

# Attachment C1: 2014 NAMCS-1

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

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**Assurance of Confidentiality** - All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

**1. Physician's address:**

**Disclaimer** - The following questionnaire is based on a computer-based questionnaire. Thus, the following questions contain the same content of the computer-based questionnaire, though the flow of the paper-questionnaire questions does not necessarily represent the flow of the computer-based questionnaire due to the limitations of a paper questionnaire.

FORM **NAMCS-1A**  
(4-22-2014)

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  
2014 PANEL**

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

Office 1	Telephone	Office 2	Telephone
	FAX		FAX

**3. 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 midlevel providers throughout the United States. Research using 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 we will request includes data about patient visits (e.g., demographics, diagnoses, services, and treatments); physician practice characteristics (e.g., practice type), and 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, 1-week reporting period. Additionally, there is a short interview (approximately 35 minutes) with you about the nature of your practice. We intend to conduct additional health care research by linking National Provider Identifiers (NPI) and Federal Tax Identification Numbers 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 stop participating at any time without penalty or loss of benefits.

The following are some key points about the survey:

- Data collection for 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 (Title 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.
- NAMCS conforms to the Privacy Rule as mandated by HIPAA because disclosure of patient data is permitted for public health purposes, and 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 Census Bureau employee, acting as our agent, will call you to schedule an appointment regarding the details of your participation. If you have any questions, please call a NAMCS representative at 1-800-392-2862. You can also find additional information on the survey by visiting the NAMCS participant website at: [http://www.cdc.gov/nchs/ahcd/namcs\\_participant.htm](http://www.cdc.gov/nchs/ahcd/namcs_participant.htm).

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

We greatly appreciate your cooperation.

Sincerely,

Charles J. Rothwell, MS, MBA  
Director

**Section I – TELEPHONE SCREENER – Continued**

<p><b>4. Specialty</b></p> <p><b>a. Your specialty is</b> <input type="text"/>, is that right?</p>	<p>1 <input type="checkbox"/> Yes – <i>SKIP to item 4c</i> 2 <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="button" value="Edit"/></p>
<p><b>b. What is your specialty (including general practice)?</b></p>	<p><input type="text"/></p> <p style="text-align: center;"><i>(Name of specialty)</i></p> <p><input type="text"/><input type="text"/><input type="text"/> Code <i>Refer to the NAMCS-252, pages 9 and 10 for codes.</i></p> <p style="text-align: right;"><input type="button" value="Edit"/></p>
<p><b>c. What is your ethnicity?</b></p>	<p>1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino</p>
<p><b>d. What is your race?</b> <i>Enter (X) one or more.</i></p>	<p>1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African-American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native</p>
<p><b>5. Which of the following categories best describes your professional activity – patient care, research, teaching, administration, or something else?</b></p>	<p>1 <input type="checkbox"/> Patient care 2 <input type="checkbox"/> Research 3 <input type="checkbox"/> Teaching 4 <input type="checkbox"/> Administration 5 <input type="checkbox"/> Something else – <i>Specify</i> ↴</p> <p><input type="text"/></p>
<p><b>6a. Do you directly care for any ambulatory patients in your work?</b></p>	<p>1 <input type="checkbox"/> Yes – <i>SKIP to item 6c</i> 2 <input type="checkbox"/> No – does not give direct care [6b PROBE] 3 <input type="checkbox"/> No longer in practice – <i>SKIP to item 8 on page 3</i></p>
<p><b>b. PROBE: We include as ambulatory patients, individuals receiving health services without admission to a hospital or other facility. Does your work include any such individuals?</b></p>	<p>1 <input type="checkbox"/> Yes, cares for ambulatory patients 2 <input type="checkbox"/> No, does not give direct care –<i>Specify reason, then read item 8 on page 3</i></p>
<p><b>c. Do you work as an employee or a contractor in a federally operated patient care setting (e. g., VA, military, prison) or in a hospital emergency or outpatient department?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to item 6e</i></p>
<p><b>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 (e. g., office based practice or community health center)?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to item 8 on page 3</i></p>
<p><b>e. Do you work in an office-based practice owned by a hospital?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to item 7a on page 3</i></p>
<p><b>f. Although the provider works in a federal patient care setting, please make sure the respondent is aware that all of the following questions are concerned with their private patients.</b></p>	<p>1 <input type="checkbox"/> Continue</p>

