Attachment C4: 2016 NAMCS-201 CHC Service Delivery Site Induction Interview, List of all questions

This table lists all proposed 2016 survey questions in the order that they would appear in the survey. Additions and modifications for 2016 are indicated in **red font**.

Variable name	Question text and answer categories
START	One button is selected to start the interview: 1. Continue 2. Noninterview (Unable to locate, refusal, etc.) 3. Issue preventing CHC facility interview 4. Quit
CHCTYPE	**How would you classify this center?** Enter all that apply - separate with commas 1. Federally-funded Community Health Center (330) • Community Health Center (CHC) • Migrant Health Center (MHC) • Health Care for the Homeless (HCH) • Public Housing Primary Care (PHPC) grant program 2. Federally Qualified Health Center, but not federally funded (330 look-alike) 3. Urban Indian (437) Health Center 4. None of the above
ADDCHECK	**We have your address and telephone number as** **(Name and Address) (Phone number)** **Is this correct?** 1. Yes 2. No, update address and phone
CHC_NAME	**What is the correct address?** ◆ Enter 1 to update the CHC name, address, and phone
PR330 PRTITLEV PROTHFED PRSTLOC PRPRIVAT PRCARE PRCAID PRFEES	**What percent of your CHC's revenue comes from the following sources?** 1. 330 Grant 2. Title V grant or contract 3. Other Federal Grant 4. State/Local Grant 5. Individual, corporation or foundation grants or donations 6. Medicare 7. Medicaid/CHIP

Variable name	Question text and answer categories
PROTHER TOTALGRANT	8. Patient payments 9. Other (including private insurance, Tricare, VA, etc.)?
AVG_WEEKS	**On average, in a normal year, how many weeks does the CHC at this location see patients?"** _____Number of weeks

WEEK_FOLLUP	**"You indicated that this CHC LOCATION does not usually see patients in a typical year, is this correct?"**
	    1. **Yes**
	    2. **No**

INTRO_SAMP	**I would like to discuss a plan for conducting the National Ambulatory Medical Care Survey (NAMCS) to a sample of your providers. This clinic (site) has been assigned to a 1-week reporting period that begins on Monday, (Reporting period start date) and ends on Sunday, (Reporting period end date).** **I will need to sample 3 providers from your Center. In order to do this, I will need the name, specialty, and estimated visit volume, corresponding to the sample week, for all physicians and mid-level providers ONLY AT THE CURRENTLY SAMPLED IN-SCOPE LOCATION.** **Please include all providers who see patients at this sampled clinic (site) even if they do NOT plan on seeing patients during the sample week. .** **Please exclude anesthesiologists, dentists, hygienists, optometrists, pathologists, psychologists, podiatrists, and radiologists. Include physicians (both MDs and DOs), nurse practitioners (NPs), physician assistants (PAs), and nurse midwives (NMWs).** ◆ List all providers only from the currently sampled in-scope location, even if they do not expect to see patients during the sampled week. Enter a zero for the expected visit volume for those providers with no expected visits. If the CHC that has been sampled is a health department, please verify that they will not be distributing the 330 grant money to other administratively unconnected community health centers. If the health department does distribute the money to other CHCs, these need to be sampled, so please contact your supervisor for further instructions.
PROV_FNAME	**What is the provider's first name?** (Include providers from only the sampled CHC location.)
PROV_MNAME	**What is the provider's middle name?**
PROV_LNAME	**What is the provider's last name?**

PROV_TYPE	**Is (Provider's name) a Medical Doctor (MD) or Doctor of Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Nurse Midwife (NMW)?**
	    1. Medical Doctor (MD)
	    2. Doctor of Osteopathy (DO)
	    3. Nurse Practitioner (NP)
	    4. Physician Assistant (PA)
	    5. Nurse Midwife (NMW)

Skip Instructions:	1,2: Goto PROV_SPEC Else goto PROVIDED
PROV_SPEC	**What is (Provider's name)'s specialty?** ◆ Enter 'XXX' if the specialty is not listed
PROV_SPEC2	◆ Is the provider an anesthesiologist, dentist, hygienist, optometrist, pathologist, psychologist, podiatrist, or radiologist? 1. Yes

