**Attachment C3:** 2015 NAMCS-1 List of all proposed questions for Traditional Office-based Physicians and CHC Providers

This table lists all proposed 2015 survey questions in the order that they would appear in the survey. In the computerized instrument, questions are not numbered, so question numbers are provided in the left column of this table, which corresponds to question numbers in the 2014 NAMCS-1 sample card found in **Attachment C1**. Question numbers 4a through 16b match exactly in 2014 and 2015. Starting at question 17, new questions were added for 2015 and will not match the 2014 sample card. Skip patterns in 2015 are included only if they diverge from 2014, otherwise, refer to **Attachment C1** for skip patterns. Additions and modifications for 2015 are indicated in **highlighted red font**. Instructions for field representatives are in blue.

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| **Q#** | **Variable**  **Name** | **Traditional Office-based Physicians** | | | **CHC Providers** |
| --- | --- | --- | --- | --- | --- |
| **Section 1: Telephone Screener** | | | | | |
| **4a** | **SPECVER** | **Your specialty is [Pre-filled Specialty],**  **Is that right?**   1. Yes 2. No | | | N/A |
| **4b** | **PRV\_SPEC** | **What is your (your/Physician name's) specialty (including general practice)?** | | | N/A |
|  | **PRV\_SPEC\_SP** | Enter verbatim response for specialty | | | N/A |
| **4c** | **PRVETHN** | **What is (your/Physician name's) ethnicity?**   1. Hispanic or Latino 2. Not Hispanic or Latino | | | Same |
| **4d** | **RACE** | **What is (your/Physician name's) race?** Enter all that apply, separate with commas   1. White 2. Black or African-American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native | | | Same |
| **5** | **PROFACT** | **Which of the following categories best describes (your/Physician name's) professional activity - patient care, research, teaching, administration, or something else?**   1. Patient Care 2. Research 3. Teaching 4. Administration 5. Something else – Specify **PROFACT\_SP** | | | Same |
| **6a** | **AMBCARE** | **(Do/Does) (you/physician's name) directly care for any ambulatory patients in (Your/ his/her) work?**   1. Yes 2. No - does not give direct care 3. No longer in practice **(i.e., retired, not licensed)** 4. **Temporarily not practicing (refers to duration of 3 months or more)** | | | Same |
|  | Skip Instructions: | 1: Goto FED 2: Goto VERIF9A 3: Goto THANK\_OOS  **4: Goto THANK\_OOS** | | | 1: If CHCPROV = 1, goto ADDCHECK 2: Goto VERIF9A 3: Goto THANK\_OOS  **4: Goto THANK\_OOS** |
| **6b** | **VERIF9A** | **We include as ambulatory patients, individuals receiving health services without admission to a hospital or other facility.  Does (your/Physician name's) work include any such individuals?**   1. Yes, cares for ambulatory patients 2. No, does not give direct care   Specify reason **VERIF9a\_SP** | | | Same |
|  | Skip Instructions: | 1: Goto FED 2: Goto VERIF9A\_SP | | | 1: If CHCPROV =1, goto ADDCHECK 2: Goto VERIF9A\_SP |
| **6c** | **FED** | **(Do/Does) (you/physician's name) work as an employee or a contractor in a federally operated patient care setting (e.g., VA, military, prison), hospital emergency department, hospital outpatient department, or community health center?**   1. Yes 2. No | | | N/A |
|  | Skip Instructions: | 1: Goto PRIVPAT 2: Goto HOSPRIVPAT | | | N/A |
| **6d** | **PRIVPAT** | **In addition to working in a federally operated patient care setting, hospital emergency department, hospital outpatient department, or community health center, (do/does) (you/physician's name) also see any ambulatory patients in another setting (e.g., office based practice ~~or community health center~~)?**   1. Yes 2. No | | | N/A |
|  | Skip Instructions: | 1: Goto HOSPRIVPAT 2: Goto THANK\_OOS | | | N/A |
| **6e** | **HOSPRIVPAT** | **(do/does) (you/physician's name)  work in an office-based practice owned by a hospital?**   1. Yes 2. No | | | N/A |
|  | Skip Instructions: | (1 or 2) AND FED = 1: Goto REMINDER (1 or 2) AND FED = 2: Goto ADDCHECK | | | N/A |
| **6f** | **REMINDER** | Although the **physician** works in a federal patient care setting, hospital emergency **department, hospital** outpatient department, or **community health center** please make sure the respondent is aware that all of the following questions are **NOT concerned with these settings/patients/visits. The survey is ONLY** concerned with their private patients. | | | N/A |
| **7a** | **ADDCHECK** | **We have (your/Physician name's) address as  ( Address)  Is that the correct address for your office?**   1. Yes 2. No, update address | | | **We have (your/Physician name's) address as  ( Address)  Is that the correct address for the CHC?**   1. Yes 2. No, update address |
| **7b** | **NEW\_PINFO** | **What is the correct address and phone number?** | | | **What is the correct address and phone number of your current CHC location?** |
| **8** | **THANK\_OOS** | **Thank you, (Respondent's name/Physician's name), but since you are not currently practicing, our questions would not be appropriate for you. I appreciate your time and interest.** | | | Same |
|  | Skip Instructions: | IF AMBCARE = 3 goto WHYNO\_PRACT **IF AMBCARE = 4 goto WHY\_UNAVAIL** | | | Same |
| **8a** | **WHYNO\_PRACT** | Why isn't the doctor practicing?   1. Retired 2. Not licensed   **Deleted ~~Temporarily not practicing~~**   1. Other | | | Same |
| **8b** | **WHY\_OOS** | Describe the provider's practice or medical activities which define him/her as  ineligible or out-of-scope.  Enter all that apply, separate with commas   1. Federally employed 2. Radiology, anesthesiology or pathology specialist 3. Administrator 4. Work in institutional setting 5. Work in hospital emergency department, **hospital** outpatient department, **or community health center** 6. Work in industrial setting 7. Ambulatory surgicenter 8. Laser vision surgery 9. Other – Specify **WHY\_OO\_SP** | | | Same |