**Section I - TELEPHONE SCREENER - Continued**

**7a. We have your address as** *(Read address shown in item 1).* **Is that the correct address for your office?**

- 1  Yes – *SKIP to item 9*  
 2  No, incorrect address – *Ask item 7b*

**b. What is the correct address and phone number of your office?**

Number and street				
City				
State		ZIP Code		
Telephone <i>(Area code and number)</i>				

*SKIP to item 9*

**8. 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.**

**9. I would like to arrange an appointment with you within the next week or so to discuss the study. It will take about 30 minutes. What would be a good time for you, before Friday, \_\_\_\_\_ (last Friday before the assigned reporting week)?**

Weekday	Month	Day	Year	Time
				a.m.
				p.m.

Physician refused to participate – *Go to item 10a.*

**Thank you, Dr. . . .**

**FR, PLEASE READ BEFORE CONTINUING**

FR Instruction – *COMPLETE QUESTIONS BELOW FOR ALL IN-SCOPE PHYSICIANS WHO HAVE REFUSED TO PARTICIPATE.*

**I appreciate that you choose not to participate in the study, but I would like to ask a few short questions about your practice so we can make sure responding physicians do not differ from nonresponding physicians.**

**10a. At how many different office locations, do you see ambulatory patients? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.**

Number of office locations

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

Number of weeks  *↘*  
*If > 26 weeks, ask item 10c.*  
*If = 0, SKIP to item 10d.*  
*If 1 to 26 weeks, SKIP to item 10e.*

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

- 1  Yes – *SKIP to item 10e.*  
 2  No – *Please explain* *↘*

*SKIP to item 10e*

**Section I – TELEPHONE SCREENER – Continued**

**10d. You typically see patients all 52 weeks of the year. Is that correct?**

- 1  Yes
- 2  No – *Please explain* ↘

**e. During your last normal week of practice, how many patient visits did you have at all office locations?**

Number of patient visits

**f. 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. Do not include hours from EDs, outpatient departments, surgicenters, or Federal clinics.*

Number of weekly hours

**g. At the office location where you see the most ambulatory patients:**

**(1) How many physicians are associated with you?**

Number of physicians

*If number of other physicians is 0, SKIP to item 10g(3).*

**(2) Is this a single- or multi-specialty group practice?**

- 1  Multi
- 2  Single

**(3) Are you a full- or part-owner, employee, or an independent contractor?**

- 1  Full-owner – *SKIP to exit items*
  - 2  Part-owner
  - 3  Employee
  - 4  Contractor
- } *SKIP to item 10g(4)*

**(4) Who owns the practice?**

**REFER TO FLASHCARD A.**

- 1  Physician or physician group
- 2  Insurance company, health plan, or HMO
- 3  Community Health Center
- 4  Medical/Academic health center
- 5  Other hospital
- 6  Other health care corporation
- 7  Other – *Specify* ↘

**Section II - INDUCTION INTERVIEW**

Before we begin, I'd like to give you some background about this study.

Medical researchers and educators are especially interested in topics like medical education, health workforce needs, and the changing nature of health care delivery. The National Ambulatory Medical Care Survey (or NAMCS) was developed to meet the need for such information.

The Centers for Disease Control and Prevention works closely with members of the medical profession to design the NAMCS each year. The NAMCS supplies essential information about how ambulatory medical care is provided in the United States, and how it is utilized by patients.

Your part in the study is very important 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 the patients you see.

First, I have some questions to ask about your practice. Your answers will only be used to provide data on the characteristics of office-based practices in the U.S. Any and all information you provide for this study will be kept confidential.

**11a. 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 11c.  
If = 0, SKIP to item 11d.  
If 1 to 26 weeks,  
SKIP to item 12a.