Variable name	Question text and answer categories
	2. No
PROV_SPEC_SP	◆ Enter verbatim response for specialty
PROVIDED	? [F1] **What is the expected visit volume during the sample week for (Provider's name)?** ◆ Enter 0 if provider does not expect to see patients during the reference period.
PREVSAMP	◆ Compare this provider ((Providers name)) to the listed providers that have been sampled from this community health center in the past. Previously sampled providers (Previously sampled providers) 1. Yes, previously sampled 2. No, not previously sampled
VER_PREVSAMP	◆ Were the previously sampled providers selected correctly? Current name Previous name (Current provider names) (Previously sampled provider names) 1. Yes 2. No
NOPATIENTS	**You have told me that NONE of these providers expect to see patients during the sample week that begins on Monday, (Reporting period start date) and ends on Sunday, (Reporting period end date). Is this correct?** **1.** Yes, there are no providers seeing patients during reference week **2.** No, incorrect - there are providers seeing patients
Skip Instructions:	1: Exit block and goto BlkBACK.THANK_OOS 2: Go back to TblProv1.PROV_FNAME for the last row.
PROV_STRT	**What is (Provider's name)'s address?** ◆ Enter number and street.
PROV_STRT2	**What is (Provider's name)'s address?** ◆ Enter line two of address.
PROV_CITY	What is (Provider's name)'s address? ◆ Enter city.
PROV_STATE	What is (Provider's name)'s address? ◆ Enter state.
PROV_ZIPCODE	What is (Provider's name)'s address? ◆ Enter zipcode.
PROV_LOCTYPE	◆ Enter location/address type **1.** Main Office address **2.** Alternative/2nd office address **3.** Home office **4.** Home **5.** Unknown
PROV_PHONE	**What is (Provider's name)'s telephone number?**
PROV_PHTYP	**What type of telephone number is this?** **1.** Main **2.** Home **3.** Work **4.** Mobile **5.** Pager, Beeper, Answering Service **6.** Public pay phone **7.** Toll Free **8.** Other **9.** Fax **10.** Unknown

Variable name	Question text and answer categories
GREET_NAME	◆ Enter Greet Name (Greet name will be used on the letter that is sent to the provider.) Provider Name: (Provider's name)
MOSTVIS_INTRO	**The next section refers to characteristics of the sampled CHC at this location.**
NUMPH (one location listed)	**The next questions are about the CHC that is associated with [Pre-fill location].** **How many physicians are associated with this CHC?** 1. 1 Physician 2. 2-3 physicians 3. 4-10 physicians 4. 11-50 physicians 5. 51-100 physicians 6. More than 100 physicians
NUMPH (two or more locations listed)	**N/A**

PCMH	**Is the CHC at this location <u>certified</u> as a patient-centered medical home?**
	
	1) Yes
	  a) If yes, by whom **CERT_WHO**
	    i) The Accreditation Association for Ambulatory Health (AAAH)
	    ii) The Joint Commission
	    iii) The National Committee for Quality Assurance (NCQA)
	      (1) [If yes:] What level of certification? **NCQAlevel**
	        (a) Level 1
	        (b) Level 2
	        (c) Level 3
	    iv) Utilization Review Accreditation Commission (URAC)
	    v) Other – Specify **PCMH_OTH**_____
	    vi) Unknown
	2) No
	3) Unknown

Variable name	Question text and answer categories

ACCESS	**Is it possible within the CHC at this location to access patient medical records using an electronic health record (EHR) system 24 hours a day?**
	
	1) Yes **ACCESS_PH**
	   a) [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
	2) No
	3) Unknown

PMETHOD	**What is the primary method by which the CHC at this location receives information about patients in this CHC when they have been seen in the emergency department or hospitalized?** (Mark only one box)
	
	1) Electronic transmission (i.e., EHR or EMR)
	2) Fax
	3) Email
	   i) [If yes:] Was this email sent over a secure network? **SECNET**
	      (a) Yes
	      (b) No
	      (c) Unknown
	4) Telephone or in-person communication with provider
	5) Paper copy
	6) Other **PMETHOD_SP**

TRANS	**Is someone in the CHC at this location responsible for assisting patients to safely transition back to the community within 72 hours of being discharged from a hospital or nursing home?**
	   1. Yes
	   2. No
	   3. Unknown

