Attachment A

OMB No. 0920-0234: Expiration date 12/31/2014

NOTICE - Public reporting burden of this collection of information is estimated to average 35 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 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).

1. Physican's address:

FORM **NAMCS-1A**
(7-25-2012)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

NATIONAL AMBULATORY MEDICAL CARE SURVEY 2013 PANEL

2. Physician's telephone and FAX numbers *(Area code and number)*

Office 1	Telephone		**Office 2**	Telephone	
	FAX			FAX	

3. Progress Record

Activity	Date Completed	FR Code	Notes
Telephone Screener			
Induction Interview			
Patient Record Forms Completed			
Final Disposition and Summary			

Section I – TELEPHONE SCREENER

4. Record of telephone calls

Call	Date	Time	Results
1			
2			
3			
4			
5			
6			
7			

INSTRUCTION *If interview is with a CHC provider, start with Section II on page 5, but remember to complete the office hours on page 4.*

5. Introduction

The Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) is conducting the National Ambulatory Medical Care Survey (NAMCS). This annual study, which has been in the field since 1973, collects information about the large portion of ambulatory care provided by physicians and mid-level providers throughout the United States. Research utilizing the NAMCS helps to inform physicians, health care researchers, and policy makers about the changing characteristics of ambulatory health care in this country. The information that will be requested includes data about the patient visit (e.g., demographics, diagnoses, services, and treatments), physician practice characteristics (e.g., practice type), and the use of electronic medical records.

Many organizations and leaders in the health care community, including those providing the enclosed letter of endorsement, have expressed their support and join me in urging your participation in this meaningful study. You will be asked to complete a short electronic questionnaire on a sample of about 30 patient encounters during a randomly assigned one-week reporting period. Additionally, there is a short interview (approximately 35 minutes) with you about the nature of your practice. You may be asked to complete a short paper supplement, which would take about an additional 20 minutes. We intend to conduct additional health care research by linking your National Provider Identifier (NPI) collected in this study to health care-related data such as Medicare records. Participation is voluntary, and you or your staff may refuse to answer any question or may stop participating at any time without penalty or loss of benefits.

insert "and Federal tax ID" after NPI

The following are some key points about the survey:

- Data collection for the NAMCS is authorized by Section 306 of the Public Health Service Act (Title 42, U.S. Code, 242k).
- All information collected will be held in the strictest confidence according to Section 308(d) of the Public Health Service Act (42, U.S. Code, 242m(d)) and the Confidential Information Protection and Statistical Efficiency Act (Title 5 of PL 107-347). This information will be used for statistical purposes only. No patient names, social security numbers, or addresses are collected.
- This study conforms to the Privacy Rule as mandated by HIPAA, because disclosure of patient data is permitted for public health purposes, the NCHS Research Ethics Review Board has approved NAMCS.
- U.S. Census Bureau employees, who administer the study, have taken an oath to abide by Title 13, U.S. Code, Section 9, which requires them to keep all information about your practice and patients confidential.

A representative of the Census Bureau, acting as our agent, will be calling you to schedule an appointment regarding the details of your participation. If you have any questions regarding your participation, please call a NAMCS representative at 1–800–392–2862. Additional information on the survey may be obtained by visiting the NAMCS participant Web site at www.cdc.gov/namcs/ahcd/namcs_participant.htm.

You may have questions about your rights as a participant in the research study. If so, please call the Research Ethics Review Board at the National Center for Health Statics, toll-free at 1–800–223–8118. Please leave a brief message with your name and phone number. Say that you are calling about Protocol #2010-02. Your call will be returned as soon as possible.

We greatly appreciate your cooperation.

Sincerely,

Edward J. Sondik, PH. D.,
Director

Section I – TELEPHONE SCREENER – Continued

6. Specialty

a. Your specialty is _____, is that right?

1 ☐ Yes – *SKIP to item 6c*
2 ☐ No

Edit

b. What is your specialty (including general practice)?

(Name of specialty)

☐☐☐ Code
Refer to the NAMCS-21, pages 3 and 4 for codes.

Edit

c. What is your ethnicity?

1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

d. What is your race?
Enter (X) one or more.

1 ☐ White
2 ☐ Black/African-American
3 ☐ Asian
4 ☐ Native Hawaiian/Other Pacific Islander
5 ☐ American Indian/Alaska Native

7. Which of the following categories best describes your professional activity – patient care, research, teaching, administration, or something else?

1 ☐ Patient care
2 ☐ Research
3 ☐ Teaching
4 ☐ Administration
5 ☐ Something else – *Specify*

8a. Do you directly care for any ambulatory patients in your work?

1 ☐ Yes – *SKIP to item 8c*
2 ☐ No – does not give direct care *[8b PROBE]*
3 ☐ No longer in practice – *SKIP to item 10 on page 4*

b. *PROBE:* **We include as ambulatory patients, any patients coming to see you for personal health services who are not currently on the premises. Does your work include any such individuals?**

1 ☐ Yes, cares for ambulatory patients
2 ☐ No, does not give direct care –*Determine reason, then read item 10 on page 4*

c. Do you work as an employee or a contractor in a federally operated patient care setting or in a hospital emergency or outpatient department?

1 ☐ Yes
2 ☐ No – *SKIP to item 9a on page 4*

d. In addition to working in a federally operated patient care setting, hospital emergency or outpatient department, do you also see any ambulatory patients in another setting?

1 ☐ Yes
2 ☐ No – *SKIP to item 10 on page 4*

If "Yes" to item 8d, all of the following questions are concerned with the private patients.

Section I – TELEPHONE SCREENER – Continued

9a. **We have your address as** *(Read address shown in item 1).* **Is that the correct address for your office?**

1 ☐ Yes – *SKIP to item 12*
2 ☐ No, incorrect address – *Ask item 9b*

b. **What is the (correct) address and telephone number of your office?**

Number and street

City

State | ZIP Code

Telephone *(Area code and number)*

SKIP to item 12

10. **Has the physician moved out of the United States?**

1 ☐ Yes – *SKIP to CHECK ITEM A on page 7*
2 ☐ No

11. **Is the physician retired or deceased?**

1 ☐ Yes – *SKIP to CHECK ITEM A on page 7*
2 ☐ No

12. **Thank you, Dr. . . ., but I believe that since you do not (see any ambulatory patients/practice any longer), our questions would not be appropriate for you. I appreciate your time and interest.** *(Go to Check Item A on page 7.)*

PROVIDER'S OFFICE SCHEDULE

INSTRUCTION *Please complete the office schedule for the week the provider is in sample.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.							
P.M.							
Office No.							

