Attachment C2:

NAMCS Draft Ambulatory Care Provider Interview (ACPI)

Form Approved:

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Exp. Date xx/xx/20XX

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**1. We have your primary specialty as: {FILL SAMPLED SPECIALTY}. Is this correct?**

* 1. Yes
  2. No **(Go to question 1a)**

**1a**. What is your specialty?

|  |  |
| --- | --- |
| **PA Specialties** | **PHYSICIAN Specialties** |
| Addiction Medicine **(Skip to question 2)**  .  .  Other **(Go to question 1b)**  .  .  Vascular Surgery **(Skip to question 2)** | Adult Cardiothoracic Anesthesiology **(Skip to question 2)**  .  .  Other Specialty **(Go to question 1b)**  .  .  Vascular Surgery **(Skip to question 2)** |

**1b.** Please specify Other Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. This survey asks about outpatient care, that is, care for patients receiving health services without admission to a hospital or other facility. Do you directly provide any outpatient care?**

1. Yes **(Skip to question 4)**
2. No

Help text [paper & Web]

Outpatient care is typically provided to individuals we consider ambulatory patients. Ambulatory patients are patients who are not being seen as inpatients in a hospital, nursing home or other institution. Patients who leave the institution and go to a doctor's office for care are considered to be ambulatory patients.

**3. Why are you not currently providing any direct outpatient care?**

* 1. Engaged in research, teaching, and/or administration
  2. Once provided direct outpatient care but now retired
  3. Once provided direct outpatient care but temporarily not practicing (duration 3+ months)
  4. Now not licensed/Never licensed
  5. Something else (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Skip to question 48)**

**4. Do you see ambulatory patients in any of the following settings? SELECT ALL THAT APPLY**.

|  |  |
| --- | --- |
| **Setting Name** |  |
| 1. Private solo or group practice | |  |  | | --- | --- | |  | *If you see patients* in  **any** *of these settings,*  *go to question 5* | |
| 2. Freestanding clinic or Urgent Care Center  (e.g., Concentra Urgent Care, Patient First, NextCare Urgent Care, FastMed Urgent Care) |
| 3. Health Center (e.g., Federally Qualified Health Center [FQHC], federally funded clinics or “look-alike” clinics) |
| 4. Mental health center |
| 5. Government clinic that is not federally funded (e.g., state, county, city, maternal and child health, etc.) |
| 6. Family planning clinic (including Planned Parenthood) |
| 7. Integrated Delivery System, Health maintenance organization, health system or other prepaid practice (e.g., Kaiser Permanente) |
| 8. Faculty practice plan (i.e., an organized group of physicians and other health care professionals that treats patients referred to an academic medical center) |
| 9. Retail health clinic (e.g., CVS MinuteClinic, Walgreen’s Healthcare Clinics, Kroger’s Little Clinic) |
| 10. Hospital outpatient department |
| 11. Hospital emergency department | *If you select* ***only*** *11, 12, 13, 14, 15 or 16 Skip to question 48* |
| 12. Ambulatory surgery center/surgicenter |
| 13. Industrial outpatient facility |
| 14. Federal government clinics (e.g., Veterans Affairs, military only clinics) |
| 15. Institutional facility |
| 16. None of the above |

**5. At which outpatient setting (1-10) in the previous question do you see the most patients in a typical week? WRITE THE NUMBER LOCATED NEXT TO THE SELECTION MADE.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **For the rest of the survey, we will refer to this as “your reporting location.”** |

**6. What is the street address, city, state, and ZIP Code of *your reporting location*? What is the e-mail address of the physician to whom this survey was mailed?**

|  |  |
| --- | --- |
| Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ZIP Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**7. During a typical week, approximately how many patient visits do you personally receive at [“your reporting location” OR fill with address from Q6]?** Your best single-number estimate is fine. By patient visit, we mean a billable encounter. Include only your visits; unless visits are to another provider supervised by you.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Help text [paper & Web]

A typical or normal week is defined by a week that does not include a holiday, vacation, conference, time off, or any other type of non-normal absence.

**8.** **In this survey, “other providers” mean any individuals administering any type of direct medical, mental, or behavioral health care. At [“your reporting location” OR fill with address from Q6], do you work in a solo medical facility, or do you work with other providers in a partnership, group practice, or in some other way (nonsolo)?**

