

Provider Based Sampling Frame Questionnaire

(Worcester County)

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| **Event:** | Provider Based Recruitment |
| **Participant:**  **Respondent:** | Provider  Provider |
| **Domain:** | Questionnaire |
| **Type of Document:**  **Allowable Mode:**  **Allowable Method:** | Self-Administered Questionnaire  In Person, Telephone, Mail  PAPI |
| **Recruitment Groups:** | PBS |
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| **Release:** | MDES 3.0 |

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| Provider-Based Sampling Frame Questionnaire |
| DEFINITIONS:   * Practice Location/Office: The physical site where the patient care services are delivered; is staffed by one or more health care providers. * Provider: A licensed clinician (e.g., physician, nurse, mid-wife, etc) who provides prenatal health care services at one or more locations within the practice. |
| 1. For Office Use Only:   PSU ID # (Worcester County): 20000228  Practice #: 🞏🞏🞏  Location #: 🞏🞏🞏 |
| 1. Date Questionnaire is completed: 🞏🞏 / 🞏🞏 / 🞏🞏🞏🞏   M M / D D / Y Y Y Y |
| 1. Name of practice (This could be the doctor’s name, the clinic name, the practice name, etc.)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Address of practice location/office:   Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suite/Unit#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: 🞏🞏 Zip Code: 🞏🞏🞏🞏🞏 - 🞏🞏🞏🞏 |
| 1. Name and contact information for practice location/office contact person:   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Position/Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suite/Unit#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: 🞏🞏 Zip Code: 🞏🞏🞏🞏🞏 - 🞏🞏🞏🞏  Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: (🞏🞏🞏) 🞏🞏🞏 - 🞏🞏🞏🞏 Ext: 🞏🞏🞏🞏  Preferred method of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Total number of providers of prenatal care at location/office:   🞏🞏🞏 Total providers |
| 1. Practice location/office provider mix (number of each provider type):   *(The total number of providers listed below should equal the number of total providers in Question #6.*)  🞏🞏🞏 Number of Obstetrics/Gynecology (OB/GYN) providers  🞏🞏🞏 Number of Obstetrics (OB) providers only  🞏🞏🞏 Number of Gynecology (GYN) providers only  🞏🞏🞏 Number of Family Medicine Providers (that provide prenatal care)  🞏🞏🞏 Number of Midwives  🞏🞏🞏 Number of Other Providers. (such as Nurse Practitioners)  Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Type of practice:   🞎 Private with no health system or university affiliation  🞎 Private with health system or university affiliation  🞎 Health system with no university affiliation  🞎 Academic medical center  🞎 Federally qualified health center  🞎 Public clinic with no university/academic affiliation  🞎 Public clinic with university/academic affiliation  🞎 Other. (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| For Questions #9 through #11 below, if you do not have precise numbers, please provide your best estimates. |
| 1. In 2011, or the last year for which you have 12 months of complete data, what was the number of all prenatal care visits across all providers within this location/office?   🞏🞏🞏🞏 *All* prenatal care visits |
| 1. In 2011, or the last year for which you have 12 months of complete data, what was the number of first prenatal care visits across all providers within this location/office? (This number is a subset ofthe total visits listed in *Question #9.)*   🞏🞏🞏🞏 *First* prenatal care visits |
| 1. In 2011, or the last year for which you have 12 months of complete data, what was the number of first prenatal care visits across all providers within this location/office of patients who reside in Worcester county? (This number is *a subset of* the first prenatal care visits listed in *Question #10.)*   🞏🞏🞏🞏 *First* prenatal care visits of *Worcester county residents* |
| 1. Approximate payer mix:   For the list of payers that follows, regarding the approximate payer mix for this practice location/office, list the percent for each payer. Please provide an estimate if the exact percent is not known. The total percentage for all payers cannot be greater than 100%.  Tricare: 🞏🞏🞏%  Medicaid: 🞏🞏🞏%  Commercial: 🞏🞏🞏%  HMO: 🞏🞏🞏%  Self Pay: 🞏🞏🞏% |
| 1. Observed or reported ethnicity of first prenatal care visits:   For the *first prenatal care visit* patients at this medical practice location/office, please indicate the percent of those patients with the following observed or reported ethnicity . Please provide an estimate if the exact percent is not known.  Hispanic, Latina, or Spanish origin 🞏🞏🞏% |
| 1. Observed or reported primary race of first prenatal care visit patients:   Using the following categories, list the observed or reported primary race of patients at this medical practice location/office. Again, the focus is on patients seen at the *first* prenatal care visit. Please provide an estimate if the exact percent is not known. The total percentage for all races cannot be greater than 100%.  White: 🞏🞏🞏%  Black or African American: 🞏🞏🞏%  American Indian or Alaska Native: 🞏🞏🞏%  Asian: 🞏🞏🞏%  Native Hawaiian/ other Pacific Islander: 🞏🞏🞏% |
| 1. Observed or reported primary language preferred by first prenatal care visit patients, by percent:   Using the following options, indicate the reported primary language of first prenatal care visit patients at this medical practice location/office. Please estimate if the exact percent is not known. The total percentage for all languages cannot be greater than 100%.  English: 🞏🞏🞏%  Spanish: 🞏🞏🞏%  Other: 🞏🞏🞏%  (If other, Specify:) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Reported age of first prenatal care visit patients by percent:   For the following groups, indicate the reported age of *first prenatal care visit* patients at this medical practice location/office. Please provide an estimate if the exact percent is not known. The total percentage for all ages cannot be greater than 100%.  Patients under 20 years old: 🞏🞏🞏%  Patients between 20 – 24 years old: 🞏🞏🞏%  Patients between 25 – 29 years old: 🞏🞏🞏%  Patients 30 or more years old: 🞏🞏🞏% |
| 1. Is this location part of a larger practice with multiple locations?   \_\_\_ Yes \_\_\_ No *→ End of Questionnaire.* |
| 1. Name of the larger practice referenced in Question 17: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Name and contact information for Administrative contact (Medical Director, CEO, etc.) for this larger practice:   🞎 Same as Question 5 *→ Go to Question 20.*  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Position/Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suite/Unit#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: (🞏🞏🞏) 🞏🞏🞏 - 🞏🞏🞏🞏 Ext: 🞏🞏🞏🞏  Preferred mode of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Number of locations in the practice where prenatal services are provided:   🞏🞏 Total Locations |
| 1. Number of births per year for all providers/clinicians in the practice listed in *Question #18*:   🞏🞏🞏🞏 Total Births |
| 1. Number of births per year for all providers in the practice from women who reside in Worcester County. (This is a subset of *Question #21*).   🞏🞏🞏🞏 Total Births In Worcester County |