NOTES

Section II – INDUCTION INTERVIEW

Before we begin, I would like to give you a little background about this study.

Systematic information about the characteristics and problems of the people who consult providers in their offices is essential for medical researchers, educators, and others who are concerned with medical education, manpower needs, and the changing nature of health care delivery.

In response to the demand for this information, the Centers for Disease Control and Prevention, in close consultation with representatives of the medical profession, developed the National Ambulatory Medical Care Survey.

Your part in the study is very simple, carefully designed, and should not take much of your time. It consists of your participation during a specified 7-day period. During that time, you would supply a minimal amount of information about patients you see.

Before COLLECTING any patient data, I have some questions to ask you about your practice. The answers you give will be used only for classification and analysis. Of course, ALL informatin you provide for this study will be held in strict confidence.

13a. **Overall, at how many office locations do you see ambulatory patients? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.**

Number of locations ↙

_____

b. **In a typical year, about how many weeks do you *NOT* see any ambulatory patients (e.g., conferences, vacations, etc.)?**

Number of weeks ↙

_____

If > 26 weeks ask item 13c.
If = 0, SKIP to item 13d.
If 1 to 26 weeks, SKIP to item 14a.

c. **You typically see patients fewer than half the weeks in each year. Is that correct?**

1 ☐ Yes – *SKIP to item 14a*
2 ☐ No – *Please explain* ↙

_____ } *SKIP to item 14a*

d. **You typically see patients all 52 weeks of the year. Is that correct?**

1 ☐ Yes
2 ☐ No – *Please explain* ↙

_____

14a. **This study will be concerned with the AMBULATORY patients you will see in your office(s) during the week of Monday,**

_____ **through Sunday,** _____.

Are you likely to see any ambulatory patients in your office(s) during that week?

(For allergists, family practitioners, etc. – if routine care such as allergy shots, blood pressure checks, and so forth will be provided by staff in physician's absence, enter "Yes.")

1 ☐ Yes –*SKIP to item 15a on page 6*
2 ☐ No

b. **Why is that?** *Record verbatim.*

_____

(If appropriate, read item 14c below. Otherwise, SKIP to item 16a on page 7.)

c. **Since it's very important that we include any ambulatory patients that you might see in your office during that week, I'll check back with your office just before** *(Starting date)* **to make sure your plans have not changed.**

PLEASE READ **BEFORE** CONTINUING

Instruction – *Even though the physician/provider is not available during the reporting week, continue with item 15a on page 6.*

Section II – INDUCTION INTERVIEW – Continued

15a. At what office location(s) will you see ambulatory patients during your practice's 7-day reporting period Monday, _____ through Sunday, _____ ?

(1) Are there any other office locations at which you will see ambulatory patients during that 7-day reporting period?

(2) What is the street address?

(3) In what city is this office located?

(4) In what state is this office?

(5) What is the Zip code for this office?

15b. *Looking at FLASHCARD B below,* ***choose ALL of the type(s) of settings that describe each location where you work.*** *For each location enter all setting types that apply. For each location, also enter the appropriate "scope" status. If any even numbered settings are entered, then enter location as out-of-scope.*

If FLASHCARD number 3 (free-standing clinic/urgicenter) is entered, ask –

Is this/that clinic in an institutional setting (#8), in an industrial outpatient facility (#10), or operated by the Federal Government (#12)? (If yes – *Enter out-of-scope.)*

If FLASHCARD number 11 (family planning clinic) is entered, ask –

If in doubt about any clinic/facility/institution, PROBE –

(1) Is this/that (clinic/facility/institution) part of a hospital emergency department or an outpatient department (#2, #4)? (If yes – *Enter out-of-scope)*

1 ☐ Yes
2 ☐ No

(2) Is this/that (clinic/facility/institution) operated by the Federal Government (#12)? If yes – *Enter out-of-scope)*

1 ☐ Yes
2 ☐ No

Edit

FLASHCARD B

(1) Private solo or group practice
(2) Hospital emergency department
(3) Freestanding clinic/urgicenter (not part of a hospital outpatient department)
(4) Hospital outpatient department
(5) Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or 'look alike' clinics)
(6) Ambulatory surgicenter
(7) Mental health center
(8) Institutional setting (school infirmary, nursing home, prison)
(9) Non-federal Government clinic (e.g., state, county, city, maternal and child health, etc.)
(10) Industrial outpatient facility
(11) Family planning clinic (including Planned Parenthood)
(12) Federal Government operated clinic (e.g., VA, military, etc.)
(13) Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente)
(14) Laser vision surgery
(15) Faculty practice plan

Office No.	Office locations *(Enter street address)*	Circle FLASHCARD number	Mark (X) In-scope	Mark (X) Out-of-scope
1		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
2		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
3		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
4		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐

15c. Are there other office locations where you NORMALLY would see patients, even though you will not see any during your 7-day reporting period? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.

1 ☐ Yes – *SKIP to item 15d*
2 ☐

d. Of these locations where you will not be seeing patients during your 7-day reporting period, how many total office visits did you have during your last week of practice at these locations?

_____ Number of visits

Section II – INDUCTION INTERVIEW – Continued

CHECK ITEM A

1 ☐ All locations listed in 15a are out-of-scope – *Read CLOSING STATEMENT below*
2 ☐ All/Some locations listed in 15a are in-scope – *Go to item 16a*

CLOSING STATEMENT **Thank you, Dr. . . ., your practice is not within the scope of this study. We appreciate your time and interest.** *(Terminate interview and complete Sections III and IV on pages 20–22.)*

Ask item 16a ONCE to obtain total for ALL in-scope locations.

16a. During the week of Monday, _____ through Sunday, _____ how many days do you expect to see any ambulatory patients? *(Only include days at in-scope locations.)*

NOTE – NON-PARTICIPATING PHYSICIANS: If refusal (Final=3) or unavailable (Final=4), enter the number of days in a normal week.

Edit

Estimated Number of Days →

Enter street name or town of in-scope location(s).

NOTE: *Keep the location numbers the same as the office numbers in item 15a.*

	Office location No.			
	#1	#2	#3	#4
	_____	_____	_____	_____

b. During your last normal week of practice, approximately how many office visit encounters did you have at each office location?