1. Solo **(Skip to question 10)**
2. Nonsolo
3. **At [“your reporting location” OR fill with address from Q6], how many other providers are employed? Do not include interns, residents, fellows, or yourself in the count.** Other providers mean any individuals administering any type of direct medical, mental, or behavioral health care.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Is [“your reporting location” OR fill with address from Q6] a multi- or single-specialty practice?** 
   1. Multi
   2. Single
2. **At [“your reporting location” OR fill with address from Q6], are you a full- or part-owner, employee, independent contractor, or a volunteer?** 
   1. Full-owner **(If PA, skip to question 14; otherwise, physicians skip to question 13)**
   2. Part-owner
   3. Employee
   4. Contractor
   5. Volunteer
3. **At [“your reporting location” OR fill with address from Q6], who owns the practice?** 
   1. Physician/Physician group
   2. Advanced practice provider/Advanced practice provider group (i.e., advanced practice provider refers to nurse practitioners, PAs (physician assistants/physician associates), or certified nurse midwives)
   3. Combination of physicians and advanced practice providers
   4. Insurance company, health plan, or HMO
   5. Health center
   6. Academic medical center or teaching hospital
   7. Other hospital
   8. Other health care corporation
   9. Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If PA, skip to question 14; otherwise, physicians go to question 13.)**

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| **Workforce, Revenue, & Compensation Questions** |

***The following questions pertain to [“your reporting location” OR fill with address from Q6].***

1. **The following questions concern advanced practice providers practicing at [“your reporting location” OR fill with address from Q6]. If the specified type of provider is not practicing at the reporting location, please select “not applicable.”**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Always | Sometimes | Never | Don’t know | Not applicable |
| Do PAs bill for services using their own NPI number? |  |  |  |  |  |
| Do Nurse Practitioners bill for services using their own NPI number? |  |  |  |  |  |
| Do Certified Nurse Midwives bill for services using their own NPI number? |  |  |  |  |  |
| Do Clinical Nurse Specialists bill for services using their own NPI number? |  |  |  |  |  |
| Do Certified Registered Nurse Anesthetists bill for services using their own NPI number? |  |  |  |  |  |

1. **Which of the following types of payment does [“your reporting location” OR fill with address from Q6] accept? SELECT ALL THAT APPLY.**
   1. Private insurance
   2. Medicare
   3. Medicaid
   4. CHIP
   5. Workers’ compensation
   6. Self-pay
   7. No charge
   8. Other (e.g., car insurance, someone other than patient pays)
2. **At [“your reporting location” OR fill with address from Q6], are you, personally, currently accepting new patients?** 
   1. Yes
   2. No
   3. Don’t know

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| **COVID-19 Questions** |

***The following questions pertain to [“your reporting location” OR fill with address from Q6].***

1. **Does [“your reporting location” OR fill with address from Q6] offer COVID-19 vaccinations?**
   1. Yes
   2. No **(Skip to question 18)**
2. **Which vaccine(s) does [“your reporting location” OR fill with address from Q6] offer? SELECT ALL THAT APPLY.**
3. Moderna
4. Johnson & Johnson/Janssen
5. Pfizer
6. Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Don’t know

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| Electronic Health Records and Telemedicine |

***The following questions pertain to [“your reporting location” OR fill with address from Q6].***

1. **Does [“your reporting location” OR fill with address from Q6] use an EHR system? Do not include billing record systems.** 
   1. Yes
   2. No **(Skip to question 20)**
   3. Don’t know **(Skip to question 20)**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Does *[“your reporting location” OR fill with address from Q6]* use an EHR to…? | Yes | No | Don’t know |
| Record social determinants of health (e.g., employment, education, race/ethnicity, language and literacy skills)? |  |  |  |
| Record behavioral determinants of health (e.g., tobacco use, physical activity, alcohol use**, drug use, diet**)? |  |  |  |
| Order prescriptions? |  |  |  |
| Send prescriptions electronically to the pharmacy? |  |  |  |

1. **At [“your reporting location” OR fill with address from Q6], what type(s) of telemedicine do you personally use for patient visits? SELECT ALL THAT APPLY.**
   1. Videoconference software with audio (e.g., Zoom, Webex, FaceTime)
   2. Audio without video conference software
   3. Telemedicine platform NOT integrated with EHR (e.g., Doxy.me)
   4. Telemedicine platform integrated with EHR (e.g., update clinical documentation during telemedicine visit)
   5. Other tool(s) (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   6. I don’t use telemedicine for patient visits **(Skip to question 23)**
2. **At [“your reporting location” OR fill with address from Q6] in a typical week, how many of your own visits use telemedicine?** 
   1. None
   2. Some
   3. Most
   4. All
3. Compared to in-person patient visits, please rate your personal overall satisfaction with using telemedicine for patient visits at [“your reporting location” OR fill with address from Q6].
   1. Very satisfied
   2. Somewhat satisfied
   3. Neither satisfied nor dissatisfied
   4. Somewhat dissatisfied
   5. Very dissatisfied
4. At [“your reporting location” OR fill with address from Q6], what, if any, issues affect your own use of telemedicine? SELECT ALL THAT APPLY.
   1. Limited Internet access and/or speed issues
   2. Telemedicine platform not easy to use
   3. Telemedicine isn’t appropriate for my specialty/type of patients
   4. Limitations in patients’ access to technology (e.g., smartphone, computer, tablet, Internet)
   5. Patients’ difficulty using technology/telemedicine platform
   6. Improved reimbursement and relaxation of rules related to use of telemedicine visits