PROTO	**Does the CHC at this location have written protocols for providing chronic care services that are used by all members of the care team?**
	   1. Yes
	   2. No
	   3. Unknown

QUAL	**Does the CHC at this location report any quality measures or quality indicators to either payers or to organizations that monitor health care quality?**
	   1. Yes
	   2. No
	   3. Unknown

Variable name	Question text and answer categories
DIFTIN	Do all other locations or offices associated with the CHC at this location use the same Federal Tax ID, also known as an Employer Identification Number (EIN), or do any locations or offices associated with the CHC at this location use a different Federal Tax ID or EIN? 1. All use the same Federal Tax ID or EIN 2. Some use a different Federal Tax ID or EIN 3. Unknown
Staffing Types (34 variables)	The next set of questions refer to the types of providers who work at [Pre-fill location]. How many of the following <u>full-time</u> and <u>part-time</u> providers are on staff at [Pre-fill location]? 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)	MD_DO_FT	MD_DO_PT
Non-Physician Clinicians		
Physician Assistants (PA)	PA_FT	PA_PT
Nurse Practitioners (NP)	NP_FT	NP_PT
Certified Nurse Midwives (CNM)	CNM_FT	CNM_PT
Clinical Nurse Specialist (CNS)	CNS_FT	CNS_PT
Nurse Anesthetists (NA)	NA_FT	NA_PT
Other Nursing Care		
Registered nurses (RN) (not an NP or CNM)	RN_FT	RN_PT
Licensed Practical Nurses (LPN)	LPN_FT	LPN_PT
Certified Nursing Assistants/Aides (CNA)	CNA_FT	CNA_PT
Allied Health		
Medical Assistants (MA)	MA_FT	MA_PT
Radiology Technicians (RT)	RT_FT	RT_PT

Variable name	Question text and answer categories		
	Laboratory Technicians (LT)	**LT_FT**	**LT_PT**
	Physical Therapists (PT)	**PT_FT**	**PT_PT**
	Pharmacists (Ph)	**PH_LT**	**PH_PT**
	Dieticians/Nutritionists (DN)	**DN_FT**	**DN_PT**
	Other		
	Mental Health Providers (MH)	**MH_FT**	**MH_PT**
	Health Educators/Counselors (HEC)	**HEC_FT**	**HEC_PT**
	Case Managers (not an RN)/Certified Social Workers (CSW)	**CSW_FT**	**CSW_PT**
	Community Health Workers (CHW)	**CHW_FT**	**CHW_PT**
Autonomy of PAs, NPs, CNMs, CNSs, & NAs (15 variables)	**The following questions concern the PAs, NPs, CNMs, CNSs, & NAs practicing at [Pre-fill location].**		

A. **Physician Assistant**	Yes, always	Yes, sometimes	No	Unknown/Not Applicable
1) Are the PA's patients logged separately from other providers at this CHC? **PA_LOG**				
2) Do/does the PA(s) bill for services using their own NPI number? **PA_BILL**				
B. **Nurse Practitioner**	Yes, always	Yes, sometimes	No	Unknown/Not Applicable
1) Are the NP's patients logged separately from other providers at this CHC? **NP_LOG**				
2) Do/does the NP(s) bill for services using their own NPI number? **NP_BILL**				
C. **Certified Nurse Midwife**	Yes, always	Yes, sometimes	No	Unknown/Not Applicable
1) Are the CNM's patients logged separately from other providers at this CHC?**CNM_LOG**				
2) Do/does the CNM(s) bill for services using their own NPI number? **CNM_BILL**				
D. **Clinical Nurse Specialist**	Yes, always	Yes, sometimes	No	Unknown/Not Applicable
Are the CNS's patients logged separately from other providers at				

Variable name	Question text and answer categories				
this CHC?**CNS_LOG**					
Do/Does the CNS(s) bill for services using their own NPI number? **CNS_BILL**					
E. Nurse Anesthetists		**Yes, always**	**Yes, sometimes**	**No**	**Unknown/Not Applicable**
Are the NA's patients logged separately from other providers at this CHC?**NA_LOG**					
Do/Does the NA(s) bill for services using their own NPI number? NA_BILL					