| **8c** | **WHY\_UNAVAIL** | Why is provider **temporarily not practicing**?  Verbatim response | | | Same |
| **9** | **INDUCT\_APPT** | **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 reference week)?** | | | Same |
| **Questions for Non-responding physicians (10a-10g)** | | | | | |
|  |  | 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 physiciansdo not differ from nonresponding physicians.  “Physicians” filled for Traditional physicians | | | I appreciate that you choose not to participate in the study, but I would like to ask a few short questions about **the CHC at this location** so we can make sure responding providers do not differ from nonresponding providers.  “Providers” filled for CHC Providers |
| **10a** | **NUMLOCR** | **Overall**, at how many different office locations do you see ambulatory patients? Do not include settings such as EDs, outpatient departments, surgicenters, Federal Clinics, and **community health centers**. | | | Same |
| **New** | **NUMLOCR\_CHC** | N/A | | | **Overall, at how many different CHC locations do you see ambulatory patients?** |
| **10b** | **NOPATSENR** | In a typical year, about how many weeks do you NOT see ambulatory patients (e.g., conferences, vacations, etc.)? | | | Same |
| **10c** | **LTHALFR**  **LTHALFR\_SP** | You typically see patients fewer than half the weeks in each year. Is that correct?   1. Yes 2. No – *Please explain* **LTHALFR\_SP** | | | Same |
| **10d** | **ALLYEARR**  **ALLYEARR\_SP** | You typically see patients all 52 weeks of each year. Is that correct?   1. Yes 2. No – *Please explain* **ALLYEARR\_SP** | | | Same |
| **10e** | **NUMVISR** | During your last normal week of practice, how many patient visits did you have at all office locations? | | | During your last normal week of practice how many patient visits did you have at all **CHC** locations? |
| **10f** | **WKHOURSR** | 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. | | | Same |
| **10g(1)** | **NUMBPAR** | At the office location where you see the most ambulatory patients:  How many physicians are associated with you? | | | **At the current CHC location:**  How many physicians are associated with you? |
| **10g(2)** | **SINGSPCR** | At the office location where you see the most ambulatory patients:  Is this a single- or multi-specialty group practice? | | | **At the current CHC location:**  Is this a single- or multi-specialty **CHC at this location**? |
| **10g(3)** | **OWNERSHR** | At the office location where you see the most ambulatory patients:  Are you a full- or part-owner, employee, or an independent contractor? | | | **At the current CHC location:**  Are you a full- or part-owner, employee, or an independent contractor? |
| **10g(4)** | **OWNSR** | At the office location where you see the most ambulatory patients:  Who owns the practice? | | | **At the current CHC location:**  Who owns the **CHC at this location**? |
| **Section 2: Induction Interview** | | | | | |
|  | **INDUCT\_INTRO** | 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. | | 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 **the CHC at this location**.  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** | **NUMLOC** | **Overall, at how many different office locations, (do/does) (you/physician's name) see ambulatory patients?  Do not include settings such as EDs, outpatient departments, surgicenters, Federal clinics, and community health centers.** | | Same | |
| **11b** | **NOPATSEN** | **In a typical year, about how many weeks (do/does) (you/physician's name) NOT see any ambulatory patients (e.g., conferences, vacations, etc.)?** | | Same | |
| **11c** | **LTHALF**  **LTHALF\_SP** | **(You/physician's name) typically (see/sees) patients fewer than half the weeks in each year.  Is that correct?**   1. Yes 2. No Please explain **LTHALF\_SP** | | Same | |
| **11d** | **ALLYEAR**  **ALLYEAR\_SP** | **(You/physician's name) typically (see/sees) patients all 52 weeks of the year. Is that correct?**   1. Yes 2. No Please explain **ALLYEAR\_SP** | | Same | |
| **12a**  **12b** | **SEEPAT**  **WHYNOPAT** | **This study will be concerned with the AMBULATORY patients (you/physician's name) will see in (Your/ his/her) (office/offices) during the week of Monday, (Reporting period begin date) through Sunday, (Reporting period end date).  (Are/Is) (you/physician's name) likely to see any ambulatory patients in (Your/ his/her) (office/offices) 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 2. No **Why is that?**   Enter verbatim response   **(12b) WHYNOPAT** | | **This study will be concerned with the AMBULATORY patients (you/physician's name) will see at this CHC location during the week of Monday, (Reporting period begin date) through Sunday, (Reporting period end date).  (Are/Is) (you/physician's name) likely to see any ambulatory patients at the current CHC location 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 2. No **Why is that?**   Enter verbatim response   **(12b) WHYNOPAT** | |
| **12c** | **CHECK\_BACK** | **Since it's very important that we include any ambulatory patients that (you/physician's name) might see in (Your/ his/her) office during that week, I'll check back with your office just before (Reporting period begin date) to make sure (Your/ his/her) plans have not changed.** Even though the physician/provider is not available during the reporting week, continue with the induction | | Since it’s very important that we include any ambulatory patients that you might see at this CHC location during that week, I’ll check back with **you** just before (starting date) to make sure your plans have not changed. | |