NOTE: If physician is in group practice, only include the visits to sampled physician.

Edit

	Number of visits				
		#1	#2	#3	#4
		_____	_____	_____	_____

c. During the week of Monday, _____ through Sunday _____, do you expect to have about the same number of visits as you saw during your last normal week in each office taking into account time off, holidays, and conferences?

NOTE: Enter (X) response. If answer is "Yes", transcribe the number in 16b to 16d for that office location. If answer is "No" then ASK item 16d for that office location.

Yes . .		1 ☐	1 ☐	1 ☐	1 ☐
No . . .		2 ☐	2 ☐	2 ☐	2 ☐

d. Approximately how many ambulatory visits do you expect to have at this office location?

	Number of visits				
		#1	#2	#3	#4
		_____	_____	_____	_____

e. Tally of estimated number of visits

NOTE: To obtain the total number of estimated visits, add the estimate for each office location in 16d.

Number of visits → _____

Answer 17a–21a for the in-scope location/practice with the most visits.

Now, I'm going to ask about your practice at *(in-scope location).*

Office Location	#1	#2	#3	#4
Solo	1 ☐	1 ☐	1 ☐	1 ☐
If Solo, SKIP to item 17d.				
Nonsolo	2 ☐	2 ☐	2 ☐	2 ☐

17a. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way (at this/that in-scope location)**?**

b. How many physicians are associated with you (at this/that in-scope location)**?**

	How many			
	_____	_____	_____	_____

c. Is this a single- or multi-specialty (group) **practice** (at this/that in-scope location)**?**

Multi	1 ☐	1 ☐	1 ☐	1 ☐
Single	2 ☐	2 ☐	2 ☐	2 ☐

Section II – INDUCTION INTERVIEW – Continued

	Office Location	#1	#2	#3	#4
17d. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with you (at this/that in-scope location)**?**	How many →				
e. Are you a full- or part-owner, employee, or an independent contractor (at this/that in-scope location)**?** *If "Owner" is marked then automatically mark "Physician or physician group" in item 17f.*	Owner	1 ☐	1 ☐	1 ☐	1 ☐
	Employee	2 ☐	2 ☐	2 ☐	2 ☐
	Contractor	3 ☐	3 ☐	3 ☐	3 ☐
f. *Give FLASHCARD A (p.15 Flashcard Booklet) and ask:* **Who owns the practice** (at this/that in-scope location)**?** Insurance company, health plan, or HMO	Physician or physician group	1 ☐	1 ☐	1 ☐	1 ☐
	~~HMO~~	2 ☐	2 ☐	2 ☐	2 ☐
	Community Health Center	3 ☐	3 ☐	3 ☐	3 ☐
	Medical/ Academic health center	4 ☐	4 ☐	4 ☐	4 ☐
	Other hospital	5 ☐	5 ☐	5 ☐	5 ☐
	Other health care corp	6 ☐	6 ☐	6 ☐	6 ☐
	Other	7 ☐	7 ☐	7 ☐	7 ☐
g. Does your practice have the ability to perform any of the following on site (at this/that in-scope location)**?**					
1. EKG/ECG		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
2. Lab testing		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
3. Spirometry		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
4. Ultrasound		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
5. X-Ray		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
h. Do you see patients in the office during the evening or on weekends?		1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK
i. What is your National Provider Identifier (NPI) at each office location?					

ADD QUESTION:
17j. What is your Federal Tax ID at each office location?

18a. **During your last normal week of practice, how many hours of direct patient care did you provide?**

NOTE – *Direct patient care includes: Seeing patients, reviewing tests, preparing for and performing surgery/procedures, providing other related patient care services.*

Number of weekly hours _____

b. **During your last normal week of practice, about how many encounters of the following type did you make with patients:**

Number of encounters per week

(1) Nursing home visits . . . . . _____

(2) Other home visits . . . . . _____

(3) Hospital visits . . . . . _____

(4) Telephone consults . . . . . _____

(5) Internet/e-mail consults . . . . . _____

Add Question 19 on Practice size
Add Questions 20 through 29 on Physician Workforce

If one location listed in NAMCS-1A display the following:

19. How many physicians, including you, are associated with this practice? Please include physicians at this location, and physicians at any other locations of this practice.

- **a) 1 physician**
- **b) 2-3 physicians**
- **c) 4-10 physicians**
- **d) 11-50 physicians**
- **e) 51-100 physicians**
- **f) More than 100 physicians**

If two or more locations listed in NAMCS-1A, display the following text and question:

The next questions are about the location where you see the most patients.

19. How many physicians, including you, are associated with that practice? Please include physicians at [fill address of location where physician sees the most patients based on NAMCS-1A], and physicians at any other locations of that practice.

- **a) 1 physician**
- **b) 2-3 physicians**
- **c) 4-10 physicians**
- **d) 11-50 physicians**
- **e) 51-100 physicians**
- **f) More than 100 physicians**

20. Is [this (if one location)/that (if two or more locations)] practice certified as a patient-centered medical home?
A Patient-Centered Medical Home (PCMH) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. It is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety.(From ACP online)

- **a. Yes**
  - **i. If yes, by whom**
    1. **The Accreditation Association for Ambulatory Health (AAAH)**
    2. **The Joint Commission**
    3. **The National Committee for Quality Assurance (NCQA)**
       - **a. [If yes:] What level of certification?**
         - **i. Level 1**
         - **ii. Level 2**
         - **iii. Level 3**
    4. **Utilization Review Accreditation Commission (URAC)**
    5. **Other:**
    6. **Unknown**
- **b. No**
- **c. Unknown**

21. How many of the following providers are on staff at the office location *where you see the most patients*? Please provide the total number.

Type of Provider	Number Full-time (>30 hours)	Number Part-time (<30 hours)
Physicians (MD and DO)		
Non-Physician Clinicians		
Physician Assistant (PA)		
Nurse Practitioner (NP)		
Certified Nurse Midwife (CNM)		

Other Nursing Care		
Registered nurse (RN) (not an NP or CNM)		
Licensed Practical Nurse (LPN)		
Certified Nursing Assistant/Aide (CNA)		
Allied Health		
Medical Assistant (MA)		
Radiology Technician (RT)		
Laboratory Technician (LT)		
Physical Therapist (PT)		
Pharmacist (Ph)		
Dietician/Nutritionist (DN)		
Other		
Mental Health Provider (MH)		
Health Educator/Counselor (HEC)		
Case Manager (not an RN)/Certified Social Worker (CSW)		
Community Health Worker (CHW)		

22. At the office location *where you see the most patients*, which type of provider <u>most commonly</u> performs the following tasks? Enter all that apply.

