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.**

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

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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 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.

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*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