| **13a** | **OFFSTRET** | **(At what office location(s) will you see ambulatory patients during your practice's 7-day reporting period Monday, ^BEGIN\_DATE through Sunday, ^END\_DA**  If this is a CHC sampled provider, DO NOT enter any other locations in the table below.  Since we sample CHC service delivery sites, we are only interested in visits to the sampled CHC site.  You SHOULD NOT follow CHC providers to other locations during the sample week.  Only include visits from the currently sampled CHC location. | | **N/A** | |
| **13a** | **OFFICE\_CITY** | **In what city is this office located?** | | **N/A** | |
| **13a** | **OFFICE\_ST** | **In what state is this office?** | | **N/A** | |
| **13a** | **OFFICE\_ZIP** | **What is the zip code for this office?** | | **N/A** | |
|  | **LOCTYPE** | Enter location/address type   1. Main Office address 2. Alternative/2nd office address 3. Home office 4. Home 5. Unknown | | **N/A** | |
|  | **CUR\_OFFICE** | Which office is the current office?  ^OFF1  ^OFF2  ^OFF3  ^OFF4  ^OFF5 | | N/A | |
| **New** | **CUR\_CHC\_ADD** | N/A | | **What does the current address below represent?**  **[Fill with original or updated CHC address]**   1. **Sampled CHC location-**goto OTHLOC 2. **Sampled CHC that moved-**goto OTHLOC 3. **Not sampled CHC location-**goto CALL\_RO\_PHYS | |
| **New** | **CALL\_RO\_PHYS** | N/A | | **Call your RO and inform them of the situation. Await resolution from the RO before continuing with this case.** | |
| **13b** | **OFFICETYP** | **Looking at this list, choose ALL of the type(s) of settings that describe the office at (Office location).**        If in doubt about any clinic/facility/institution, PROBE -          Is this/that clinic/facility/institution part of a hospital emergency department or an outpatient          department?If yes, select 2 or 4         Is this/that clinic/facility/institution part operated by the Federal Government?If yes, select 12  Enter up to 3, separate with commas   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)~~**   **Moved to #16 out-of-scope**   1. Ambulatory surgicenter 2. Mental health center 3. Institutional setting (school infirmary, nursing home, prison) 4. Non-federal Government clinic (e.g., state, county, city, maternal and child health, etc.) 5. Industrial outpatient facility 6. Family planning clinic (including Planned Parenthood) 7. Federal Government operated clinic (e.g., VA, military, etc.) 8. Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente) 9. Laser vision surgery 10. Faculty practice plan 11. **Community Health Center (e.g. Federally Qualified Health Center (FQHC), federally funded clinics or 'look alike' clinics)** | | Choice #5 will be automatically populated:  **(5) Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or ‘look alike’ clinics)** | |
| **13b** | **FREESTAND\_PROBE** | **Is this/that clinic in an institutional setting, in an industrial outpatient facility, or operated by the Federal Government?**   1. Yes 2. No | | N/A | |
| **13b** | **FAMPLAN\_PROBE** | **Is this/that clinic operated by the Federal Government?**   1. Yes 2. No | | N/A | |
| **13c** | **OTHLOC** | **Are there other office locations where (you/physician's name) NORMALLY would see patients, even though (you/physician's name) will not see any during (Your/ his/her) 7-day reporting period?  Do not include settings such as EDs, outpatient departments, surgicenters, Federal clinics, and community health centers.**   1. Yes Go to OTHLOCVS 2. No Skip to ESTDAYS | | **Are there other CHC locations where (you/physician's name) NORMALLY would see patients, even though (you/physician's name) will not see any during (Your/ his/her) 7-day reporting period?**   1. Yes **Go to OTHLOC\_NUM** 2. No Skip to ESTDAYS | |
| **New** | **OTHLOC\_NUM** | **N/A** | | **In how many other CHC locations do you NORMALLY see patients?**  **\_\_\_\_\_\_ Number of locations** | |
| **13d** | **OTHLOCVS** | **Of these locations where (you/physician's name) will not be seeing patients during (Your/ his/her) 7-day reporting period, how many total office visits did (you/physician's name) have during (Your/ his/her) last week of practice at these locations?** | | **Of these CHC locations where (you/physician's name) will not be seeing patients during (Your/ his/her) 7-day reporting period, how many total office visits did (you/physician's name) have during (Your/ his/her) last week of practice at these CHC locations?** | |
| **14a** | **ESTDAYS** | **During the week of Monday, [Fill Date] through Sunday, [Fill Date] how many days do you expect to see any ambulatory patients at the following locations?** | | **During the week of Monday, [Fill Date] through Sunday, [Fill Date] how many days do you expect to see any ambulatory patients at this CHC location?** | |
| **14b** | **ESTVIS** | **During (Your/ his/her) last normal week of practice, approximately how many office visit encounters did (you/physician's name) have at each office location?**           If physician is in group practice, only include the visits to sampled physician. | | **During (Your/ his/her) last normal week of practice, approximately how many office visit encounters did (you/physician's name) have at this CHC location?**  **Only include the visits to the sampled CHC provider.**            If physician is in group practice, only include the visits to sampled physician. | |
| **14c** | **SAME** | **During the week of Monday, (Reporting period begin date) through Sunday (Reporting period end date), (do/does) (you/physician's name) expect to have about the same number of visits as (you/physician's name) saw during (Your/ his/her) last normal week in each office taking into account time off, holidays, and conferences?**   1. Yes 2. No | | During the week of Monday, (fill) through Sunday (fill), do you expect to have about the same number of visits as you saw during your last normal week **at the current CHC location** taking into account time off, holidays, and conferences?   1. Yes 2. No | |