Drop-down list	
Based on the staff selected in Q2, a drop-down list will be made available in Q3, but will only contain those selected providers as well as 'NA-not applicable' if needed. The same drop down list will be provided for A-M.	
A. Records body measurements (such as height and weight) and vital signs (such as BP, temperature, heart rate)	
B. Performs office-based testing such as EKG and hearing/vision testing (do not include laboratory testing)	
C. Draws blood for lab testing	
D. Provides immunizations (includes both childhood and adult)	
E. Conducts cancer screenings (such as breast, cervical, and prostate screenings)	
F. Provides behavioral health screenings (such as depression, alcohol and substance abuse)	
G. Provides counseling services (such as diet/nutrition, weight reduction, tobacco cessation, stress management)	
H. Manages the routine care of patients with chronic conditions (such as hypertension, asthma, diabetes)	
I. Writes refill prescriptions for medications	
J. Enters patient information into medical/billing records	
K. Performs imaging tests (such as X-rays and ultrasounds)	
L. Make referrals (for example, to specialty care, or to community-based services)	
M. Contacts patients, who are transitioning from hospital or nursing home back to the community	

23. The following questions concern the mid-level providers practicing at the location *where you see the most patients*.

4a. Physician Assistant	Yes, always	Yes, sometimes	No	Unknown/Not Applicable
Are PA(s) supervised by someone on-site?				
Do you sign-off on the medical records of the patients the PA(s) see(s)?				
Do the PA's patients have a separate log from your patients?				
Is your approval required before the PA(s) prescribe(s) medication?				

4b. Nurse Practitioner	Yes, always	Yes, sometimes	No	Unknown
Are NP(s) supervised by someone on-site?				
Do you sign-off on the medical record of the patients the NP(s) see(s)?				
Do the NP's patients have a separate log from your patients?				
Is your approval required before the NP(s) prescribe(s) medication?				
Do/does the NP(s) bill for services using their own NPI number?				
4c.Certified Nurse Midwife	Yes, always	Yes, sometimes	No	Unknown
Are CNM(s) supervised by someone on-site?				
Do you sign-off on the medical record of the patients the CNM(s) see(s)?				
Do the CNM's patients have a separate log from your patients?				
Is your approval required before the CNM(s) prescribe(s) medication?				
Do/does the CNM(s) bill for services using their own NPI number?				

24. Is it possible within your practice to access patient medical records 24-hours a day?
    a. Yes
        [If yes:] Is this access available to physicians only, or is it also available to other non-physician clinicians?
        i. Physicians (MD/DO) only.
        ii. All Physicians and Non-physician Clinicians.
        iii. Unknown
    b. No
    c. Unknown

25. What is the primary method by which your practice receives information about patients in your practice when they have been seen in the emergency department or hospitalized? (Mark all that apply)

    a. Electronic transmission (i.e., EHR or EMR)
    b. Fax
    c. Email
        [If yes:] Was this email sent over a secure network?
        i. Yes
        ii. No
        iii. Unknown
    d. Telephone or in-person communication with provider
    e. Paper copy
    f. Other

26. Is someone in your practice responsible for assisting patients to safely transition back to the community within 72 hours of being discharged from a hospital or nursing home?
    a. Yes
    b. No
    c. Unknown

27. Does your practice report any quality measures or quality indicators to either payers or to organizations that monitor health care quality?
    a. Yes
    b. No

28. A Tax Identification Number, or TIN, is required by payers such as Medicare to pay physician claims. What is the Tax Identification Number that you use?

29. **Do all other locations or offices associated with this practice use the same Tax Identification Number, or TIN, or do any locations or offices associated with this practice use a different TIN?**
    a. **All use the same TIN**
    b. **Some use a different TIN**
    c. **Unknown**

Add Question:
31c. Does your current system meet meaningful use criteria as defined by the Department of Health and Human Services?
1 Yes
2 No
3 Unknown

Answer ALL remaining questions for the in-scope location/practice with the most visits.

~~19a~~. Does your practice submit any claims electronically (electronic billing)? 30

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. ~~Do you or your staff verify an individual patient's insurance eligibility electronically?~~

1 ☐ ~~Yes~~ – *~~Go to 19c~~*
2 ☐ ~~No~~
3 ☐ ~~Unknown~~

c. ~~How do you or your staff electronically verify an individual patient's insurance eligibility? Is it through an EHR/EMR system, a stand-alone practice management system, or some other electronic system?~~

1 ☐ ~~Stand-alone practice management system~~
2 ☐ ~~EHR/EMR system~~
3 ☐ ~~Another electronic system~~
4 ☐ ~~Unknown~~

d. ~~When you electronically verify a patient's insurance eligibility, do you usually get results back before the patient leaves the office?~~

1 ☐ ~~Yes~~
2 ☐ ~~No~~
3 ☐ ~~Unknown~~

~~20a~~. Does your practice use an electronic *health* record (EHR) or electronic *medical* record (EMR) system? Do not include billing record systems. 31a

1 ☐ Yes, all electronic } *Go to Question ~~20b~~*
2 ☐ Yes, part paper and part electronic }
3 ☐ No } *SKIP to Question ~~21a~~ on page 10*
4 ☐ Unknown }

b. In which year did your practice install your EHR/EMR system?

☐☐☐☐ Year

d. **c. What is the name of your practice's current EHR/EMR system?**

Enter (X) only one box.

ADD Checkboxes:
2 Amazing Charts
3 athenahealth
6 e-MDs
12 Practice Fusion

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ eClinicalWorks
4 ☐ Epic
5 ☐ GE/Centricity
6 ☐ Greenway Medical
7 ☐ McKesson/Practice Partner
8 ☐ NextGen
9 ☐ Sage/Viteral~~Medical~~
10 ☐ Other
11 ☐

e. **~~d~~. At your practice, are there plans for installing a new EHR/EMR system within the next 18 months?**

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section II – INDUCTION INTERVIEW – Continued

~~21a~~. Medicare and Medicaid offer incentives to practices that demonstrate "meaningful use of health IT." At your practice, are there plans to apply for these incentive payments? 32a

1 ☐ Yes, we already applied – *Go to ~~21b~~*
2 ☐ Yes, we intend to apply – *Go to ~~21c~~*
3 ☐ Uncertain if we will apply
4 ☐ No, we will not apply

b. When did you first apply?

