Attachment E:

NAMCS Ambulatory Care Provider Interview (ACPI)

Advanced Practice Provider and their Proxies

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?**

* + Yes **(Skip to question 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?**

* Yes **(Skip to question 4)**
  + 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?**

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

**(Skip to question 36)**

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

|  |  |
| --- | --- |
| **Setting Name** |  |
| A) Private solo or group practice | |  |  | | --- | --- | |  | *If you see*  *patients* in  **any** *of these*  *settings (A-J),*  *Go to*  *question 5* | |
| B) Freestanding clinic or Urgent Care Center  (e.g., Concentra Urgent Care, Patient First, NextCare Urgent Care, FastMed Urgent Care) |
| C) Health Center (e.g., Federally Qualified Health Center [FQHC], federally funded clinics or “look-alike” clinics) |
| D) Mental health center |
| E) Government clinic that is not federally funded (e.g., state, county, city, maternal and child health, etc.) |
| F) Family planning clinic (including Planned Parenthood) |
| G) Integrated Delivery System, Health maintenance organization, health system or other prepaid practice (e.g., Kaiser Permanente) |
| H) Faculty practice plan (i.e., an organized group of physicians and other health care professionals that treats patients referred to an academic medical center) |
| I) Retail health clinic (e.g., CVS MinuteClinic, Walgreen’s Healthcare Clinics, Kroger’s Little Clinic) |
| J) Hospital outpatient department |
|  |  |
| K) Hospital emergency department | *If you select* ***only*** *K, L, M, N, O or P Skip to question 36* |
| L) Ambulatory surgery center/surgicenter |
| M) Industrial outpatient facility |
| N) Federal government clinics (e.g., Veterans Affairs, military only clinics) |
| O) Institutional facility |
| P) None of the above |

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

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

|  |
| --- |
| **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 provider 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)?**

* Solo **(Skip to question 10)**
  + Nonsolo

1. **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?** 
   * Multi
   * 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?** 
   * Full-owner **(skip to question 13)**
   * Part-owner
   * Employee
   * Contractor
   * Volunteer
3. **At [“your reporting location” OR fill with address from Q6], who owns the practice?** 
   * Physician/Physician group
   * 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)
   * Combination of physicians and advanced practice providers
   * Insurance company, health plan, or HMO
   * Health center
   * Academic medical center or teaching hospital
   * Other hospital
   * Other health care corporation
   * Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

1. **Which of the following types of payment does [“your reporting location” OR fill with address from Q6] accept? SELECT ALL THAT APPLY.**
   * Private insurance
   * Medicare
   * Medicaid
   * CHIP
   * Workers’ compensation
   * Self-pay
   * No charge
   * Other (e.g., car insurance, someone other than patient pays)
   * Don’t know
2. **At [“your reporting location” OR fill with address from Q6], are you, personally, currently accepting new patients?** 
   * Yes
   * No
   * 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.** 
   * Yes
   * No **(Skip to question 17)**
   * Don’t know **(Skip to question 17)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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.**
   * Videoconference software with audio (e.g., Zoom, Webex, FaceTime)
   * Audio without video conference software
   * Telemedicine platform NOT integrated with EHR (e.g., Doxy.me)
   * Telemedicine platform integrated with EHR (e.g., update clinical documentation during telemedicine visit)
   * Other tool(s) (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * I don’t use telemedicine for patient visits **(Skip to question 20)**

*Help text*

*If you selected Option 2 or Option 3 for Question 18 (indicating that you “don’t have an EHR system” or “don’t know if you have an EHR system”) and selected Option 3 and/or Option 4 for Question 20, your current response indicates the presence of an EHR system. Please check your responses to these questions.*