| **14d** | **ESTVISP** | **Approximately how many ambulatory visits (do/does) (you/physician's name) expect to have at this office location?** | | Approximately how many ambulatory visits do you expect to have at this **CHC** location? | |
| **14e** | **ESTTOTVS** | **Tally of estimated number of visits** | | Same | |
| **15a** | **SOLO** | **Now, I'm going to ask about (your/Physician name's) practice at (Office location).  (Do/Does) (you/physician's name) have a solo practice, or (are/is) (you/physician's name) associated with other physicians in a partnership, in a group practice, or in some other way at this location?**   1. Solo 2. Nonsolo | | **Now, I'm going to ask about the CHC at [Pre-fill location].  Do you work in a solo CHC, or are you associated with other physicians in a partnership, in a group CHC, or in some other way at this location?**   1. Solo 2. Nonsolo | |
| **15b** | **OTHPHY** | **How many physicians are associated with (you/physician's name) at (Office location)?** | | Same | |
| **15c** | **MULTI** | **Is this a single- or multi-specialty (group) practice at (Office location)?**   1. Multi 2. Single | | **Is this a single- or multi-specialty CHC at [Pre-fill location]?**   1. Multi 2. Single | |
| **15d** | **MIDLEV** | **How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with (you/physician's name) at (Office location)?** | | Same | |
| **15e** | **OWNERSH** | **(Are/Is) (you/physician's name) a full- or part-owner, employee, or an independent contractor at (Office location)?**   1. Full-owner 2. Part-owner 3. Employee 4. Contractor | | Same | |
| **15f** | **OWNS** | **Who owns the practice at (Office location)?**   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 | | **Who owns the CHC at (Office location)?**   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 | |
| **15g** | **ONSITE\_EKG**  **ONSITE\_PHLEB**  **ONSITE\_LAB**  **ONSITE\_SPIRO**  **ONSITE\_ULTRA**  **ONSITE\_XRAY** | **Does (your/Physician name's) practice have the ability to perform any of the following on site at (Office location)?**   1. EKG/ECG 2. Phlebotomy 3. Lab testing (not including urine dipstick, urine pregnancy, fingerstick blood glucose, or rapid swab testing for infectious diseases) 4. Spirometry 5. Ultrasound 6. X-ray 7. Yes 8. No 9. Don’t know | | **Does the CHC have the ability to perform any of the following on site at (Office location)?**   1. EKG/ECG 2. Phlebotomy 3. Lab testing (not including urine dipstick, urine pregnancy, fingerstick blood glucose, or rapid swab testing for infectious diseases) 4. Spirometry 5. Ultrasound 6. X-ray 7. Yes 8. No 9. Don’t know | |
| **15h** | **PATEVEN** | **(Do/Does) (you/physician's name) see patients in the office during the evening or on weekends at (Office location)?**   1. Yes 2. No 3. Don’t know | | **(Do/Does) (you/physician's name) see patients in the CHC during the evening or on weekends at (Office location)?**   1. Yes 2. No 3. Don’t know | |
| **15i** | **NPI** | **What is (your/Physician name's) National Provider Identifier (NPI) at (Office location)?** | | Same | |
| **15j** | **FEDTXID** | **What is your Federal Tax ID, also known as an Employer Identification Number (EIN), at (Office location)?** | | Same | |
| **16a** | **WKHOURS** | **During (your/Physician name's) last normal week of practice, how many hours of direct patient care did (you/physician's name) provide?** Direct patient care includes: Seeing patients, reviewing tests, preparing for and performing surgery/procedures, providing other related patient care services. | | Same | |
| **16b** | **NHVISWK**  **HOMVISWK**  **HOSVISWK**  **TELCONWK**  **ECONWK** | **During (Your/ his/her) last normal week of practice, about how many encounters of the following type did (you/physician's name) make with patients:**   1. Nursing home visits 2. Other home visits 3. Hospital visits 4. Telephone consults 5. Internet/e-mail consults | | Same | |
| **New National CLAS Standards Questions** | | | | | |
|  | **CLASTRAIN** | **(The following two questions must be answered by the sampled provider.) Within the past 12 months, have you participated in any cultural competence training?**   1. **Yes** 2. **No** | | Same | |
|  | **CLASKNOW** | **(The following question must be answered by the sampled provider.) How familiar are you with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)?**   1. **Never heard of it** 2. **Heard of it but do not know much about it** 3. **Know something about it** 4. **Very familiar with it** | | Same | |
| **New Alcohol Screening and Brief Intervention (SBI) Questions (17-22)** | | | | | |
|  | **ALCOHOL\_INTRO** | **The next set of questions are only administered to primary care providers and seeks to determine the extent to which alcohol screening and brief intervention (SBI) is being conducted within their practices.** | | Same | |
| **17** | **ALCSCREEN** | **Screening for alcohol misuse (excessive consumption and alcohol-related problems) is often conducted in clinical settings. How do you screen for alcohol misuse?**   1. **I don’t screen** 2. **T-ACE** 3. **TWEAK** 4. **CAGE** 5. **CRAFFT** 6. **AUDIT** 7. **Ask number of drinks per occasion** 8. **Ask frequency of drinking** 9. **Ask binge question** 10. **I don’t use a formal screening instrument** 11. **Other (specify) ALCSCREENOTH** | | Same | |
| **18** | **ASCREENOFT** | **How often do you screen for alcohol misuse?**   1. **At every health maintenance visit (annually)** 2. **At every health care visit** 3. **When I suspect a patient has a substance/alcohol-related problem** 4. **Almost never or never** | | Same | |
| **19** | **ASCREENADM** | **How are screening question(s) administered?**   1. **Interview** 2. **Patient completes a form** 3. **Electronic** 4. **Other (specify) ASCREENADMOTH** | | Same | |