1 ☐ 2011
2 ☐ 2012
3 ☐ ~~Unknown~~ 2013

4 Unknown

c. When do you intend to first apply?

1 ☐ ~~2012~~ 2013
2 ☐ ~~2013~~ or later
3 ☐ Unknown

2014 or later

Notes

Section II – INDUCTION INTERVIEW – Continued

~~22.~~ 33 *Give FLASHCARD C-1 (p.17 Flashcard booklet) and ask:* **Please indicate whether your practice <u>has</u> each of the following <u>computerized capabilities</u> and how often these capabilities are used.** *Enter (X) only one per row.*

	Yes, used routinely	Yes, but NOT used routinely	Yes, but turned off or not used	No	Unknown
a. Recording patient history and demographic information?	1 ☐ *Go to 22a(1)*	2 ☐ *Go to 22a(1)*	3 ☐ *Skip to 22b*	4 ☐ *Skip to 22b*	5 ☐ *Skip to 22b*
If Yes, ask – **(1)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Recording and charting vital signs?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Recording patient smoking status?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Recording clinical notes?	1 ☐ *Go to 22d(1)*	2 ☐ *Go to 22d(1)*	3 ☐ *Skip to 22e*	4 ☐ *Skip to 22e*	5 ☐ *Skip to 22e*
If Yes, ask – **(1)** Do the notes include a list of the patient's medications and allergies?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Insert 33e. f. **e. Ordering prescriptions?**	1 ☐ *Go to 22e(1)*	2 ☐ *Go to 22e(2)*	3 ☐ *Skip to 22f*	4 ☐ *Skip to 22f*	5 ☐ *Skip to 22f*
If Yes, ask – **(1)** Are prescriptions sent electronically to the pharmacy?	1 ☐ *Go to 22e(2)*	2 ☐ *Go to 22e(2)*	3 ☐ *Skip to 22e(2)*	4 ☐ *Skip to 22e(3)*	5 ☐ *Skip to 22e(3)*
~~*If Yes, ask* – **(2)** When orders for prescriptions are submitted electronically, are they submitted by the prescribing practitioner, or by someone else? *Enter all that apply.*~~	1 ☐ Prescribing practitioner 2 ☐ Someone else 3 ☐ Unknown				
If Yes, ask – **(3)** Are warnings of drug interactions or contraindications providers?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. ~~**f.**~~ **Providing reminders for guideline-based interventions or screening tests?**	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
~~**g. Providing standard order sets related to a particular condition or procedure?**~~	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Ordering lab tests?	1 ☐ *Go to 22h(1)*	2 ☐ *Go to 22h(1)*	3 ☐ *Skip to 22i*	4 ☐ *Skip to 22i*	5 ☐ *Skip to 22i*
If Yes, ask – **(1)** Are orders sent electronically?	1 ☐ *Go to 22h(2)*	2 ☐ *Go to 22h(2)*	3 ☐ *Go to 22h(2)*	4 ☐ *Skip to 22i*	5 ☐ *Skip to 22i*
~~*If Yes, ask* – **(2)** When orders for lab tests are submitted electronically, are they submitted by the prescribing practitioner, or by someone else? *Enter all that apply.*~~	1 ☐ Prescribing practitioner 2 ☐ Someone else 3 ☐ Unknown				
i. Viewing lab results?	1 ☐ *Go to 22i(1)*	2 ☐ *Go to 22i(1)*	3 ☐ *Skip to 22j*	4 ☐ *Skip to 22j*	5 ☐ *Skip to 22j*
If Yes, ask – **(1)** Can the EHR/EMR automatically graph a specific patient's lab results over time?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. ~~Viewing data on quality of care measu~~ Identifying educational resources for patients' specific conditions?					
l. Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Section II – INDUCTION INTERVIEW – Continued

~~22.~~ 33 **Please indicate whether your practice has each of the following computerized capabilities and how often these capabilities are used.** *Enter (X) only one per row.*	Yes, used routinely	Yes, but NOT used routinely	Yes, but turned off or not used	No	Unknown
m. Generating lists of patients with particular health conditions?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
n. Electronic reporting to immunization registries?	1 ☐ *Go to 22n(1)*	2 ☐ *Go to 22n(1)*	3 ☐ *Skip to 22o*	4 ☐ *Skip to 22o*	5 ☐ *Skip to 22o*
~~*If Yes, ask –* **(1)** Is the electronic reporting to immunization registries reported in standards specified by Meaningful Use criteria?~~	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
o. Providing patients with clinical summaries for each visit?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
p. Exchanging secure messages with patients?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Insert r. **q. Providing patients with an electronic copy of their health information?**	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

~~23a.~~ 34a **Do you share any patient health information (electronically, not fax) with other providers, including hospitals, ambulatory providers, or labs?**	1 ☐ Yes 2 ☐ No
b. How do you electronically share patient health information?	1 ☐ EHR/EMR 2 ☐ Web portal (separate from EHR/EMR) 3 ☐ Other electronic method – *Specify*

~~24.~~ 35 *Give FLASHCARD C-2 (p.18 Flashcard Booklet) and ask:* **Please indicate which types of health data you share electronically (not fax) with the health care providers listed.** *Enter all that apply.*	Hospitals with which you are affiliated	Ambulatory providers inside your office/group	Hospitals with which you are not affiliated	Ambulatory providers outside your office/group
a. Lab results?	1 ☐	2 ☐	3 ☐	4 ☐
b. Imaging reports?	1 ☐	2 ☐	3 ☐	4 ☐
c. Patient problem lists	1 ☐	2 ☐	3 ☐	4 ☐
d. Medication lists	1 ☐	2 ☐	3 ☐	4 ☐
e. Medication Allergy lists	1 ☐	2 ☐	3 ☐	4 ☐

f. Do you share any of the previously mentioned types of information using a "Summary Care Record"? [A Summary Care Record is an electronic file that contains the previously mentioned health data in a standardized format.]	1 ☐ Yes 2 ☐ No 3 ☐ Unknown

33e. Reconciling lists of patient medications to identify the most accurate list?
33r. Providing patients the ability to view online, download or transmit information from their medical record?