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| **Health Equity and Language Barriers** |

***The following questions pertain to [“your reporting location” OR fill with address from Q6].***

1. **At [“your reporting location” OR fill with address from Q6], do you personally see patients during the evening or on weekends?** 
   1. Yes
   2. No
   3. Don’t know
2. **Does [“your reporting location” OR fill with address from Q6] set time aside for same day appointments?**
3. Yes
4. No
5. Don’t know
6. **On average, about how long does it take to get an appointment with you for a routine medical exam at [“your reporting location” OR fill with address from Q6]? By “routine medical exam,” we mean any medical care considered “routine” for your specialty.**
7. Within 1 week
8. 1-2 weeks
9. 3-4 weeks
10. 1-2 months
11. 3 or more months
12. Do not provide routine medical exams
13. Don't know
14. **Are you** **comfortable providing care to a patient in another language? Please include American Sign Language (ASL).**
15. Yes
16. No
17. **At [“your reporting location” OR fill with address from Q6], how many of your own patients have limited English proficiency?**
18. None **(Skip to question 31)**
19. Some
20. Most
21. All
22. Don’t know

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **When you use interpreters at [“your reporting location” OR fill with address from Q6], how often do you personally use each type?** | Often | Sometimes | Rarely | Never | Don’t know |
| Staff/contractor trained as a medical interpreter |  |  |  |  |  |
| Bilingual Staff (not formally trained as an interpreter) |  |  |  |  |  |
| Patient’s relative or friend |  |  |  |  |  |
| Language translation service (iPad/phone-based) |  |  |  |  |  |

1. **What types of materials at [“your reporting location” OR fill with address from Q6], in at least one other language other than English, are available to your own patients? SELECT ALL THAT APPLY.**
2. Wellness/Illness related education
3. Patient rights/Informed consent documents
4. Advanced directives
5. Payment
6. Care plan
7. Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. No translated materials are available to my patients
9. Don’t know
10. **What information does [“your reporting location” OR fill with address from Q6] record on patients’ culture and language characteristics? SELECT ALL THAT APPLY.**
11. Nationality/Nativity
12. Primary language
13. Sexual orientation
14. Gender identity
15. Race/Ethnicity
16. Religion
17. Income
18. Education
19. Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
20. We do not collect information related to patient characteristics.

**(If PA, skip to question 41; otherwise, physicians go to question 32.)**

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| **Physician Only: Pain Treatment and Treatment with Opioids** |

***The following questions pertain to [“your reporting location” OR fill with address from Q6].***

1. **At [“your reporting location” OR fill with address from Q6], do you personally currently treat any patients for pain?**
2. Yes, I currently treat patients for chronic pain only.
3. Yes, I currently treat patients for both chronic and acute pain.
4. Yes, I currently treat patients for acute pain only.
5. No **(Skip to question 39)**
6. Don’t know **(Skip to question 39)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **When managing your own pain patients at [“your reporting location” OR fill with address from Q6], how often do you…** | Never | Rarely | Sometimes | Often | Always | Don’t know | Not applicable |
| Establish treatment goals with your recently diagnosed pain patients (e.g., less pain, improved function, increased social activities, better sleep quality, etc.)? |  |  |  |  |  |  |  |
| Recommend non-pharmacological approaches to your recently diagnosed pain patients before or instead of opioid therapy? |  |  |  |  |  |  |  |

1. **What types of non-opioid medications do you currently recommend to pain patients at [“your reporting location” OR fill with address from Q6]? SELECT ALL THAT APPLY.**
   1. Acetaminophen
   2. Anticonvulsants
   3. Antidepressants
   4. Benzodiazepines
   5. Non-steroidal anti-inflammatory (NSAIDS)
   6. Other non-opioid drugs
   7. None of the above
   8. Don’t know
2. **How many of your own pain patients at [“your reporting location” OR fill with address from Q6] are currently being treated with opioids prescribed by you?**
3. None **(Skip to question 39)**
4. A few
5. Some
6. Almost all
7. All
8. Don’t know

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Prior to starting opioids for pain management at [“your reporting location” OR fill with address from Q6], how often do you personally do the following?** | Never | Rarely | Sometimes | Often | Always | Don’t know |
| Screen patients for depression and other mental health disorders. |  |  |  |  |  |  |
| Discuss risks and benefits of using opioids for pain treatment. |  |  |  |  |  |  |