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

1  Yes – SKIP to item 12a

2  No – Please explain ↴

} SKIP to item 12a

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

1  Yes

2  No – Please explain ↴

**12a. 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, mark "Yes.")

1  Yes –SKIP to item 13a on page 6

2  No

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

(If appropriate, read item 12c below. Otherwise, SKIP to item 13a on page 6.)

**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.**

**FR, PLEASE READ BEFORE CONTINUING**

FR Instruction – Even though the physician/provider is not available during the reporting week, continue with item 13a on page 6.

**Section II – INDUCTION INTERVIEW – Continued**

**13a. 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?** *(Up to 5 offices can be recorded).*

**(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?**

**13b. 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. *(If any even numbered settings are entered, they are 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 FLASHCARD number 11 (family planning clinic) is entered, ask –*

**Is this/that clinic operated by the Federal Government (#12)?**

*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?** *If yes, select 2 or 4.*

**(2) Is this/that clinic/facility/institution operated by the Federal Government?** *If yes, select 12.*

**Edit**

**FLASHCARD B**

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

**13c. 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 13d  
 2  No – SKIP to item 14a

**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**

Ask item 14a ONCE to obtain total for ALL in-scope locations.

**14a. During the week of Monday, [ ] through Sunday, [ ] how many days do you expect to see any ambulatory patients at the following locations?** (Only include days at in-scope locations.)

**NOTE - NON-PARTICIPATING PHYSICIANS:** If refusal or unavailable, 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 13a.

					Office location No.				
					#1	#2	#3	#4	#5

**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.

Number of visits

Edit

**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", instrument copies the number in 14b to 14d for that office location. If answer is "No" then item 14d is ASKED for that office location.

Yes . . .  
No . . . .

1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>

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

Number of visits

**e. Tally of estimated number of visits**

**NOTE:** To obtain the total number of estimated visits, instrument adds the estimate for each office location in 14d.

Number of visits

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

**15a. 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)?**

Office Location	#1	#2	#3	#4	#5
Solo . . . . .	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>

**If Solo, SKIP to item 15d.**

Nonsolo . . .	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
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**b. How many physicians are associated with you at (this/that in-scope location)?**

How many →

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

Multi . . . . .	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Single . . . . .	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>



**Section II - INDUCTION INTERVIEW - Continued**

	Office Location	#1	#2	#3	#4	#5
<b>15d. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with you at (this/that in-scope location)?</b>	How many →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>e. Are you a full- or part-owner, employee, or an independent contractor at (this/that in-scope location)?</b> <i>If "Owner" is marked then automatically mark "Physician or physician group" in item 15f.</i>	Full-owner . . . . .	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	Part-owner . . . . .	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	Employee . . . . .	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
	Contractor . . . . .	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>f. Give FLASHCARD A (p.1 Flashcard and Job Aid Booklet) and ask:  Who owns the practice at (this/that in-scope location)?</b>	Physician – Physician group . . . .	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	Insurance company, health plan, or HMO . . . . .	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	Community Health Center . . . . .	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
	Medical/ Academic health center . . . . .	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
	Other hospital . . . . .	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
	Other health care corp	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
	Other . . . . .	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>
<b>g. Does your practice have the ability to perform any of the following on site at (this/that in-scope location)?</b>						
<b>1. EKG/ECG</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>2. Phlebotomy</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>3. Lab testing (not including urine dipstick, urine pregnancy, fingerstick blood glucose, or rapid swab testing for infectious diseases)</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>4. Spirometry</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>5. Ultrasound</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>6. X-Ray</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>h. Do you see patients in the office during the evening or on weekends at (this/that in-scope location)?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
<b>i. What is your National Provider Identifier (NPI) at (this/that in-scope location)?</b>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>j. What is your Federal Tax ID at (this/that in-scope location)?</b>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



**Section II – INDUCTION INTERVIEW – Continued**

**16a. 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:**

- (1) Nursing home visits .....
- (2) Other home visits .....
- (3) Hospital visits .....
- (4) Telephone consults .....
- (5) Internet/e-mail consults .....