1. **At [“your reporting location” OR fill with address from Q6] in a typical week, how many of your own visits use telemedicine?** 
   * None
   * Some
   * Most
   * All
2. 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].
   * Very satisfied
   * Somewhat satisfied
   * Neither satisfied nor dissatisfied
   * Somewhat dissatisfied
   * Very dissatisfied
3. At [“your reporting location” OR fill with address from Q6], what, if any, issues affect your own use of telemedicine? SELECT ALL THAT APPLY.
   * Limited Internet access and/or speed issues
   * Telemedicine platform not easy to use\_
   * Telemedicine isn’t appropriate for my specialty/type of patients
   * Limitations in patients’ access to technology (e.g., smartphone, computer, tablet, Internet)
   * Patients’ difficulty using technology/telemedicine platform
   * Improved reimbursement and relaxation of rules related to use of telemedicine visits
   * Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * None of the above

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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?** 
   * Yes
   * No
   * Don’t know
2. **Does [“your reporting location” OR fill with address from Q6] set time aside for same day appointments?** 
   * Yes
   * No
   * Don’t know
3. **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.** 
   * Within 1 week
   * 1-2 weeks
   * 3-4 weeks
   * 1-2 months
   * 3 or more months
   * Do not provide routine medical exams
   * Don't know
4. **Are you** **comfortable providing care to a patient in another language? Please include American Sign Language (ASL).** 
   * Yes
   * No
5. **At [“your reporting location” OR fill with address from Q6], how many of your own patients have limited English proficiency?**

* None **(Skip to question 28)**
  + Some
  + Most
  + All
  + 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.** 
   * Wellness/Illness related education
   * Patient rights/Informed consent documents
   * Advanced directives
   * Payment
   * Care plan
   * Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * No translated materials are available to my patients
   * Don’t know
2. **What information does [“your reporting location” OR fill with address from Q6] record on patients’ culture and language characteristics? SELECT ALL THAT APPLY.**
   * Nationality/Nativity
   * Primary language
   * Sexual orientation
   * Gender identity
   * Race/Ethnicity
   * Religion
   * Income
   * Education
   * Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * We do not collect information related to patient characteristics.

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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?** 
   * 0-1 years
   * 2-4 years
   * 5-9 years
   * 10-20 years
   * 21 or more years
2. **How many years have you worked clinically as a PA?** 
   * 0-1 years
   * 2-4 years
   * 5-9 years
   * 10-20 years
   * 21 or more years
3. **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?** 
   * Yes
   * No
   * Don’t know
4. **At [“your reporting location” OR fill with address from Q6], do you have your own panel of patients?** 
   * Yes, entirely
   * Yes, but I also see patients from the practice
   * No
   * Don’t know
5. **At [“your reporting location” OR fill with address from Q6], how are claims submitted most of the time?** 
   * My NPI
   * A physician’s NPI
   * Sometimes my own NPI and sometimes a physician’s NPI
   * I don’t bill for my medical services
   * Don’t know
6. **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.**

* Admissions (i.e., conduct admission history and physical, write admission orders)
  + Develop treatment plans
  + Perform minor surgical procedures
  + Perform non-surgical procedures
  + Order referrals and consults
  + Order and interpret diagnostic testing and therapeutic modalities
  + Perform new patient encounters
  + Perform post-op patient encounters
  + Perform post-op global visits
  + Perform pre-op history and physicals (H&Ps)
  + See consults
  + Prescribe non-schedule medications
  + Prescribe schedule (II-V) medications
  + Order durable medical equipment (DME)
  + See urgent visits
  + Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + None of the above

1. **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?** Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Provider Demographics |

1. **Are you of Hispanic, Latino/a, or Spanish origin?** **SELECT ALL THAT APPLY.**
   * No, not of Hispanic, Latino/a, or Spanish origin
   * Yes, Mexican, Mexican American, Chicano/a
   * Yes, Puerto Rican
   * Yes, Cuban
   * Yes, Another Hispanic, Latino/a, or Spanish origin
2. **What is your race? SELECT ALL THAT APPLY.**

* American Indian or Alaska Native
* Asian
* Black or African American
* Hispanic or Latino
* Middle Eastern or North African
* Native Hawaiian or Pacific Islander
* White

1. **Are you... SELECT ALL THAT APPLY.**
   * Male
   * Female
   * Transgender, non-binary, or another gender
2. **Who completed this survey? SELECT ALL THAT APPLY.**
   * The provider to whom the survey was addressed
   * Office staff
   * Other