

Submission under  
0920-0572 Health Message Testing System

**Attachment 4: Provider Message Testing for Zika Response Project  
Provider Survey Screening Instrument**

Public reporting burden of this collection of information is estimated to average 10 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-0572)

## Provider Survey Screening Instrument

Hello, my name is \_\_\_\_\_ and I'm contacting you on behalf of Abt Associates, a private research organization, and the Centers for Disease Control and Prevention (CDC).

We are not selling or promoting any product. We are contacting health care providers to take part in a health education initiative.

The purpose of the initiative is to learn health care providers' thoughts on [INSERT TOPIC HERE] being developed for [INSERT TARGET AUDIENCE] and involves participating in a survey.

If you are eligible and choose to participate in the survey, you will receive \$75 as a token of our appreciation for participating in the survey. We estimate the survey will take about 30 minutes to complete.

To see if you are eligible to participate in the survey, we need to ask you some questions. It is your choice to answer these questions. Your answers will be kept private. You can refuse to answer a question or stop at any time.

All of your responses will be kept private. If you are not eligible and/or choose not to be part of the survey, all responses you give me today will be destroyed and you will not be contacted again.

My questions will only take a few minutes. May I proceed?

Yes\_\_\_\_ [CONTINUE]

No\_\_\_\_ [THANK/END]

### Sampling plan for Health Care Provider Survey:

#### Sampling Table for Continental U.S.

	Physicians	Physician Assistants	Nurse Practitioners	Registered Nurses	TOTAL
Family practice	6	4	4	4	18
OB/GYN	9	5	-	5	19
Infectious disease	6	2	-	2	10
ER	5	3	4	3	15
Women's health	-	-	9	-	9
Certified Nurse Midwives (CNM)	-	-	9	-	9
<b>TOTAL</b>	<b>26</b>	<b>14</b>	<b>26</b>	<b>14</b>	<b>80</b>

#### Sampling Table for Puerto Rico

	Physicians	Physician Assistants	Nurse Practitioners	Registered Nurses	TOTAL
Family practice	6	4	4	4	18
OB/GYN	9	5	-	5	19
Infectious disease	6	2	-	2	10
ER	5	3	4	3	15
Women's health	-	-	9	-	9

<b>Certified Nurse Midwives (CNM)</b>	-	-	9	-	<b>9</b>
<b>TOTAL</b>	<b>26</b>	<b>14</b>	<b>26</b>	<b>14</b>	<b>80</b>

Eligibility criteria

- Licensed to practice in the U.S.
- Actively practicing medicine in the US for the past 2 years
- Zip code of practice is within the locations listed below

Location: Puerto Rico and CONUS: **Florida: Miami-Dade County**  
**\*Texas: Lower Rio Grande Valley, Del Rio to the Gulf**  
**(Harlingen, McAllen, Brownsville)**  
New York: New York City  
California: Los Angeles  
Illinois: Chicago  
\*Priority sampling locations  
**Bold** indicates over-sample locations

1. Are you currently licensed to practice medicine in the US?  
<sub>1</sub> Yes [CONTINUE]  
<sub>0</sub> No [TERMINATE]
  
2. How long have you been practicing medicine/providing healthcare services?  
\_\_\_\_\_ [YEARS] \_\_\_\_\_ [MONTHS]
  
3. In what ZIP Code(s) do you currently practice?  
\_\_\_\_\_ [SCREENING OUT PROGRAMMING WILL DEPEND ON MARKET LOCATIONS]
  
4. What is your profession? [PROVIDERS WOULD BE SCREENED OUT ACCORDING TO OBJECTIVES OF EACH STUDY]  
<sub>1</sub> Physician  
<sub>2</sub> Nurse Practitioner [SKIP TO 6]  
<sub>3</sub> Physician Assistant  
<sub>4</sub> Registered Nurse [SKIP TO 7]  
<sub>5</sub> Other [SPECIFY:\_\_\_\_\_]
  