Number of encounters per week ↘

  
  
  
  


*The next set of questions pertain to characteristics of the sampled physician's healthcare workforce, including physicians and other allied health care providers.*

**IF ONE LOCATION LISTED IN NAMCS-1A DISPLAY THE FOLLOWING:**

**17. How many physicians, including you, are associated with this practice? Please include physicians at [fill address of sampled location], and physicians at any other locations of this practice.**

- 1  1 physician
- 2  2–3 physicians
- 3  4–10 physicians
- 4  11–50 physicians
- 5  51–100 physicians
- 6  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 have the most office visits.

**17. How many physicians, including you, are associated with that practice? Please include physicians at [fill address of location with the most office visits based on NAMCS-1A], and physicians at any other locations of that practice.**

- 1  1 physician
- 2  2–3 physicians
- 3  4–10 physicians
- 4  11–50 physicians
- 5  51–100 physicians
- 6  More than 100 physicians

**18. Is your practice certified as a patient-centered medical home?**

- a  Yes – By whom is your practice certified as a patient-centered medical home? *Mark (X) all that apply.*
  - 1  Accreditation Association for Ambulatory Health (AAAH)
  - 2  Joint Commission
  - 3  National Committee for Quality Assurance (NCQA)
    - What is the level of certification for the National Committee for Quality Assurance (NCQA)?**
    - (a)  Level 1
    - (b)  Level 2
    - (c)  Level 3
  - 4  Utilization Review Accreditation Commission (URAC)
  - 5  Other – *Specify*
  - 6  Unknown
- b  No
- c  Unknown

**19.** Give FLASHCARD H (p. 8 Flashcard and Job Aid Booklet) and ask: **How many of the following full-time and part-time providers are on staff at the office location where you have the most office visits? Full-time is 30 or more hours per week. Part-time is less than 30 hours per week. Please provide the total number of full-time and part-time providers. Please include the sampled provider in the total count of staff below.**

Type of Provider	Number Full-time (≥ 30 hours)	Number Part-time (<30 hours)
Physicians (MD and DO)	<input type="text"/>	<input type="text"/>
<b>Non-Physician Clinicians</b>		
Physician Assistants (PA)	<input type="text"/>	<input type="text"/>
Nurse Practitioners (NP)	<input type="text"/>	<input type="text"/>
Certified Nurse Midwives (CNM)	<input type="text"/>	<input type="text"/>
<b>Other Nursing Care</b>		
Registered nurses (RN) (not an NP or CNM)	<input type="text"/>	<input type="text"/>
Licensed Practical Nurses (LPN)	<input type="text"/>	<input type="text"/>
Certified Nursing Assistants/Aides (CNA)	<input type="text"/>	<input type="text"/>
<b>Allied Health</b>		
Medical Assistants (MA)	<input type="text"/>	<input type="text"/>
Radiology Technicians (RT)	<input type="text"/>	<input type="text"/>
Laboratory Technicians (LT)	<input type="text"/>	<input type="text"/>
Physical Therapists (PT)	<input type="text"/>	<input type="text"/>
Pharmacists (Ph)	<input type="text"/>	<input type="text"/>
Dietitians/Nutritionists (DN)	<input type="text"/>	<input type="text"/>
<b>Other</b>		
Mental Health Providers (MH)	<input type="text"/>	<input type="text"/>
Health Educators/Counselors (HEC)	<input type="text"/>	<input type="text"/>
Case Managers (not RNs)/Certified Social Workers (CSW)	<input type="text"/>	<input type="text"/>
Community Health Workers (CHW)	<input type="text"/>	<input type="text"/>