| **20** | **ASCREENWHO** | **If patient is interviewed, who administers the screening?**   1. **Physician, nurse practitioner, physician assistant** 2. **Nurse, excluding nurse practitioner** 3. **Medical assistant** 4. **Administrative staff** 5. **Other (specify) ASCREENWHOTH** | | Same | |
| **21** | **ABRFINTERV** | **Brief interventions for risky alcohol use are short discussions with patients who drink too much or in ways that are harmful. These interventions typically include some of the following elements:**   * **Feedback on screening results** * **Gathering further information on drinking patterns, alcohol-related harm, or symptoms of alcohol dependence** * **Discussing the risks and consequences of drinking too much** * **Providing advice about cutting back or stopping**   **Among patients who screen positive for risky alcohol use, how often are brief interventions conducted?**   1. **Never** 2. **Sometimes** 3. **Often** 4. **Always** | | Same | |
| **22** | **ARESOURCE** | **What resources would be helpful in implementing alcohol/substance screening and intervention in primary care settings? (Select all that apply)**   1. **Implementation guide for alcohol screening and intervention** 2. **Training on how to conduct alcohol screening** 3. **Training on how to conduct intervention** 4. **Office-based mentoring** 5. **Access to patient education materials** 6. **Scripts on what to say to patients** 7. **Information about reimbursement for services** 8. **Information about where or how to refer for additional services** 9. **Other (specify) ARESOURCEOTH** | | Same | |
| **Workforce Questions (23-34)** | | | | | |
| **23** | **MOSTVIS\_INTRO** | **The next section refers to characteristics of the sampled physician’s practice.** | | **The next section refers to characteristics of the sampled CHC.** | |
| **24** | **NUMPH**  (one location listed) | **The next questions are about the practice that is associated with [Pre-fill location].**    **How many physicians, including you are associated with this practice? Please include physicians at [Pre-fill 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 | | **The next questions are about the CHC that is associated with [Pre-fill location].**    **How many physicians, including you 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 | |
| **24** | **NUMPH**  (two or more locations listed) | **The next questions are about the practice that is associated with [Pre-fill location], which is the location where the physician has the most office visits.**  **How many physicians, including you are associated with that practice? Please include physicians at [Pre-fill location], 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 | | **N/A** | |
| **25** | **PCMH** | **Is your practice certified as a patient-centered medical home?**   1. Yes    1. If yes, by whom **CERT\_WHO**       1. The Accreditation Association for Ambulatory Health (AAAH)       2. The Joint Commission       3. The National Committee for Quality Assurance (NCQA)          1. [If yes:]  What level of certification? **NCQAlevel**             1. Level 1             2. Level 2             3. Level 3       4. Utilization Review Accreditation Commission (URAC)       5. Other – Specify **PCMH\_OTH**\_\_\_\_\_\_\_\_\_\_\_\_       6. Unknown 2. No 3. Unknown | | **Is the CHC at this location certified as a patient-centered medical home?** | |
| **26** | **ACCESS** | **Is it possible within your practice to access patient medical records using an electronic health record (EHR) system 24-hours a day?**   1. Yes **ACCESS\_PH**    1. [If yes:] Is this access available to physicians only, or is it also available to other non-physician clinicians?       1. Physicians (MD/DO) only.       2. All Physicians and non-physician Clinicians.       3. Unknown 2. No 3. Unknown | | 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? | |
| **27** | **PMETHOD** | **What is the primary method by which your practicereceives information about patients in your practice 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    * 1. [If yes:] Was this email sent over a secure network? **SECNET**         + 1. Yes           2. No           3. Unknown 4. Telephone or in-person communication with provider 5. Paper copy 6. Other **PMETHOD\_SP** | | 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? | |
| **28** | **TRANS** | **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?**   * 1. Yes   2. No   3. Unknown | | 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? | |
| **29** | **PROTO** | **Does your practice have written protocols for providing chronic care services that are used by all members of the care team?**   * 1. Yes   2. No   3. Unknown | | Does **the CHC at this location** have written protocols for providing chronic care services that are used by all members of the care team? | |
| **30** | **QUAL** | Does your practice report any quality measures or quality indicators to either payers or to organizations that monitor health care quality?   1. Yes 2. No 3. **Unknown** | | 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** | |
| **31** | **DIFTIN** | Do all other locations or offices associated with this practice use the same Federal Tax ID, also known as an **Employer Identification Number (EIN),** or do any locations or offices associated with this practice 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 | | 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 | |
| **32** | **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 full-time and part-time 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. | | **Same** | |
|  | |  |  |  | | --- | --- | --- | | 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** | | 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** | | 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** | | | | | |