Variable name	Question text and answer categories
EMR_INTRO	**Answer ALL remaining questions for the current CHC location, which is [Pre-fill].**
EBILLREC	**Does the CHC reporting location submit any claims electronically (electronic billing)?** 1) Yes 2) No 3) Unknown
EMEDREC	**Does the CHC reporting location use an electronic health record (EHR) or electronic medical record (EMR) system? Do not include billing record systems.** 1) Yes, all electronic 2) Yes, part paper and part electronic 3) No 4) Unknown
EHRINSYR	**In which year did the CHC install your current EHR/EMR system?**
HHSMU	**Does the CHC's current system meet meaningful use criteria as defined by the Department of Health and Human Services?** 1) Yes 2) No 3) Unknown
EHRNAM	What is the name of **the CHC's** current EHR/EMR system? 1) Allscripts 2) Amazing Charts 3) athenahealth 4) Cerner 5) eClinicalWorks 6) e-MDs 7) Epic 8) GE/Centricity 9) Greenway Medical 10) McKesson/Practice Partner 11) NextGen 12) Practice Fusion 13) Sage/Vitera 14) Other-Specify **EHRNAMOTH** 15) Unknown

Variable name	Question text and answer categories
EMRINS	At the **CHC** reporting location are there plans for installing a new EHR/EMR system within the next 18 months? 1) Yes 2) No 3) Maybe 4) Unknown

EDEMOG
EPROLST
EPNOTES
EMEDALG
EMEDID
EREMIND
ECPOE
ESCRIP
EWARN
ECONTRSUB
ECONTRSUBS
ECTOE
ERESULT
ERADI
EIMGRES
EIDPT
EGENLIST
EDATAREP
ESUM
EMSG
EPTREC
	Please indicate whether the CHC reporting location has each of the following computerized capabilities and how often these capabilities are used.
	
	These 5 answer choices are for each of the following items a-q.
	1. Yes
	2. No
	3. Unknown
	
	a) Recording patient history and demographic information?
	b) Recording patient problem list?
	c) Recording clinical notes?
	d) Recording patient's medications and allergies?
	e) Reconciling lists of patient medications to identify the most accurate list?
	f) Providing reminders for guideline-based interventions or screening tests?
	g) Ordering prescriptions?
	   1. If Yes, ask – Are prescriptions sent electronically to the pharmacy?
	   2. If Yes, ask – Are warnings of drug interactions or contraindications provided?
	h) Do you prescribe controlled substances?
	   1. If Yes, ask Are prescriptions for controlled substances sent electronically to the pharmacy?
	i) Ordering lab tests?
	   1. If Yes, ask – Are orders sent electronically?
	j) Viewing lab results?
	   1. If yes, ask – Can the EHR/EMR automatically graph a specific patient's lab results over time?
	k) Ordering radiology tests?
	l) Viewing imaging results?
	m) Identifying patients due for preventive or follow-up care in order to send patients reminders?
	n) Providing data to generate lists of patients with particular health conditions?
	o) Providing data to create reports on clinical care measures for patients with specific chronic conditions (e.g. HbA1c for diabetics)?
	p) Providing patients with clinical summaries for each visit?
	q) Exchanging secure messages with patients?

REFOUT	◊**Please remind the CHC administrator that when responding to any of the remaining questions with the word "you"/"your" in the text, they should refer to the currently sampled CHC location.** **Do you refer any patients to providers outside of the CHC? Electronic does not include fan, eFax, or mail.**

Variable name	Question text and answer categories
	1. **Yes** 2. **No**
REFOUTHOW	**How do you send patient health information to them?** 1. **Electronically** 2. **Via paper-based methods** 3. **Do not send patient health information to the provider**
REFIN	**Do you see patients from providers outside of the CHC? Electronic does not include fan, eFax, or mail.** 1. **Yes** 2. **No**
REFINHOW	**How do you receive patient health information from them? Check all that apply.** 1. **Electronically** 2. **Via paper-based methods** 3. **Do not send patient health information to the provider**
ESHARE	**The next questions are about sharing (either sending or receiving) patient health information.** **Do you share any patient health information <u>electronically</u>?** **Electronically does not include scanned or pdf documents, fax, eFax, or mail.** 1. Yes 2. No
ESHARES	**Do you electronically send patient health information to another provider whose EHR system is different from your own?** 1. Yes 2. No 3. Don't know
ESHARER	**Do you electronically receive patient health information from another provider whose EHR system is different from your own?** 1. Yes 2. No 3. Don't know
EDISCHSR	**Do you electronically send or receive hospital discharge summaries to or from providers outside of your medical organization? Check all that apply.** 1. Send electronically 2. Receive electronically 3. Do not send or receive