**Section II - INDUCTION INTERVIEW - Continued**

20. At the office location where you have the most office visits, which type of provider most commonly performs the following tasks? <i>Mark (X) all that apply.</i>	Mark (X) all that apply.			
	Yes	No	Unknown	Task is not performed in this office
Based on the staff selected in <b>Question 19</b> , a drop-down list will be made available for each of the following questions <b>a-m</b> , but will only contain those selected providers as well as "Unknown" and "Task is not performed in this office" if needed.				
<b>a. Records Body Measurements (such as height and weight) and vital signs (such as blood pressure, temperature, heart rate)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>b. Performs office-based testing such as EKG and hearing/vision testing (do not include laboratory testing)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>c. Draws blood for lab testing</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>d. Provides immunizations (includes both childhood and adult)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>e. Conducts cancer screenings (such as breast, cervical, and prostate screenings)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>f. Provides behavioral health screenings (such as depression, alcohol and substance abuse)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>g. Provides counseling services (such as diet/nutrition, weight reduction, tobacco cessation, stress management)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>h. Manages the routine care of patients with chronic conditions (such as hypertension, asthma, diabetes)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>i. Writes refill prescriptions for medications</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>j. Enters patient information into medical/billing records</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>k. Performs imaging tests (such as X-rays and ultrasounds)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>l. Makes referrals (for example, to specialty care, or to community-based services)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>m. Contacts patients, who are transitioning from hospital or nursing home back to the community</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>21a. The following questions concern the mid-level providers practicing at the location where you have the most office visits.</b>	Yes, always	Yes, sometimes	No	Unknown/ Not applicable
<b>Physician Assistant</b>				
<b>(1) Are PA(s) supervised by someone on-site? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(2) Do you sign-off on the medical records of the patients the PA(s) see(s)? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(3) Do the PA's patients have a separate log from your patients? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(4) Is your approval required before the PA(s) prescribe(s) medication? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>b. Nurse Practitioner</b>				
<b>(1) Are NP(s) supervised by someone on-site? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(2) Do you sign-off on the medical record of the patients the NP(s) see(s)? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(3) Do the NP's patients have a separate log from your patients? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(4) Is your approval required before the NP(s) prescribe(s) medication? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(5) Do/does the NP(s) bill for services using their own NPI number? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>c. Certified Nurse Midwife</b>				
<b>(1) Are CNM(s) supervised by someone on-site? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(2) Do you sign-off on the medical record of the patients the CNM(s) see(s)? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(3) Do the CNM's patients have a separate log from your patients? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(4) Is your approval required before the CNM(s) prescribe(s) medication? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(5) Do/does the CNM(s) bill for services using their own NPI number? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

**The remaining questions are to be answered for the practice that is associated with the location where the physician has the most office visits. When defining this location, include only in-scope locations previously listed.**

<p><b>22. Is it possible within your practice to access patient medical records using an electronic health record (EMR) system 24 hours a day?</b></p>	<p>a <input type="checkbox"/> Yes – <b>Is this access available to physicians only, or is it also available to other non-physician clinicians?</b> <i>Mark (X) all that apply.</i></p> <p>1 <input type="checkbox"/> Physicians (MD/DO) only                  2 <input type="checkbox"/> All Physicians and Non-physician Clinicians                  3 <input type="checkbox"/> Unknown</p> <p>b <input type="checkbox"/> No                  c <input type="checkbox"/> Unknown</p>
<p><b>23. 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?</b></p>	<p>1 <input type="checkbox"/> Electronic transmission (i.e., EHR or EMR)                  2 <input type="checkbox"/> Fax                  3 <input type="checkbox"/> Email – <i>If yes</i> – <b>Was this email sent over a secure network?</b></p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> <p>4 <input type="checkbox"/> Telephone or in-person communication with provider                  5 <input type="checkbox"/> Paper copy                  6 <input type="checkbox"/> Other</p>
<p><b>24. 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?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>
<p><b>25. Does your practice have written protocols for providing chronic care services that are used by all members of the care team?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>
<p><b>26. Does your practice report any quality measures or quality indicators to either payers or to organizations that monitor health care quality?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No</p>
<p><b>27. Do all other locations or offices associated with this practice use the same Federal Tax ID or do any locations or offices associated with this practice use a different Federal Tax ID?</b></p>	<p>1 <input type="checkbox"/> All use the same Federal Tax ID                  2 <input type="checkbox"/> Some use a different Federal Tax ID                  3 <input type="checkbox"/> Unknown</p>

