

TSS-PROVIDERS INTERNET SURVEY – 2019 ADMINISTRATION



[PN: Use image in upper-left corner of all screens]



[PN: Use image in the center of all screens]

OMB NO.: 0720-0031

EXPIR. DATE: MM/DD/YYYY

[PN: Display text above in the upper-right corner of all screens]

(PN: WHEN “INSERT” IS INDICATED IN THE QUESTION TEXT, WE NEED TO POP-IN THE PROVIDER’S NAME AND CREDENTIALS [IF APPLICABLE] FROM THE “FULL_CL” AND “CREDENTIALS_CL” VARIABLES FROM THE SAMPLE RECORD. GROUP 0101 (PHYSICIANS) WILL HAVE “FULL_CL” AND “CREDENTIALS_CL” POPULATED, WHEREAS GROUP 0201 (MENTAL HEALTH) WILL ONLY HAVE “FULL_CL” POPULATED.

EXAMPLE 1: Respondent 123 is from group 0101, has “JOHN DOE” in FULL_CL, and has “MD” in CREDENTIALS_CL. His pop-in for provider name should read “JOHN DOE, MD”. NOTE THE COMMA SEPARATES THE INFORMATION.

EXAMPLE 2: Respondent 2 is from group 0201, has “JOHN DOE” in FULL_CL, and CREDENTIALS_CL is blank. His pop-in for provider name should read “JOHN DOE”. NOTE THAT THERE ARE NO CREDENTIALS AND NO COMMA IN THE POP-IN TEXT.

INTRO1

Thank you in advance for participating in the Department of Defense’s effort to survey civilian health care providers across the U.S. to determine whether military service members and their families have access to the health care they need.

We recognize that there may be more than one provider in your office and ask that you please answer this survey only on behalf of the provider indicated on the letter that you received in the mail. Since we may survey more than one provider in your office, please complete this survey only for the appropriate provider listed on the letter you received. If you have received more than one survey for other providers, you will be able to login at the end of this questionnaire to complete the survey for those providers.

The survey that follows should only take five minutes of your time. After logging in, simply select the button that best represents your response. Once you have completed the survey, all you need to do is click on the "Submit" button and your completed survey will automatically be sent.

To begin, please enter your unique login name (including any leading zeros) and password indicated on the letter that you received in the mail in the boxes below and click “Submit”.

Login Name: [PN: Add box for this]

Password: [PN: Add box for this]

[PN: Add “Submit” button]

TRANSITION

OMB Number 0720-0031 (Expiration Date: MM/DD/YYYY)

We estimate this survey will take an average five (5) minutes to complete, including the time for reviewing instructions, getting the needed data, and completing and reviewing the survey. Please send comments regarding our estimate or any other aspect of this survey, including suggestions for reducing the completion time, to Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. The OMB number above is currently valid, and you are not required to respond, unless this number is displayed.

Privacy Advisory Statement

Information is being collected for this Survey under the authority of the FY2015 National Defense Authorization Act (NDAA), Section 712 and will be used to help TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Select health care benefit option, and provide aggregated input to improve the Military Health System. **TRICARE Select replaced TRICARE Standard and Extra as of January 1, 2018 – bringing together features of both Standard and Extra into a single plan.** All information will be de-identified prior to being reported. Completing the Survey is voluntary; you may stop the Survey at any time and skip any questions you choose. There is no penalty if you choose not to respond, although maximum participation is encouraged so the data will be complete and representative.

[PN: Add "Next" button]

Q1

(PN: ASK OF ALL GROUPS)

**(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')**

SINGLE RESPONSE

Does [INSERT] provide health care to patients through *private practice*? (Is he/she working in a setting where providers, individually or as a group, decide or influence which health insurance to accept?)

Yes [PN: Go to Instructions before Q1b]

No, does not provide treatment, or has retired [PN: Go to End screen]

No, not in private practice [PN: Go to Q1A]

[PN: Add "Next" button]

Q1A

(PN: ASK IF 'NO, NOT IN PRIVATE PRACTICE' AT Q1)

**(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')**

SINGLE RESPONSE

What type of practice is [INSERT] in?