5. Are you board certified in any of the following? [CHECK ALL THAT APPLY] [PROVIDERS WOULD BE SCREENED OUT ACCORDING TO OBJECTIVES OF EACH STUDY]  
<sub>1</sub> Internal Medicine  
<sub>2</sub> Family Practice  
<sub>3</sub> Pediatrics  
<sub>4</sub> Infectious Diseases  
<sub>5</sub> Obstetrics and Gynecology  
<sub>6</sub> Neurology  
<sub>7</sub> Neonatology  
<sub>8</sub> Other [SPECIFY:\_\_\_\_\_]
  
6. Are you certified in any of the following? [CHECK ALL THAT APPLY. ] [PROVIDERS WOULD BE SCREENED OUT ACCORDING TO OBJECTIVES OF EACH STUDY]  
<sub>1</sub> Women's Health  
<sub>2</sub> Family Medicine  
<sub>3</sub> Pediatrics  
<sub>4</sub> Neonatal  
<sub>5</sub> Acute Care  
<sub>6</sub> Emergency  
<sub>7</sub> Other [SPECIFY:\_\_\_\_\_]
  
7. [IF 4 = REGISTERED NURSE] Are you a Certified Nurse-Midwife?  
<sub>1</sub> Yes  
<sub>0</sub> No
  
8. Do you (see/treat/counsel) women of reproductive age? [PROVIDERS WOULD BE SCREENED OUT ACCORDING TO OBJECTIVES OF EACH STUDY]  
<sub>1</sub> Yes  
<sub>0</sub> No
  
9. In what setting(s) do you see patients? [CHECK ALL THAT APPLY] [SCREEN OUT DEPENDING ON STUDY OBJECTIVES]

- <sub>1</sub> Private Practice (By private practice, we mean a private physician’s office or group practice)
- <sub>2</sub> Community Hospital
- <sub>3</sub> HMO (such as Kaiser)
- <sub>4</sub> Academic/University-Affiliated Hospital
- <sub>5</sub> Community Clinic/Health Center
- <sub>6</sub> Government Facility (e.g. City, County or State Health Department)
- <sub>7</sub> Military Facility
- <sub>8</sub> Other [SPECIFY:\_\_\_\_\_]

10. Approximately how many patients do you have in your current caseload?\*

\_\_\_\_\_ [RECORD NUMBER OF PATIENTS]

<sub>99</sub> Don’t know

**NOTE: SCREEN OUT DEPENDING ON WHETHER STUDY AIMS TO INCLUDE PROVIDERS WITH CERTAIN NUMBER OF PATIENTS IN THEIR CASELOAD.**

11. Approximately how many patients have you seen or treated for Zika in the past 6 months?

\_\_\_\_\_ [RECORD NUMBER OF PATIENTS]

<sub>99</sub> Don’t know

**NOTE: SCREEN OUT DEPENDING ON WHETHER THE STUDY AIMS TO INCLUDE PROVIDERS WHO HAVE TREATED PATIENTS WITH ZIKA OR THOSE WHO HAVE NOT.**

12. What percentage of patients in your total caseload have been infected with the Zika virus?

\_\_\_\_\_ [RECORD NUMBER OF PATIENTS]\*

13. Do you accept any of the following payment options? [CHECK ALL THAT APPLY]

- <sub>1</sub> Medicaid
- <sub>2</sub> Medicare

14. [IF 9 =1] Approximately how many of the following staff are in your private practice/office?

Nurses (RN/LPN)	
Nurse Practitioners	
Physician Assistants	
Other (specify: _____)	

**CONSENT TO PARTICIPATE FOR ELIGIBLE INDIVIDUALS**

\* Rescreening question to be confirmed prior to start of survey as needed.

Now that [you/we] are ready to begin, I am required to share the following information with you: There are no costs to you for being in this study and your participation is completely voluntary. This interview will take about [30] minutes to complete. The study is funded by the Center for Disease Control and Prevention. You may refuse to answer any questions and may choose to quit the study at any time. The risks to you for participating in this study are minimal. You may experience some discomfort when answering some of the more personal questions.

We can assure you that procedures to protect the privacy of your data will be strictly followed, with your answers kept in a secure database only accessible to the researchers working on this study.

**Would you like to continue with the [survey]?**

Yes\_\_\_\_ [CONTINUE]

No\_\_\_\_ [THANK/END]