1. **After you start opioid therapy on a pain patient at [“your reporting location” OR fill with address from Q6], when do you personally re-evaluate him/her?** 
   1. Within 1 week
   2. Within 4 weeks
   3. Within 3 months
   4. Within 1 year
   5. I don’t re-evaluate patients after starting opioid therapy
   6. Don’t know

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **When prescribing opioid therapy to your pain patients at [“your reporting location” OR fill with address from Q6], how often do you personally …** | Never | Rarely | Sometimes | Often | Always | Don’t know | Not Applicable |
| Perform substance abuse risk assessment before prescribing opioids (e.g., CAGE, COWS, TAPS)? |  |  |  |  |  |  |  |
| Establish an opioid treatment plan with your patients? |  |  |  |  |  |  |  |
| Review the patient’s history of abuse? |  |  |  |  |  |  |  |
| Perform a urine toxicology screening before starting opioid therapy? |  |  |  |  |  |  |  |
| Review your state’s prescription drug monitoring program database (PDMP)? |  |  |  |  |  |  |  |
| Prescribe naloxone to patients receiving opioids? |  |  |  |  |  |  |  |
| Perform a random urine toxicology screening quarterly for long-term opioid therapy? |  |  |  |  |  |  |  |

1. **At [“your reporting location” OR fill with address from Q6], how many of your own patients are you currently treating for opioid use disorder?**
2. None
3. A few
4. Some
5. Almost all
6. All
7. Don’t know
8. **Does [“your reporting location” OR fill with address from Q6] have an opioid treatment program where patients could be referred for opioid use disorder?**
9. Yes
10. No
11. Don’t know

**(If physician, skip to 48; otherwise, PAs go to 41.)**

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| --- |
| PA Only: Autonomy Questions |

**The following questions pertain to [“your reporting location” OR fill with address from Q6].**

1. **How long have you practiced in your current specialty?** 
   1. 0-1 years
   2. 2-4 years
   3. 5-9 years
   4. 10-20 years
   5. 21 or more years
2. **How many years have you worked clinically as a PA?**
3. 0-1 years
4. 2-4 years
5. 5-9 years
6. 10-20 years
7. 21 or more years
8. **At [“your reporting location” OR fill with address from Q6], are there supervision/collaboration guidelines describing the types of decisions you can make or activities you can perform without direct physician involvement in your own patients’ care?**
9. Yes
10. No
11. Don’t know
12. **At [“your reporting location” OR fill with address from Q6], do you have your own panel of patients?**
13. Yes, entirely
14. Yes, but I also see patients from the practice
15. No
16. Don’t know
17. **At [“your reporting location” OR fill with address from Q6], how are claims submitted most of the time?**
18. My NPI
19. A physician’s NPI
20. Sometimes my own NPI and sometimes a physician’s NPI
21. I don’t bill for my medical services
22. Don’t know
23. **At [“your reporting location” OR fill with address from Q6], which of the following tasks do you personally perform on a regular and ongoing basis? SELECT ALL THAT APPLY.**
24. Admissions (i.e., conduct admission history and physical, write admission orders)
25. Develop treatment plans
26. Perform minor surgical procedures
27. Perform non-surgical procedures
28. Order referrals and consults
29. Order and interpret diagnostic testing and therapeutic modalities
30. Perform new patient encounters
31. Perform post-op patient encounters
32. Perform post-op global visits
33. Perform pre-op history and physicals (H&Ps)
34. See consults
35. Prescribe non-schedule medications
36. Prescribe schedule (II-V) medications
37. Order durable medical equipment (DME)
38. See urgent visits
39. Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
40. **At [“your reporting location” OR fill with address from Q6], are there any major activities that you are personally qualified to perform but must refer out to another provider to perform?** Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Provider Demographics |

1. **Are you of Hispanic, Latino/a, or Spanish origin?** **SELECT ALL THAT APPLY.**
2. No, not of Hispanic, Latino/a, or Spanish origin
3. Yes, Mexican, Mexican American, Chicano/a
4. Yes, Puerto Rican
5. Yes, Cuban
6. Yes, Another Hispanic, Latino/a, or Spanish origin
7. **What is your race? SELECT ALL THAT APPLY.**
8. White
9. Black or African American
10. American Indian or Alaska Native
11. Asian Indian
12. Chinese
13. Filipino
14. Japanese
15. Korean
16. Vietnamese
17. Other Asian
18. Native Hawaiian
19. Guamanian or Chamorro
20. Samoan
21. Other Pacific Islander
22. **Are you... SELECT ALL THAT APPLY.**
    1. Male
    2. Female
    3. Another sex or gender
23. **Who completed this survey? SELECT ALL THAT APPLY.**
24. The provider to whom the survey was addressed
25. Office staff
26. Other