**Answer ALL remaining questions for the in-scope location with the most visits which is (in-scope location).**

<p><b>28. Does the reporting location submit any claims electronically (electronic billing)?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>																		
<p><b>29a. Does the reporting location use an electronic health record (EHR) or electronic medical record (EMR) system? Do not include billing record systems.</b></p>	<p>1 <input type="checkbox"/> Yes, all electronic                  2 <input type="checkbox"/> Yes, part paper and part electronic                  3 <input type="checkbox"/> No                  4 <input type="checkbox"/> Unknown</p> <p><i>} Go to Question 29b</i>  <i>} SKIP to Question 32 on page 13</i></p>																		
<p><b>b. In which year did you install your current EHR/EMR system?</b></p>	<p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year</p>																		
<p><b>c. Does your current system meet meaningful use criteria as defined by the Department of Health and Human Services?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>																		
<p><b>d. What is the name of your current EHR/EMR system?</b></p> <p><i>Enter (X) only one box. If "Other" is checked, please specify the name.</i></p>	<table border="0"> <tr> <td>1 <input type="checkbox"/> Allscripts</td> <td>9 <input type="checkbox"/> Greenway Medical</td> </tr> <tr> <td>2 <input type="checkbox"/> Amazing Charts</td> <td>10 <input type="checkbox"/> McKesson/Practice Partner</td> </tr> <tr> <td>3 <input type="checkbox"/> athenahealth</td> <td>11 <input type="checkbox"/> NextGen</td> </tr> <tr> <td>4 <input type="checkbox"/> Cerner</td> <td>12 <input type="checkbox"/> Practice Fusion</td> </tr> <tr> <td>5 <input type="checkbox"/> eClinicalWorks</td> <td>13 <input type="checkbox"/> Sage/Vitera</td> </tr> <tr> <td>6 <input type="checkbox"/> e-MDs</td> <td>14 <input type="checkbox"/> Other – Specify <input type="text"/></td> </tr> <tr> <td>7 <input type="checkbox"/> Epic</td> <td></td> </tr> <tr> <td>8 <input type="checkbox"/> GE/Centricity</td> <td></td> </tr> <tr> <td></td> <td>15 <input type="checkbox"/> Unknown</td> </tr> </table>	1 <input type="checkbox"/> Allscripts	9 <input type="checkbox"/> Greenway Medical	2 <input type="checkbox"/> Amazing Charts	10 <input type="checkbox"/> McKesson/Practice Partner	3 <input type="checkbox"/> athenahealth	11 <input type="checkbox"/> NextGen	4 <input type="checkbox"/> Cerner	12 <input type="checkbox"/> Practice Fusion	5 <input type="checkbox"/> eClinicalWorks	13 <input type="checkbox"/> Sage/Vitera	6 <input type="checkbox"/> e-MDs	14 <input type="checkbox"/> Other – Specify <input type="text"/>	7 <input type="checkbox"/> Epic		8 <input type="checkbox"/> GE/Centricity			15 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Allscripts	9 <input type="checkbox"/> Greenway Medical																		
2 <input type="checkbox"/> Amazing Charts	10 <input type="checkbox"/> McKesson/Practice Partner																		
3 <input type="checkbox"/> athenahealth	11 <input type="checkbox"/> NextGen																		
4 <input type="checkbox"/> Cerner	12 <input type="checkbox"/> Practice Fusion																		
5 <input type="checkbox"/> eClinicalWorks	13 <input type="checkbox"/> Sage/Vitera																		
6 <input type="checkbox"/> e-MDs	14 <input type="checkbox"/> Other – Specify <input type="text"/>																		
7 <input type="checkbox"/> Epic																			
8 <input type="checkbox"/> GE/Centricity																			
	15 <input type="checkbox"/> Unknown																		

