OMB #: 0925-0593 OMB Expiration Date: 07/31/ 2013 Provider Based Sampling Frame Questionnaire Jefferson County, Phase 2e



## Provider Based Sampling Frame Questionnaire (Jefferson County)

**Event:** Provider Based Recruitment

Participant: Provider

**Respondent:** Provider

**Domain:** Questionnaire

**Type of Document:** Self-Administered Questionnaire

Allowable Mode: In Person, Telephone, Mail

Allowable Method: PAPI

Recruitment Groups: PBS

Version: 1.0

Release: MDES 3.0

| Provider-Based Sampling Frame Questionnaire |                                                                                                                                                                                                                                                                                                              |  |  |  |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| DE<br>•                                     | 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 # (Jefferson County): 20000223  Practice #:                                                                                                                                                                                                                                     |  |  |  |
| 2.                                          | Date Questionnaire is completed:  M M / D D / Y Y Y Y                                                                                                                                                                                                                                                        |  |  |  |
| 3.                                          | Name of practice (This could be the doctor's name, the clinic name, the practice name, etc.)                                                                                                                                                                                                                 |  |  |  |
| 4.                                          | Address of practice location/office:  Street Address:  Suite/Unit#:  City:  State:  Zip Code:                                                                                                                                                                                                                |  |  |  |

|                                                                                                             | 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. |                                                                                                                                                                                      |                                                         |  |  |  |
|                                                                                                             |                                                                                                                                                                                      |                                                         |  |  |  |
| 9.                                                                                                          | 9. In 2011, or the last year for which you have 12 months of complete data, what was the number of <u>all</u> prenatal care visits across all providers within this location/office? |                                                         |  |  |  |
|                                                                                                             |                                                                                                                                                                                      |                                                         |  |  |  |
|                                                                                                             |                                                                                                                                                                                      | All prenatal care visits                                |  |  |  |
| 10                                                                                                          | first<br>the                                                                                                                                                                         |                                                         |  |  |  |

| 12. | 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: Website Medicaid: Medicaid |
|     | Commercial:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|     | HMO: White the second of the s |
|     | Self Pay:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 12  | Observed or reported ethnicity of first prenatal care visits:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ΞΟ. | For the <u>first prenatal care visit</u> 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| 14. | Observed or reported <u>primary race</u> of first prenatal care visit patients:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|     | Using the following categories, list the observed or reported <u>primary race</u> of patients at this medical practice location/office. Again, the focus is on patients seen at the <u>first</u> 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: LJ LJ 5%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|     | American Indian or Alaska Native:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|     | Asian:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|     | Native Hawaiian/ other Pacific Islander:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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| Using the following options, indicate                                       | the reported primary language of first prenatal care visit patients  e. Please estimate if the exact percent is not known. The total  be greater than 100%. |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                             |                                                                                                                                                             |
|                                                                             | e reported <b>age</b> of <i>first prenatal care visit</i> patients at this medical ride an estimate if the exact percent is not known. The total            |
| Patients under 20 years old:                                                |                                                                                                                                                             |
| Patients between 20 – 24 years old:                                         |                                                                                                                                                             |
| Patients between 25 – 29 years old:                                         |                                                                                                                                                             |
| Patients 30 or more years old:                                              |                                                                                                                                                             |
|                                                                             |                                                                                                                                                             |
| <b>17. Is this location part of a larger pra</b> Yes No → <b>End of Q</b> o |                                                                                                                                                             |
| 18. Name of the larger practice refere                                      | nced in Question 17:                                                                                                                                        |

| 19. Name and cor<br>larger practice                                       | ntact information for Administrative contact (Medical Director, CEO, etc.) for this                                                                              |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| □ Name: Position/Role: Street Address Suite/Unit#: City: State: Zip Code: | Same as Question 5 → <b>Go to Question 20.</b>                                                                                                                   |
|                                                                           | :                                                                                                                                                                |
|                                                                           | cations in the practice where prenatal services are provided:  _ocations                                                                                         |
| 21. Number of <u>bir</u>                                                  | ths per year for all providers/clinicians in the practice listed in <i>Question #18</i> :  Total Births                                                          |
|                                                                           | ths per year for all providers in the practice from women who reside in Jefferson is a subset of <i>Question #21</i> ).  Total Births In <b>Jefferson</b> County |