36. Do you refer any of your patients to providers outside of your office or group?

☐1 Yes → *Go to Question 21a*

☐2 No → *Skip to Question 22*

36a. Do you receive a report back from the other provider with results of the consultation?

☐1 Yes, routinely

☐2 Yes, but not routinely

→

☐3 No → *Skip to Question 22*

36b. Do you receive it <u>electronically</u> (not fax)?

☐1 Yes, routinely

☐2 Yes, but not routinely

☐3 No

37. Do you see any patients referred to you by providers outside of your office or group?

☐1 Yes → *Go to Question 22a*

☐2 No → *Skip to Question 23*

37a. Do you receive notification of both the patient's history and reason for consultation?

☐1 Yes, routinely

☐2 Yes, but not routinely

→

☐3 No → *Skip to Question 23*

37b. Do you receive them <u>electronically</u> (not fax)?

☐1 Yes, routinely

☐2 Yes, but not routinely

☐3 No

38. Do you take care of patients after they are discharged from an inpatient setting?

☐1 Yes → *Go to Question 23a*

☐2 No → *Skip to Question 24*

38a. Do you receive all of the information you need to continue managing the patient?

☐1 Yes, routinely

☐2 Yes, but not routinely

→

☐3 No → *Skip to Question 24*

38b. Is the information available when needed?

☐1 Yes, routinely

☐2 Yes, but not routinely

☐3 No → *Skip to Question 24*

38c. Do you receive it <u>electronically</u> (not fax)?

☐1 Yes, routinely ☐2 Yes, but not routinely ☐3 No

Section II – INDUCTION INTERVIEW – Continued

	Yes, routinely	Yes, but NOT routinely	No	Does not apply
25a. When you refer your patient to a provider outside of your office or group, do you receive a report back from the other provider with results of the consultation?	1 ☐ *Go to 25b*	2 ☐ *Go to 25b*	3 ☐ *Skip to 25c*	4 ☐ *Skip to 25c*
b. Do you receive it electronically (not fax)?	1 ☐	2 ☐	3 ☐	4 ☐
c. When you see a patient referred to you by a provider outside of your office or group, do you receive notification of both the patient's history and reason for consultation?	1 ☐ *Go to 25d*	2 ☐ *Go to 25d*	3 ☐ *Skip to 26*	4 ☐ *Skip to 26*
d. Do you receive them electronically?	1 ☐	2 ☐	3 ☐	4 ☐
26. When your patient is discharged from an inpatient setting, do you receive all of the information you need to continue managing the patient?	1 ☐	2 ☐	3 ☐	4 ☐
a. Is the information timely, available when needed?	1 ☐	2 ☐	3 ☐	4 ☐
b. Do you receive it electronically (not fax)?	1 ☐	2 ☐	3 ☐	4 ☐

39

Give FLASHCARD D (p. 19 Flashcard Booklet) and ask: **The following questions are about your practice revenue and contracts with managed care plans.**

27. Roughly, what percent of your patient care revenue comes from –

Percent of patient care revenue ↙

(1) Medicare?	_____ %
(2) Medicaid?	_____ %
(3) Private insurance?	_____ %
(4) Patient payments?	_____ %
(5) Other? – *(including charity, research, Tricare, VA, etc.)*	_____ %

FR NOTE – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value.

40

28. Roughly, what percentage of the patient care revenue received by this practice comes from managed care contracts?

Percent of revenue from managed care ↙

_____ %

Edit

Section II – INDUCTION INTERVIEW – Continued

~~29.~~ 41 *Give FLASHCARD E (p.20 Flashcard Booklet) and ask:* **Roughly, what percent of your patient care revenue comes from each of the following methods of payment?**

Percent of patient care revenue

(a) Fee-for-service? _____ %

(b) Capitation? _____ %

(c) Case rates (e.g., package pricing/episode of care)? _____ %

(d) Other? _____ %

FR NOTE – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value.

~~30a.~~ 42a **Are you currently accepting "new" patients into your practice(s)** (at in-scope locations)**?**

1 ☐ Yes – *Go to 30b*
2 ☐ No
3 ☐ Don't know

b. From those "new" patients, which of the following types of payment do you accept (at in-scope locations)**?**

(1) Capitated private insurance?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(2) Non-capitated private insurance?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(3) Medicare?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(4) Medicaid?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(5) Workers compensation?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(6) Self-pay?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know
(7) No charge?	1 ☐ Yes	2 ☐ No	3 ☐ Don't know

~~31.~~ 43 **Which of the following methods best describes your basic compensation?**

1 ☐ Fixed salary
2 ☐ Share of practice billings or workload
3 ☐ Mix of salary and share of billings or other measures of performance (e.g., your own billings, practice's financial performance, quality measures, practice profiling)
4 ☐ Shift, hourly or other time-based payment
5 ☐ Other

~~32.~~ 44 **Clinical practices may take various factors into account in determining the compensation (salary, bonus, pay rate, etc.) paid to the physicians in the practice. Please indicate whether the practice explicitly considers each of the following factors in determining your compensation.**

Enter all that apply.

1 ☐ Factors that reflect your own productivity
2 ☐ Results of satisfaction surveys from your own patients
3 ☐ Specific measures of quality, such as rates of preventive services for your patients
4 ☐ Results of practice profiling, that is, comparing your pattern of using medical resources with that of other physicians
5 ☐ The overall financial performance of the practice

~~33a.~~ 45a **Roughly, what percent of your daily visits are same day appointments?**

_____ %

b. Does your practice set time aside for same day appointments?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know

c. On average, about how long does it take to get an appointment for a routine medical exam?

