Attachment D:

NAMCS Ambulatory Care Provider Interview (ACPI)

Providers and their Proxies

Form Approved:

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

* + Yes
  + No **(Go to question 1a)**

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

|  |  |
| --- | --- |
| **PA Specialties** | **Provider 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 39)**

**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 39* |
| 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

1. **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

1. **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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **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.**

* Private insurance
* Medicare
* Medicaid
* CHIP
* Workers’ compensation
* Self-pay
* No charge
* Other (e.g., car insurance, someone other than patient pays)
* Don’t know

1. **At [“your reporting location” OR fill with address from Q6], are you, personally, currently accepting new patients?**

* Yes
* No
* Don’t know

|  |
| --- |
| 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 18)**
* Don’t know **(Skip to question 18)**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 21)**

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

1. 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

1. 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

|  |
| --- |
| **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

1. **Does [“your reporting location” OR fill with address from Q6] set time aside for same day appointments?**

* Yes
* No
* Don’t know

1. **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

1. **Are you** **comfortable providing care to a patient in another language? Please include American Sign Language (ASL).**

* Yes
* No

1. **At [“your reporting location” OR fill with address from Q6], how many of your own patients have limited English proficiency?**

* None **(Skip to question 29)**
* 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

1. **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.

**(Continue to question 30)**

|  |
| --- |
| **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?**

* Yes, I currently treat patients for chronic pain only.
* Yes, I currently treat patients for both chronic and acute pain.
* Yes, I currently treat patients for acute pain only.
* No **(Skip to question 37)**
* Don’t know **(Skip to question 37)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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.**

* Acetaminophen
* Anticonvulsants
* Antidepressants
* Benzodiazepines
* Non-steroidal anti-inflammatory (NSAIDS)
* Other non-opioid drugs
* None of the above
* Don’t know

1. **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?**

* None **(Skip to question 37)**
* A few
* Some
* Almost all
* All
* 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?**

* Within 1 week
* Within 4 weeks
* Within 3 months
* Within 1 year
* I don’t re-evaluate patients after starting opioid therapy
* 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?**

* None
* A few
* Some
* Almost all
* All
* Don’t know

1. **Does [“your reporting location” OR fill with address from Q6] have an opioid treatment program where patients could be referred for opioid use disorder?**

* Yes
* No
* Don’t know

|  |
| --- |
| 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

1. **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