**Section II – INDUCTION INTERVIEW – Continued**

<b>30. Has your practice made an assessment of the potential risks and vulnerabilities of your electronic health information within the last 12 months? This would help identify privacy or security related issues that may need to be corrected.</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown				
<b>31. Does your EHR have the capability to electronically send health information to another provider whose EHR system is different from your system?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown				
<b>32. At the reporting location, are there plans for installing a new EHR/EMR system within the next 18 months?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Maybe 4 <input type="checkbox"/> Unknown				
<b>33a. Medicare and Medicaid offer incentives to practices that demonstrate "meaningful use of health IT." At the reporting location, are there plans to apply for Stage 1 of these incentive payments?</b>	1 <input type="checkbox"/> Yes, we already applied – Go to 33b 2 <input type="checkbox"/> Yes, we intend to apply 3 <input type="checkbox"/> Uncertain if we will apply 4 <input type="checkbox"/> No, we will not apply <span style="float: right; font-size: 2em;">}</span> SKIP to Question 34				
<b>b. Are there plans to apply for Stage 2 incentive payments?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Maybe 4 <input type="checkbox"/> Unknown				
<b>34. Give FLASHCARD C (p.3 Flashcard and Job Aid Booklet) and ask: Please indicate whether the ambulatory reporting location has each of the following computerized capabilities and how often these capabilities are used. Enter (X) only one per row.</b>	Yes, used routinely	Yes, but NOT used routinely	Yes, but turned off or not used	No	Unknown
<b>a. Recording patient history and demographic information? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>b. Recording patient problem list? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>c. Recording and charting vital signs? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>d. Recording patient smoking status? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>e. Recording clinical notes? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>f. Recording patient's medications and allergies? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>g. Reconciling lists of patient medications to identify the most accurate list? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>h. Providing reminders for guideline-based interventions or screening tests? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>i. Ordering prescriptions? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>If Yes, ask – (1) Are prescriptions sent electronically to the pharmacy?</i>	Go to 34i(1)	Go to 34i(1)	Skip to 34j	Skip to 34j	Skip to 34j
<i>If Yes, ask – (2) Are warnings of drug interactions or contraindications provided?</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>If Yes, ask – (3) Are drug formulary checks performed?</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>j. Ordering lab tests? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>If Yes, ask – (1) Are orders sent electronically?</i>	Go to 34j(1)	Go to 34j(1)	Skip to 34k	Skip to 34k	Skip to 34k
<b>k. Viewing lab results? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>If Yes, ask – (1) Can the EHR/EMR automatically graph a specific patient's lab results over time?</i>	Go to 34k(1)	Go to 34k(1)	Skip to 34l	Skip to 34l	Skip to 34l
1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**Section II - INDUCTION INTERVIEW - Continued**

	Yes, used routinely	Yes, but NOT used routinely	Yes, but turned off or not used	No	Unknown
<b>34l. Ordering radiology tests? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>m. Viewing imaging results? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>n. Identifying educational resources for patients' specific conditions? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>o. Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>p. Identifying patients due for preventive or follow-up care in order to send patients reminders? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>q. Generating lists of patients with particular health conditions? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>r. Electronic reporting to immunization registries? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>s. Providing patients with clinical summaries for each visit? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>t. Exchanging secure messages with patients? ...</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>u. Providing patients the ability to view online, download, or transmit information from their medical record? .....</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>35a. Do you refer any of your patients to providers outside of your office or group?</b>	1 <input type="checkbox"/> Yes – Go to Question 35b 2 <input type="checkbox"/> No – SKIP to Question 36a				
<b>b. Do you send the patient's clinical information to the other providers?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 36a				
<b>c. Do you send it electronically (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No				
<b>36a. Do you see any patients referred to you by providers outside of your office or group?</b>	1 <input type="checkbox"/> Yes – Go to Question 36b 2 <input type="checkbox"/> No – SKIP to Question 37a				
<b>b. Do you send a consultation report with clinical information to the other providers?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 37a				
<b>c. Do you send it electronically (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No				
<b>37a. Do you take care of patients after they are discharged from an inpatient setting?</b>	1 <input type="checkbox"/> Yes – Go to Question 37b 2 <input type="checkbox"/> No – SKIP to Question 38a				
<b>b. Do you receive a discharge summary with clinical information from the hospital?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 38a				
<b>c. Do you receive it electronically (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 38a				
<b>d. Can you automatically incorporate the received information into your EHR system without manually entering the data?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not applicable, I do not have an EHR system				