Government: Federal, State or other municipality

School, University or other academic institution

Hospital staff

Contractor providing services exclusively to government clients

Rehab facility, Nursing Home, or Home Health Provider

Closed Panel HMO

Other [SPECIFY]

[PN: Add "Next" button]

Q1B

(PN: ASK IF GROUP = 0201 (MENTAL HEALTH PROVIDER) AND ('YES' OR 'NO, NOT IN PRIVATE PRACTICE' AT Q1))

(PN: INSERT 'FULL_CL' FOR INSERT)

MULTIPLE RESPONSE

What type of health care provider is [INSERT]? Select all that apply.

- Certified Clinical Social Worker
- Certified Psychiatric Nurse Specialist
- Clinical Psychologist
- Certified Marriage and Family Therapist
- Pastoral Counselor
- Mental Health Counselor
- Other [SPECIFY]

[PN: Add "Next" button]

Q2

(PN: ASK ALL)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

SINGLE RESPONSE

Is [INSERT] aware of the TRICARE health care program?

- Yes
- No
- I Don't Know

[PN: Add "Next" button]

Q3

(PN: ASK ALL)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

SINGLE RESPONSE

As of today, is [INSERT] a contracted member of the TRICARE network of health care providers?

- Yes
- No
- I Don't Know

[PN: Add "Next" button]

Q4

(PN: ASK ALL)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

SINGLE RESPONSE

As of today, is [INSERT] accepting new TRICARE Select (formerly known as TRICARE Standard or Extra) patients?

- | | |
|-------------------------------------|----------------|
| No | [PN: Go to Q5] |
| Yes, on a claim by claim basis only | [PN: Go to Q6] |
| Yes, for all claims | [PN: Go to Q6] |
| I Don't know | [PN: Go to Q6] |

[PN: Add "Next" button]

Q5

(PN: ASK IF 'NO' AT Q4)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

OPEN-END RESPONSE

You answered "no" to the previous question. Why is [INSERT] not accepting new TRICARE Select patients? Please list all the reasons.

[PN: Include box for open-ended response]

[PN: Add "Next" button]

Q6

(PN: ASK ALL)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

SINGLE RESPONSE

What percentage of patients seen by [INSERT] use any form of TRICARE? If unsure, please enter your best guess. If none, please enter 0.

- [PN: Capture numeric response, 0-100]
I Don't Know

[PN: Do not allow for a numeric answer to be provided and 'I Don't Know' marked]

[PN: Add "Next" button]

Q7

(PN: ASK ALL)

**(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')**

Does [INSERT] accept *Medicare patients*?

Yes

No

I Don't Know

[PN: Add "Next" button]

Q8

(PN: ASK ALL)

**(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')**

As of today, is [INSERT] accepting *new Medicare patients*?

Yes [PN: Go to END]

No [PN: Go to Q9]

I Don't Know [PN: Go to Q10]

[PN: Add "Next" button]

Q9

(PN: ASK IF 'NO' AT Q8)

**(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')**

OPEN-END RESPONSE

You answered "no" to the previous question. Why is [INSERT] *not accepting new Medicare patients*? Please list all the reasons.

[PN: Include box for open-ended response]

[PN: Add "Next" button]

Q10

(PN: ASK IF 'NO' OR 'I DON'T KNOW' AT Q8)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

Does [INSERT] accept payment from government or private health insurance plans?

Yes

No

[PN: Add "Next" button]

Q11

(PN: ASK IF 'NO' OR 'I DON'T KNOW' AT Q8)

(PN: INSERT 'FULL_CL, CREDENTIALS_CL' FROM SAMPLE IF GROUP 0101.
IF GROUP 0201, INSERT 'FULL_CL')

As of today, is [INSERT] accepting *new* patients?

Yes

No

I Don't Know

[PN: Add "Next" button]

END

[PN: Mark interview as Complete]

Thank you for taking the time to complete this survey.

If you have questions about TRICARE, its specific health plans, or the benefits it provides, please visit the TRICARE web site at www.tricare.mil for assistance.

To take this survey for another provider, please click on the link below.

[PN: Add "Begin Another Survey" link. This should redirect the respondent to the splash page.]