1 ☐ Within 1 week
2 ☐ 1–2 weeks
3 ☐ 3–4 weeks
4 ☐ 1–2 months
5 ☐ 3 or more months
6 ☐ Do not provide routine medical exams
7 ☐ Don't know

DELETE Page

Section II – INDUCTION INTERVIEW – Continued

34. **Do you see any patients for whom you provide asthma diagnosis, education and/or ongoing clinical management?**

1 ☐ Yes – *If yes, asthma supplement will be left with the respondent.*
2 ☐ No

Note – Respondents are to answer all items (1 – 9); even if answering "No" for one item, one must still complete the remaining items

35. **The following questions are about complementary and alternative medicine, or "CAM," and how you may utilize it in your medical practice. Some CAM therapies are now commonly used, and you may think of them as mainstream.**

a. **During the past 12 months, did you recommend any of the following therapies or practices to patients?** *Please select "Yes" or "No" for each.*

	Yes *Go to 35b for that item*	No *Skip to 35f for that item*
1. Herbs and other non vitamin supplements	1 ☐	2 ☐
2. Mind-body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]	1 ☐	2 ☐
3. Chiropractic or osteopathic manipulation	1 ☐	2 ☐
4. Acupuncture	1 ☐	2 ☐
5. Naturopathic treatment	1 ☐	2 ☐
6. Massage therapy	1 ☐	2 ☐
7. Homeopathic treatment	1 ☐	2 ☐
8. Biofeedback or hypnosis	1 ☐	2 ☐
9. Yoga	1 ☐	2 ☐

Note – Respondents are to answer all items (1 – 9); even if answering "Never," "Don't know," or "Refusal" for one item, one must still complete the remaining items

b. **During the past 12 months, how often did each of the following therapies arise in conversation between you and your patients? Would you say –**

	Rarely *Go to 35c for that item*	Sometimes *Go to 35c for that item*	Often *Go to 35c for that item*	Never *Skip to 35d for that item*	Don't know *Skip to 35d for that item*	Refusal *Skip to 35d for that item*
1. Herbs and other non vitamin supplements	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
2. Mind-body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
3. Chiropractic or osteopathic manipulation	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
4. Acupuncture	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
5. Naturopathic treatment	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
6. Massage therapy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
7. Homeopathic treatment	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
8. Biofeedback or hypnosis	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
9. Yoga	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

DELETE Page

Section II – INDUCTION INTERVIEW – Continued

35c. Thinking back to these conversations, who brought up the topic of the following therapies most often?

	Patients	Physician	About equal
1. Herbs and other non-vitamin supplements	1 ☐	2 ☐	3 ☐
2. Mind body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]	1 ☐	2 ☐	3 ☐
3. Chiropractic or osteopathic manipulation	1 ☐	2 ☐	3 ☐
4. Acupuncture	1 ☐	2 ☐	3 ☐
5. Naturopathic treatment	1 ☐	2 ☐	3 ☐
6. Massage therapy	1 ☐	2 ☐	3 ☐
7. Homeopathic treatment	1 ☐	2 ☐	3 ☐
8. Biofeedback or hypnosis	1 ☐	2 ☐	3 ☐
9. Yoga	1 ☐	2 ☐	3 ☐

d. Did you recommend (Therapy) to patients for any of the following reasons? *Please select "Yes" or "No" for each.*

	Yes	No
1. For physical symptoms, such as pain	1 ☐	2 ☐
2. For emotional symptoms, such as stress or anxiety	1 ☐	2 ☐
3. For general health maintenance and wellbeing	1 ☐	2 ☐
4. Because the patient asked for it	1 ☐	2 ☐
5. OTHER reasons		

e. Which of the following factors influenced your decision to recommend (Therapy) to patients? *Please select "Yes" or "No" for each.*

	Yes	No
1. Personal experience	1 ☐	2 ☐
2. Patient reports	1 ☐	2 ☐
3. Colleague recommendation	1 ☐	2 ☐
4. Evidence in peer reviewed literature	1 ☐	2 ☐
5. OTHER reasons		

f. Which of the following factors prevented you from recommending (Therapy) to patients? *Please select "Yes" or "No" for each.*

	Yes	No
1. Limited health insurance coverage	1 ☐	2 ☐
2. Lack of affordability for the patient	1 ☐	2 ☐
3. Lack of information sources	1 ☐	2 ☐
4. Lack of places/providers to refer patients	1 ☐	2 ☐
5. Patient's lack of interest or openness to (Therapy)	1 ☐	2 ☐
6. Lack of perceived benefit	1 ☐	2 ☐
7. OTHER reasons		

Section II – INDUCTION INTERVIEW – Continued

46

~~36.~~ Provider demographics –

a. What is your year of birth?

1 9 ☐☐

b. What is your sex?

1 ☐ Male
2 ☐ Female

c. *Give FLASHCARD G (p. 22 Flashcard Booklet) and ask:*
What is your highest medical degree?

1 ☐ MD
2 ☐ DO
} *Go to item 36d*
3 ☐ Nurse practitioner
4 ☐ Physician assistant
5 ☐ Nurse midwife
6 ☐ Other

d. What is your primary specialty?

Name of specialty _____ Code ☐☐☐

e. What is your secondary specialty?

Name of specialty _____ Code ☐☐☐

f. What is your primary board certification?

Board certification _____

g. What is your secondary board certification?

Board certification _____

h. What year did you graduate medical school?

☐☐☐☐ Year

i. Did you graduate from a foreign medical school?

1 ☐ Yes
2 ☐ No

47

Section II – INDUCTION INTERVIEW – Continued

37. Who will be helping you at each location? *(Below enter the location and person's name and position.)*
NOTE: *Keep the location numbers the same as the office numbers in item 15a.*

Office No.	Location *(Enter street name)*	Name	Position
1			
2			
3			
4			

NOTE – We will review some of the questions found on the Patient Record form. *Go to page 19 for instructions.*

Visit Sampling

To select a sample of patient visits, the physician's office will need to know where to start sampling **(Start With)** and how to select subsequent patient visits **(Take Every)**.

To determine the Take Every **(TE)** number, the system automatically calculates the intersection of the "Estimated visits for week" column (corresponding to the total entry in ITEM 16e) with the "Days physician will see patients that week" line (based on the entry in ITEM 16a).