| **33** | **Tasks performed (13 variables)** | | **At [Pre-fill location], which type of provider most commonly performs the following tasks?**  Enter all that apply.  The providers listed are generated from the previous staffing question. If any providers in your office are missing, please go back to the staffing question and check the appropriate box(es). | Same | |
|  | |  |  | | --- | --- | | Based on the staff selected in Question 32, a checkbox answer list of staffing types will be made available for each of the following questions A-M, but will only contain those selected providers as well as “Task is not performed in this office” and “Unknown”. |  | | A.      Records body measurements (such as height and weight) and vital signs (such as BP, temperature, heart rate) | **Task\_Body** | | B.      Performs office-based testing such as EKG and hearing/vision testing (do not include laboratory testing) | **Task\_Test** | | C.      Draws blood for lab testing | **Task\_Blood** | | D.      Provides immunizations (includes both childhood and adult) | **Task\_Immun** | | E.       Conducts cancer screenings ( such as breast, cervical, and prostate screenings) | **Task\_Screen** | | F.       Provides behavioral health screenings (such as depression, alcohol and substance abuse) | **Task\_Behav** | | G.      Provides counseling services (such as diet/nutrition, weight reduction, tobacco cessation, stress management) | **Task\_Counsel** | | H.      Manages the routine care of patients with chronic conditions (such as hypertension, asthma, diabetes) | **Task\_Rout** | | I.        Writes refill prescriptions for medications | **Task\_Refill** | | J.        Enters patient information into medical/billing records | **Task\_Enter** | | K.      Performs imaging tests (such as X-rays and ultrasounds) | **Task\_Image** | | L.       Make referrals (for example, to specialty care, or to community-based services) | **Task\_Ref** | | M.     Contacts patients, who are transitioning from hospital or nursing home back to the community | **Task\_Contacts** | | | | | |
| **34** | **Autonomy of PAs, NPs, and CNMs (15 variables)** | **The following questions concern the PAs, NPs, and CNMs practicing at [Pre-fill location].** | | Same | |
|  | |  |  |  |  |  | | --- | --- | --- | --- | --- | | A.      **Physician Assistant** | **Yes, always** | **Yes, sometimes** | **No** | **Unknown/Not Applicable** | | 1. Are PA(s) supervised by someone on-site? **PA\_SUP** |  |  |  |  | | 1. Do you sign-off on the medical records of the patients the PA(s) see(s)? **PA\_SIGN** |  |  |  |  | | 1. Do the PA’s patients have a separate log from your patients? **PA\_LOG** |  |  |  |  | | 1. Is your approval required before the PA(s) prescribe(s) medication? **PA\_APPROVAL** |  |  |  |  | | 1. **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 NP(s) supervised by someone on-site? **NP\_SUP** |  |  |  |  | | 1. Do you sign-off on the medical record of the patients the NP(s) see(s)? **NP\_SIGN** |  |  |  |  | | 1. Do the NP’s patients have a separate log from your patients? **NP\_LOG** |  |  |  |  | | 1. Is your approval required before the NP(s) prescribe(s) medication? **NP\_APPROVAL** |  |  |  |  | | 1. 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 CNM(s) supervised by someone on-site? **CNM\_SUP** |  |  |  |  | | 1. Do you sign-off on the medical record of the patients the CNM(s) see(s)? **CNM\_SIGN** |  |  |  |  | | 1. Do the CNM’s patients have a separate log from your patients? **CNM\_LOG** |  |  |  |  | | 1. Is your approval required before the CNM(s) prescribe(s) medication? **CNM\_APPROVAL** |  |  |  |  | | 1. Do/does the CNM(s) bill for services using their own NPI number? **CNM\_BILL** |  |  |  |  | | | | | |
| **Electronic Health Record (EHR) Questions #35-51** (see Attachment C1 #28-38d) | | | | | |
| 35 | **EMR\_INTRO** | **Answer ALL remaining questions for the in-scope location with the most visits which is (Office location with most visits)** | | **Answer ALL remaining questions for the current CHC location, which is [Pre-fill].** | |
| 36 | **EBILLREC** | **Does the reporting location submit any claims electronically (electronic billing)?**   1. Yes 2. No 3. Unknown | | Does the **CHC** reporting location submit any claims electronically (electronic billing)? | |
| 37a | **EMEDREC** | **Does the 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 | | Does the **CHC** reporting location use an electronic health record (EHR) or electronic medical record (EMR) system? Do not include billing record systems. | |
| 37b | **EHRINSYR** | **In which year did you install your current EHR/EMR system?** | | In which year did **the CHC** install your current EHR/EMR system? | |
| 37c | **HHSMU** | **Does your current system meet meaningful use criteria as defined by the Department of Health and Human Services?**   1. Yes 2. No 3. Unknown | | Does **the CHC’s** current system meet meaningful use criteria as defined by the Department of Health and Human Services? | |
| 37d | **EHRNAM** | **What is the name of your 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 | | What is the name of **the CHC’s** current EHR/EMR system? | |
| 38 | **SECURCHCK** | **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.**   1. Yes 2. No 3. Unknown | | Has **the CHC** 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. | |
| 39 | **DIFFEHR** | **Does your EHR have the capability to electronically send health information to another provider whose EHR system is different from your system?**   1. Yes 2. No 3. Unknown | | Does **the CHC’s** EHR have the capacity to electronically send health information to another provider whose EHR system is different from **the CHC’s** system? | |
| 40 | **EMRINS** | **At the 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 | | At the **CHC** reporting location are there plans for installing a new EHR/EMR system within the next 18 months? | |