Variable name	Question text and answer categories

EEDSR	**Do you electronically send or receive summary of care records for transitions of car or referrals to or from providers outside of your medical organization? Check all that apply.**
	    1. Send electronically
	    2. Receive electronically
	    3. Do not send or receive

ESUMCSR	**Do you electronically send or receive summary of care records for transitions of care or referrals to or from providers outside of your medical organization? Check all that apply.**
	    1. Send electronically
	    2. Receive electronically
	    3. Do not send or receive

PTONLINE	**Can patients seen at the reporting location do the following online activities? Check all that apply.**
	
	    1. View their medical record online
	    2. Download and transmit health information in the electronic medical record to their personal files
	    3. Request corrections to their electronic medical record
	    4. Enter their health information online (e.g. weight, symptoms)?
	    5. Upload their data from self-monitoring devices (e.g. blood glucose readings)?

Revenue & Contracts, Compensation, New Patients	

PRMCARE
PRMAID
PRPRVT
PRPATPAY
PROTH
	Please remind the CHC administrator that the remaining questions refer to **the current CHC location, which is [Pre-fill-in location].**
	
	I would like to ask a few questions about the current CHC's revenue and contracts with managed care plans.
	
	Roughly, what percent of your patient care revenue comes from –
	
	    1. Medicare?
	    2. Medicaid?
	    3. Private insurance?
	    4. Patient payments
	    5. Other (including charity, research, Tricare, VA, etc.)?

PCTRVMAN	**Roughly, what percent of the patient care revenue received by this CHC comes from managed care contracts?**

REVFFS
REVCAP
REVCASE
REVOTHER
	Roughly, what percent of your patient care revenue comes from each of the following methods of payment?
	
	    1. Fee-for-service?
	    2. Capitation?
	    3. Case rates (e.g., package pricing/episode of care)?
	    4. Other?

Variable name	Question text and answer categories

ACEPTNEW	**Are you currently accepting "new" patients into the CHC at [Fill-in location]?**
	    1. Yes
	    2. No
	    3. Don't know

CAPITATE
NOCAP
NMEDICARE
NMEDICAID
NWORKCMP
NSELFPAY
NNOCHARGE
	From those "new" patients, which of the following types of payment do you accept at [Fill-in location]?
	
	    1. Capitated private insurance?
	    2. Non-capitated private insurance?
	    3. Medicare?
	    4. Medicaid?
	    5. Workers' compensation?
	    6. Self-pay?
	    7. No charge?
	
	The following answer choices are used for each of the above seven payment types:
	    1. Yes
	    2. No
	    3. Don't know

PHYSCOMP	**Which of the following methods best describes your basic compensation?**
	Bold answer choices & add FR instruction to prompt them to read answers aloud.
	    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**

COMP	**CHCs may take various factors into account in determining the compensation (salary, bonus, pay rate, etc.) paid to the physicians/providers in the CHC. Please indicate whether the CHC explicitly considers each of the following factors in determining your compensation.**
	  ◆ Enter all that apply, separate with commas
	
	    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

SASDAPPT	**Does the CHC set time aside for same day appointments?**
	    1. Yes
	    2. No
	    3. Don't know

Skip Instructions:	1. Goto SDAPPT

Variable name	Question text and answer categories
	SKIP to APPTTIME
APPTTIME	**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 Don't know
CALLBACKNOTES	**I'd like to schedule a DATE to (conduct/complete) the interview.** **What DATE AND TIME would be best to visit again?** ◆ Today is: ^IntDate
Skip Instructions:	RF: Goto CBREF All others, goto THANKCB
CBREF	◆ Exit this case now. Call the case up again and make it a non-interview before transmitting.
THANKCB	**Thank you.** **I will call/come back at the time suggested** ◆ Revisit (Appointment information)
THANKYOU	**This concludes the interview. Thank you for your patience, and for taking the time to answer our questions.**
THANK_OOS	**Thank you (Respondent name), your center is not within the scope of this study.** **We appreciate your time and interest.**