TAKE EVERY NUMBER

Estimated Visits for Week	Days physician will see patients that week						
	1	**2**	**3**	**4**	**5**	**6**	**7**
0–12	1	1	1	1	1	1	1
13–24	2	1	1	1	1	1	1
25–39	3	2	1	1	1	1	1
40–44	4	2	2	1	1	1	1
45–49	4	2	2	2	2	2	2
50–64	5	3	2	2	2	2	2
65–74	10	3	2	2	2	2	2
75–89	10	4	3	2	2	2	2
90–104	10	4	3	3	3	3	3
105–114	10	5	3	3	3	3	3
115–129	10	5	4	3	3	3	3
130–134	15	10	4	3	3	3	3
135–154	15	10	4	4	4	4	4
155–174	15	10	5	4	4	4	4
175–194	15	10	5	5	5	5	5
195–209	20	10	10	5	5	5	5
210–219	20	10	10	10	5	5	5
220–254	20	10	10	10	10	10	10
255–319	25	15	10	10	10	10	10
320–364	30	15	10	10	10	10	10
365+	30	30	30	30	30	30	30

Take Every Number _____

Section II – INDUCTION INTERVIEW – Continued

~~38.~~ START WITH NUMBER

The system automatically determines the Start With **(SW)** *number based on the previoiusly calculated Take Every number. Based on the Take Every number, a corresponding Start With number is assigned, as shown in the table to the right.*

If the Take Every Number is:	Then the Start With Number is:
1	
2	
3	
4	
5	
10	
15	
20	
25	
30	

Start With Number

_____

INSTRUCTIONS

(1) Who to list/who not to list on the Patient Visit Worksheet found in the back of the NAMCS-26

- List every ambulatory patient visit to all in-scope locations during the reporting period.
- INCLUDE patients the physician doesn't see but who receive care from an assistant, nurse, nurse practitioner, physician assistant, etc.
- EXCLUDE patients who do not seek care or services (e.g., they come to pay a bill or leave a specimen).
- EXCLUDE telephone contacts with patients.

Section III – NONINTERVIEW

~~39.~~ 49 What is the reason the provider did not participate in this study?

Explanations for noninterview codes 6 and 11 –

- Temporarily not practicing –Refers to duration of 3 months or more
- Unavailable during reporting period –Absence must be for duration of LESS than 3 months

Edit

1 ☐ Refused/Breakoff – *SKIP to item 41a*
2 ☐ Non-office based
3 ☐ Sees no ambulatory patients } *SKIP to item 40*
4 ☐ Retired
5 ☐ Deceased } *SKIP to item 44*
6 ☐
☐
☐ } *SKIP to item 40*
☐
☐
11 ☐ Unavailable during reporting period – *SKIP to item 42 on page 21*
12 ☐ Moved out of PSU – *SKIP to item 43a on page 21*

~~40.~~ 50 Check all that apply to describe provider's practice or medical activities which define him/her as ineligible or out-of-scope.

1 ☐ Federally employed
2 ☐ Radiology, anesthesiology or pathology specialist
3 ☐ Administrator
4 ☐ Work in institutional setting
5 ☐ Work in hospital emergency department or outpatient department
6 ☐ Work in industrial setting
7 ☐ Other – *Specify* ↙

} *SKIP to item 44 page 22*

~~41a.~~ 51a At what point in the interview did the refusal/break-off occur?

(Enter (X) one.)

1 ☐ During telephone screening
2 ☐ During induction interview
3 ☐ After induction but prior to assigned reporting days
4 ☐ At reminder call
5 ☐ During assigned reporting days or mid-week calls
6 ☐ At follow-up contact

b. By whom?

(Enter (X) one.)

1 ☐ Sampled provider
2 ☐ Sampled provider through nurse
3 ☐ Nurse/Secretary
4 ☐ Receptionist
5 ☐ Office manager/Administrator
6 ☐ Other office staff – *Specify* ↙

c. What reason was given? *(Verbatim)*

d. Date refusal/breakoff was reported to supervisor

Month ☐☐ Day ☐☐ Year ☐☐☐☐

e. Conversion attempt result

1 ☐ No conversion attempt
2 ☐ Sampled provider refused } *SKIP to item 44 on page 22*
3 ☐ Sampled provider agreed to see Field Representative – *Complete Section II*

Section III – NONINTERVIEW – Continued

~~42.~~ Why is provider unavailable or not in practice?

52

SKIP to item 44 on page 22

~~43a.~~ What is the provider's new address?

53a

Number and street

City, State, ZIP Code

Telephone

b. Name of Field Representative

RO	PSU	Date transferred

Continue with item 44 on page 22

NOTES

Section IV – DISPOSITION AND SUMMARY

~~44~~. FINAL DISPOSITION

54 **(a) Eligible physician/provider**

1 ☐ **Completed Patient Record forms** →

2 ☐ **Out-of-scope** (Item 35, codes 2, 3, 4, 5, 6, 8, 9, or 10)
3 ☐ **Refused-Breakoff** (Item 35, code 1)
4 ☐ **Unavailable during reporting period** (Item 35, code 11)
5 ☐ **Moved out of PSU** (Item 35, code 12–final)
6 ☐ **Can't locate** (Item 35 code 7)

} End of Interview –*Make certain all items are accurately completed before returning materials to the office.*

(b) Unused CHC NAMCS-1

7 ☐ **Less than 3 providers sampled**
8 ☐ **Parent CHC Out-of-scope**
9 ☐ **Parent CHC Refused to participate**

(c) Transfer cases

☐ **Moved out of PSU** (Item 35, code 12 –pending)

~~45~~. CASE SUMMARY

55

1. Number of patient visits during reporting week . . . . . ☐☐☐

2. Number of days during reporting week on which patients were seen . . . . . ☐

3. Number of patient record forms completed . . . . . ☐☐☐

NOTE – *For items 45(1) and 45(3), see instruction below.* ↙

Edit | Edit

PLEASE READ BEFORE CONTINUING

Item 45(1) – Accurate determination of "Number of patient visits during reporting week" is **EXTREMELY IMPORTANT**! This count is to include any days the provider may have skipped or not participated. This information may be obtained from either the office staff or from the PRF Folio cover. Only inlcude visits to sampled provider and NOT the total number of visits to entire practice or clinic.

Item 45(3) – If the number of Patient Record forms completed is less than 20 or greater than 40, then explain why in the NOTES section below.

Items 17e and 45(1) – If applicable, record explanation of why items 17e and 45(1) differ significantly and any other information regarding this case which may help to understand it at a later date.

Notes

56

Part 3 — Missing Patient Record Form Items (1–13)

~~46.~~ List missing items, and refer to the FR manual for guidelines on retrieving missing information.

Patient Record number (a)	Item number(s) (b)	Comments (c)

~~47.~~ Was provider/office staff contacted for any reason during the editing process?

57 ☐ Yes ☐ No

~~48.~~ For all Final = 1 cases, transfer information from front of Patient Record Folio.

58

WEEK OF – FROM Month ☐☐ Day ☐☐ TO Month ☐☐ Day ☐☐

SURVEY WEEK		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	**Total**
Complete a Patient Record for patient **SW** ☐ *and every* **TE** ☐ *nth patient thereafter.*	Number of patient visits								
	Number of records completed								

NOTES