| 41a | **MUINC** | **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?**   1. Yes, we already applied 2. Yes, we intend to apply 3. Uncertain if we will apply 4. No, we will not apply | | Medicare and Medicaid offer incentives to **CHCs** that demonstrate “meaningful use of health IT.” At the **CHC** reporting location, are there plans to apply for Stage 1of these incentive payments? | |
| 41b | **MUSTAGE2** | **Are there plans to apply for Stage 2 incentive payments?**   1. Yes 2. No 3. Maybe 4. Unknown | | Same | |
| 42 | **EDEMOG EPROLST**  **EVITAL**  **ESMOKE**  **EPNOTES**  **EMEDALG**  **EMEDID**  **EREMIND**  **ECPOE**  **ESCRIP**  **EWARN**  **EFORMULA**  **ECTOE**  **EORDER**  **ERESULT**  **EGRAPH**  **ERADI**  **EIMGRES**  **EPTEDU**  **ECQM**  **EIDPT**  **EGENLIST**  **EIMMREG**  **ESUM**  **EMSG**  **EPTREC** | **Please indicate whether the ambulatory 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-u.   1. Yes, used routinely 2. Yes, but NOT used routinely 3. Yes, but turned off or not used 4. No 5. Unknown 6. Recording patient history and demographic information? 7. Recording patient problem list? 8. Recording and charting vital signs? 9. Recording patient smoking status 10. Recording clinical notes? 11. Recording patient’s medications and allergies? 12. Reconciling lists of patient medications to identify the most accurate list? 13. Providing reminders for guideline-based interventions or screening tests? 14. Ordering prescriptions? 15. If Yes, ask – Are prescriptions sent electronically to the pharmacy? 16. If Yes, ask – Are warnings of drug interactions or contraindications provided? 17. If Yes, ask – Are drug formulary checks performed? 18. Ordering lab tests? 19. If Yes, ask – Are orders sent electronically? 20. Viewing lab results? 21. If yes, ask – Can the EHR/EMR automatically graph a specific patient’s lab results over time? 22. Ordering radiology tests? 23. Viewing imaging results? 24. Identifying educational resources for patients’ specific conditions? 25. Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)? 26. Identifying patients due for preventive or follow-up care in order to send patients reminders? 27. Generating lists of patients with particular health conditions? 28. Electronic reporting to immunization registries? 29. Providing patients with clinical summaries for each visit? 30. Exchanging secure messages with patients? 31. Providing patients the ability to view online, download, or transmit information from their medical record? | | Please indicate whether the **CHC** reporting location has each of the following computerized capabilities and how often these capabilities are used.  Same | |
| 44a | **REFOUT** | **^DoDoes (you/physician's name) refer any of (Your/ his/her) patients to providers outside of (Your/ his/her) office or group?**   1. Yes 2. No | | Do you refer any of your patients to providers outside of **the CHC**? | |
| 44b | **REFOUTS** | **^DoDoes (you/physician's name) send the patient's clinical information to the other providers?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 44c | **REFOUTSE** | **^DoDoes (you/physician's name) send it electronically (not fax)?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 45a | **REFIN** | **^DoDoes (you/physician's name) see any patients referred to (you/physician's name)  by providers outside of (you/physician's name)  office or group?**   1. Yes 2. No | | Do you see any patients referred to you by providers outside of the **CHC**? | |
| 45b | **REFINS** | **^DoDoes (you/physician's name) send a consultation report with clinical information to the other providers?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 45c | **REFINSE** | **^DoDoes (you/physician's name) send it electronically (not fax)?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 46a | **INPTCARE** | **^DoDoes (you/physician's name) take care of patients after they are discharged from an inpatient setting?**   1. Yes 2. No | | Same | |
| 46b | **DISSUM** | **^DoDoes (you/physician's name) receive a discharge summary with clinical information from the hospital?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 46c | **DISSUME** | **Do you receive it electronically (not fax)?**   1. Yes, routinely 2. Yes, but not routinely 3. No | | Same | |
| 46d | **INCORINFO** | **Can you automatically incorporate the received information into your EHR system without manually entering the data?**   1. Yes 2. No 3. Not applicable, I do not have an EHR system | | Can you automatically incorporate the received information into the **CHC’s** EHR system without manually entering the data? | |
| 47a | **ESHARE** | **The next questions are about sharing (either sending or receiving) patient health information.  Do you share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?**   1. Yes 2. No | | Same | |
| 47b | **ESHAREHOW** | **How do you electronically share patient health information?** Enter all that apply, separate with commas   1. EHR/EMR 2. Web portal (separate from EHR/EMR) 3. Other electronic method (not fax) **ESHAREHOWOTH** | | Same | |
| 47c | **EHRTOEHR** | **Is the patient health information that you share electronically sent directly from your EHR system to another EHR system?**  [Pre-filled location is displayed.]   1. Yes, routinely 2. Yes, but not routinely 3. No 4. Unknown | | Is the patient health information that you share electronically sent directly from **the CHC’s** EHR system to another EHR system?  [Pre-filled location is displayed.]   1. Yes, routinely 2. Yes, but not routinely 3. No 4. Unknown | |
| 47d | **ESHAREPROV** | **With what types of providers do you electronically share patient health information (e.g., lab results, imaging reports, problem lists, medication lists)?**   1. Ambulatory providers inside your office/group 2. Ambulatory providers outside your office/group 3. Hospitals with which you are affiliated 4. Hospitals with which you are not affiliated 5. Behavioral health providers 6. Long-term care providers 7. Home health providers | | Same | |
