□2 Independent group practice – three or more physicians□3 Group or staff model HMO□4 Network of physicians owned by a hospital, hospital system or medical school□5 Hospital or medical school staff□6 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Overall, how many locations does this medical organization have to do clinical work?

\_\_\_\_\_\_\_\_\_\_Number of locations. | 1. Approximately how many physicians work for this medical organization, across all of its locations?

\_\_\_\_\_\_ Number of physicians 1. What are the three most common physician specialties represented in your medical organization?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**1. Who owns the medical organization? CHECK ALL THAT APPLY

□1 Physicians in the practice□2 Another physician group□3 Insurance company, health plan, or HMO □4 Community health center□5 Medical school or university/academic health center □6 Other public or private hospital, health system, or foundation owned by a hospital □7 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. How would you rate this medical organization’s performance in each of the following areas over the past 12 months?
 | Excellent | Very Good | Good | Fair | Poor | Uncertain |
|  Financial Performance. | □1 | □2 | □3 | □4 | □5 | □6 |
|  Leadership of the organization | □1 | □2 | □3 | □4 | □5 | □6 |
|  Quality of patient care | □1 | □2 | □3 | □4 | □5 | □6 |

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| 1. Who is most involved with decisions for each of the following activities? CHECK ONE ONLY
 | **Physicians at their location** | **Administrators at each clinical location** | **Administrators off-site** **within my organization** | **Administrators outside of my medical organization** | Not applicable |
| a. Contracting with insurance plans | □1 | □2 | □3 | □4 | □5 |
| b. Purchasing medical equipment used at your reporting location | □1 | □2 | □3 | □4 | □5 |
| c. Hiring new physicians | □1 | □2 | □3 | □4 | □5 |
| d. Hiring support staff | □1 | □2 | □3 | □4 | □5 |

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| 1. Who primarily provides the following services for clinical locations in the medical organization? CHECK ONE ONLY
 | **Each clinicallocation** | **The medical organization** | **Network affiliation** (e.g., PHO, IPA) | **Independent Vendor****(e.g.,**management service compay) | N/A |
| a. Billing services | □1 | □2 | □3 | □4 | □5 |
| b. Clinical health information system implementation and support | □1 | □2 | □3 | □4 | □5 |
| c. Shared clinical support services such as nurse care managers or patient educators | □1 | □2 | □3 | □4 | □5 |
| d. Quality improvement program | □1 | □2 | □3 | □4 | □5 |
| e. Malpractice insurance | □1 | □2 | □3 | □4 | □5 |

The next two questions are about types of insurance accepted by the medical organization.

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| 1. About what percent of physician patient care revenue comes from each type of insurance in your medical organization?
 | 1. Is the medical organization accepting new patients for each type of insurance?
 |
| **Types of insurance** | **Percent** | **Yes** | **No** | **Unknown** |
| 1. Private insurance capitated | \_\_\_\_% | □1 | □2 | □3 |
| 2. Private insurance non-capitated | \_\_\_\_% | □1 | □2 | □3 |
| 3. Medicare | \_\_\_\_% | □1 | □2 | □3 |
| 4. Medicaid/SCHIP | **\_\_\_\_%** | □1 | □2 | □3 |
| 5. Workers compensation | \_\_\_\_% | □1 | □2 | □3 |
| 6. Self pay | \_\_\_\_% | □1 | □2 | □3 |
| 7. No charge | \_\_\_\_% | □1 | □2 | □3 |
|  Other: specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_% | □1 | □2 | □3 |
|  | 100% |  |  |  |

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| 1. Does the medical organization receive any additional compensation beyond routine visit fees for offering *Patient-Centered Medical Home (PCMH)* type services or participate in a certified PCMH arrangement?

1□ Yes (Skip to 12)2□ No (Go to 11a)3□ Uncertain (Go to 11a)11a. Are there plans to participate in a PCMH arrangement in the next 12 months?1□ Yes2□ No3□ Uncertain1. Does the medical organization participate in an *Accountable Care Organization* (ACO) arrangement with Medicare or private insurers? An ACO is an entity typically composed of primary care physicians, specialist, and hospitals that is held financially accountable for the cost and quality of care delivered to a defined group of patients.