**Section II – INDUCTION INTERVIEW – Continued**

**The next questions are about sharing (either sending or receiving) patient health information.**

<p><b>38a. Do you share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Question 39</i></p>
<p><b>b. How do you electronically share patient health information?</b> <i>Enter (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> EHR/EMR 2 <input type="checkbox"/> Web portal (separate from EHR/EMR) 3 <input type="checkbox"/> Other electronic method (not fax)</p>
<p><b>c. Is the patient health information that you share electronically sent directly from your EHR system to another EHR system?</b></p>	<p>1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown</p>
<p><b>d. With what types of providers do you electronically share patient health information (e.g., lab results, imaging reports, problem lists, medication lists)?</b></p>	<p>1 <input type="checkbox"/> Ambulatory providers inside your office/group 2 <input type="checkbox"/> Ambulatory providers outside your office/group 3 <input type="checkbox"/> Hospitals with which you are affiliated 4 <input type="checkbox"/> Hospitals with which you are not affiliated 5 <input type="checkbox"/> Behavioral health providers 6 <input type="checkbox"/> Long-term care providers 7 <input type="checkbox"/> Home health providers</p>

*Please remind physician/provider that the remaining questions refer to all offices that were determined to be in-scope.*

*Give FLASHCARD E (p. 5 Flashcard and Job Aid Booklet) and ask: I would like to ask a few questions about your practice revenue and contracts with managed care plans.*

<p><b>39. Roughly, what percent of your patient care revenue comes from –</b></p> <p><b>(1) Medicare?</b> .....</p> <p><b>(2) Medicaid?</b> .....</p> <p><b>(3) Private insurance?</b>.....</p> <p><b>(4) Patient payments?</b> .....</p> <p><b>(5) Other (including charity, research, Tricare, VA, etc.)?</b> .....</p>	<p>Percent of patient care revenue ↘</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p>Revenue sources should sum close to 100%.</p>
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<p><b>40. Roughly, what percentage of the patient care revenue received by this practice comes from managed care contracts?</b></p>	<p>Percent of revenue from managed care ↘</p> <p><input type="text"/> %</p>
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<p><b>41. Give FLASHCARD F (p.6 Flashcard and Job Aid Booklet) and ask: Roughly, what percent of your patient care revenue comes from each of the following methods of payment?</b></p> <p><b>(a) Fee-for-service?</b> .....</p> <p><b>(b) Capitation?</b> .....</p> <p><b>(c) Case rates (e.g., package pricing/episode of care)?</b> .....</p> <p><b>(d) Other?</b> .....</p>	<p>Percent of patient care revenue ↘</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p><input type="text"/> %</p> <p>Revenue sources should sum close to 100%.</p>
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**Section II – INDUCTION INTERVIEW – Continued**

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

- 1  Yes – Go to 42b  
 2  No  
 3  Don't know } SKIP to item 43

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

- (1) **Capitated private insurance?** .....
- (2) **Non-capitated private insurance?** .....
- (3) **Medicare?** .....
- (4) **Medicaid?** .....
- (5) **Workers' compensation?** .....
- (6) **Self-pay?** .....
- (7) **No charge?** .....

- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know
- 1  Yes 2  No 3  Don't know

**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

**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 (X) 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

**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

**Section II - INDUCTION INTERVIEW - Continued**

If provider is part of the community health center sample, item 46 is asked.

**46. Provider demographics -**

**a. What is your year of birth?**

1	9			
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**b. What is your sex?**

- 1  Male  
2  Female

**c. What is your highest medical degree?**

- 1  MD } Go to item 46d  
2  DO }  
3  Nurse practitioner }  
4  Physician assistant } SKIP to patient  
5  Nurse midwife } record forms  
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 from medical school?**

Year					

**i. Did you graduate from a foreign medical school?**

- 1  Yes  
2  No

**Section III - DISPOSITION AND SUMMARY**

**47. CASE SUMMARY**

**a. Number of patient visits during reporting week .**

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**b. Number of days during reporting week on which patients were seen .....**

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**c. Number of patient record forms completed .....**

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Edit