| 48 | **EOUTINFO** | Are you/your staff able to electronically find health information (e.g. medications, outside encounters) from sources outside of the office for your patients? Please reference (fill location), which is the in-scope office with the most visits.  Enter all that apply.   1. Yes routinely 2. Yes, but not routinely 3. No 4. Unknown | | Are you/your staff able to electronically find health information (e.g. medications, outside encounters) from sources outside of the **CHC** for your patients? Please reference (fill location), which is the **current CHC location**. | |
| **49** | **EOUTHOW**  **EOUTOSP** | If Yes to EOUTINFO, How do you look up patient health information from sources outside of the office? Please reference (fill location), which is the in-scope office with the most visits.  Enter all that apply.  Through your EHR/EMR  Web portal (separate from EHR/EMR)  View only or restricted access to other providers’ EHR system  Other electronic method (not fax) **EOUTOSP** | | If Yes to EOUTINFO, How do you look up patient health information from sources outside of the **CHC**? Please reference (fill location), which is the **current CHC location**. | |
| **50** | **EOUTYP**  **EOUTYPSP** | What types of information do you routinely look up?  Enter all that apply.  1. Lab results  2. Imaging reports  3. patient problem lists  4. Medication lists  5. Other **EOUTYPSP** | | Same | |
| **51** | **EOUTINCORP** | Do you or your staff routinely incorporate the information you look up into your EHR?  1. Yes, via manual entry or scanned copy  2. Yes, automatically able to incorporate without manual entry or scanning  3. No, we do not routinely incorporate into our EHR | | Same | |
| **Revenue & Contracts, Compensation, New Patients** (#52 to end of induction) | | | | | |
| 52 | **PRMCARE PRMAID**  **PRPRVT**  **PRPATPAY**  **PROTH** | Please remind physician/provider that the remaining questions refer to all offices that were determined to be in-scope. **I would like to ask a few questions about (your/Physician name's) practice revenue and contracts with managed care plans.  Roughly, what percent of (your/Physician name's) patient care revenue comes from –**   1. Medicare? 2. Medicaid? 3. Private insurance? 4. Patient payments 5. Other (including charity, research, Tricare, VA, etc.)? | | Please remind physician/provider 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.** | |
| 53 | **PCTRVMAN** | **Roughly, what percent of the patient care revenue received by this practice comes from managed care contracts?** | | **Roughly, what percent of the patient care revenue received by this CHC comes from managed care contracts?** | |
| 54 | **REVFFS**  **REVCAP**  **REVCASE**  **REVOTHER** | **Roughly, what percent of (your/Physician name's) 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? | | Same | |
| 55 | **ACEPTNEW** | **(Are/Is) (you/physician's name) currently accepting "new" patients into (Your/ his/her) practice(s) at [Fill-in location]?**   1. Yes 2. No 3. Don’t know | | **(Are/Is) (you/physician's name) currently accepting "new" patients into the CHC at [Fill-in location]?** | |
| 56 | **CAPITATE**  **NOCAP**  **NMEDICARE**  **NMEDICAID**  **NWORKCMP**  **NSELFPAY**  **NNOCHARGE** | **From those "new" patients, which of the following types of payment (do/does) (you/physician's name) 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 | | Same | |
| 56 | **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** | | Same | |
| 57 | **COMP** | **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, 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 | | **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.** | |
| 58a | **SASDAPPT** | **Does (your/Physician name's) practice set time aside for same day appointments?**   1. Yes 2. No 3. Don’t know | | **Does the CHC set time aside for same day appointments?** | |
|  | Skip Instructions: | 1. Goto SDAPPT 2. **SKIP to APPTTIME** | | Same | |
| 58b | **SDAPPT** | **Roughly, what percent of (your/Physician name's) daily visits are same day appointments?** | | Same | |
| 58c | **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 7. Don't know | | Same | |
| 59a | **PRVBYEAR** | **N/A** | | **What is (your/Physician name's) year of birth?** | |
| 59b | **PRVSEX** | **N/A** | | **What is (your/Physician name's) sex?**   1. Female 2. Male | |
| 59c | **PRVDEGR** | **N/A** | | **What is (your/Physician name's) highest medical degree?**   1. MD 2. DO 3. Nurse practitioner 4. Physician assistant 5. Nurse midwife 6. Other | |
| 59d | **PRVPSPEC PRVPSPEC\_SP** | **N/A** | | **What is (your/Physician name's) primary specialty?**  Enter verbatim response for specialty | |
| 59e | **PRVSSPEC PRVSSPEC\_SP** | **N/A** | | **What is (your/Physician name's) secondary specialty?** Enter verbatim response for specialty | |
| 59f | **PRVPBC** | **N/A** | | **What is (your/Physician name's) primary board certification?** | |
| 59g | **PRVSBC** | **N/A** | | **What is (your/Physician name's) secondary board certification?** | |
| 59h | **PRVYRGRD** | **N/A** | | **What year did (you/physician's name) graduate from medical school?** | |
| 59i | **PRVFMS** | **N/A** | | **Did (you/physician's name) graduate from a foreign medical school?**   1. Yes 2. No | |
|  | **PHY\_UNAVAIL** | **Thank you for your time and cooperation ^RESPNAME\_FILL.  The information you provided will improve the accuracy of the NAMCS in describing office-based patient care in the United States.  I will call you on Monday, (Reporting period begin date) to see if your plans have changed. If you have any questions** (Hand respondent your business card) **please feel free to call me.** | | Same | |