1□ Yes (Skip to 13)2□ No (Go to 12a)3□ Uncertain (Go to 12a) | 12a. Are there plans to participate in an Accountable Care Organization arrangement in the next 12 months?1□ Yes2□ No3□ Uncertain1. Is this medical organization affiliated with an Independent Practice Association (IPA) or Physician Hospital Organization (PHO)?

1□ No (skip to 14)2□ Yes (Go to 13a)3□ Uncertain (Go to 13a)13a. What percentage of your patients come to you through your IPA or PHO?\_\_ \_\_ \_\_ percent of patients 0□ Uncertain |

1. Do physicians in your medical organization manage patients that have at least one chronic condition?

 1□ Yes 🡪 Continue to Q14a 2□ No 🡪SKIP to Q 15 3□ Uncertain 🡪SKIP to Q15

14a. Among patients cared for by the medical organization, what percent of patients with at least one chronic condition are managed by your physicians?

 \_\_ \_\_ \_\_ % of patients

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| **14b What percent of patients with at least one chronic condition receive the following services, and indicate who provides the service.**  | **Percent of patients receiving service** | **Service provided by…** |
| **Your organization** | **IPA, PHO, or ACO** | **Health plan or other payer** | **Service not provided** |
| a. Clinicans use guideline-based reminders during patient visit | \_\_ \_\_ \_\_ % | □1 | □2 | □3 | □0 |
| b. Patients are sent reminders for preventive or follow-up care  | \_\_ \_\_ \_\_ % | □1 | □2 | □3 | □0 |
| c. Non-physician staff meets with patients to provide them with education or help manage their condition | \_\_ \_\_ \_\_ % | □1 | □2 | □3 | □0 |
| d. Specially trained nurse care managers are used to coordinate care. | \_\_ \_\_ \_\_ % | □1 | □2 | □3 | □0 |

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| 1. Indicate whether this medical organization provides each of the following to its physicians. Do not include reports from other organizations that only cover a portion of the physicians’ patient panels.
 | Yes | No | Uncertain |
| a. Reports on the clinical quality of care the physician individually provide to patients | □1 | □2 | □3 |
| b. Reports on the physician’s individual resource use when treating patients | □1 | □2 | □3 |
| c. A registry of patients with specific conditions.  | □1 | □2 | □3 |

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| 1. What percentage of your organization’s patient care revenue comes from the following?
 | **Percent** |
|
| a. **Traditional *fee-for-service*.**  *Note: does not include performance adjustments, shared savings, etc*. | \_\_ \_\_ \_\_ |
| b. **Modified *fee-for-service* with adjustments for performance quality or cost measures.** Includes quality bonuses, pay for performance | \_\_ \_\_ \_\_ |
| c. **Shared savings**. Organization receives fee-for-service payments but has financial incentives to reduce *health care spending* for a *defined* patient population. Organization receives a percentage of any net savings resulting from care improvement efforts and may bear risk for higher costs. | \_\_ \_\_ \_\_ |
| d. **Bundling payments**. Organization alone or in conjunction with others receives financial incentive for reducing total service use during episodes of care experienced by a specific patient population. | \_\_ \_\_ \_\_ |
| e. **Capitation payments.** Set payment covers full or partial patient services. | \_\_ \_\_ \_\_ |
| f. **Other.** (*Please specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_ \_\_ |

1. Are you either a full or part owner at the medical organization?

1□ Part owner

2□ Full owner

3□ Not an owner

1. Which of the following best describes your role in this medical organization? Select all that apply.

1□ Practice administrator

2□ Medical director

3□ Physician

4□ Office Manager

5□ Other (*Please specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Would you have preferred to complete this questionnaire through a Website or would you have preferred to complete this questionnaire by paper?

1□ Strong paper preference

2□ Slight paper preference

3□ Slight website preference

4□ Strong website preference

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| **Thank you for your participation. Please return your survey in the envelope provided. If you have misplaced this envelope, please send survey to: 2605 Meridian Parkway, Suite 200, Durham, NC 27713**  | Boxes for Admin Use |