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1. Physician's address:

FORM **NAMCS-1A**
(9-27-2012)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

**NATIONAL AMBULATORY
MEDICAL CARE SURVEY
2012 PANEL**

2. Physician's telephone and FAX numbers (Area code and number)

| Office 1 | Telephone | Office 2 | Telephone |
|-------------|-----------|-------------|-----------|
| | FAX | | FAX |
| | | | |

3. Progress Record

| Activity | Date Completed | FR Code | Notes |
|--------------------------------|----------------|---------|-------|
| Telephone Screener | | | |
| Induction Interview | | | |
| Patient Record Forms Completed | | | |
| Final Disposition and Summary | | | |

Section I - TELEPHONE SCREENER

4. Record of telephone calls

| Call | Date | Time | Results |
|------|------|------|---------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |

INSTRUCTION

If interview is with a CHC provider, start with Section II on page 5, but remember to complete the office hours on page 4.

5. Introduction

The Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) is conducting the National Ambulatory Medical Care Survey (NAMCS). This annual study, which has been in the field since 1973, collects information about the large portion of ambulatory care provided by physicians and mid-level providers throughout the United States. Research utilizing the NAMCS helps to inform physicians, health care researchers, and policy makers about the changing characteristics of ambulatory health care in this country. The information that will be requested includes data about the patient visit (e.g., demographics, diagnoses, services, and treatments), physician practice characteristics (e.g., practice type), and the use of electronic medical records.

Many organizations and leaders in the health care community, including those providing the enclosed letter of endorsement, have expressed their support and join me in urging your participation in this meaningful study. You will be asked to complete a short electronic questionnaire on a sample of about 30 patient encounters during a randomly assigned one-week reporting period. Additionally, there is a short interview (approximately 35 minutes) with you about the nature of your practice. You may be asked to complete a short paper supplement, which would take about an additional 20 minutes. We intend to conduct additional health care research by linking your National Provider Identifier (NPI) collected in this study to health care-related data such as Medicare records. Participation is voluntary, and you or your staff may refuse to answer any question or may stop participating at any time without penalty or loss of benefits.

The following are some key points about the survey:

- Data collection for the NAMCS is authorized by Section 306 of the Public Health Service Act (Title 42, U.S. Code, 242k).
- All information collected will be held in the strictest confidence according to Section 308(d) of the Public Health Service Act (42, U.S. Code, 242m(d)) and the Confidential Information Protection and Statistical Efficiency Act (Title 5 of PL 107-347). This information will be used for statistical purposes only. No patient names, social security numbers, or addresses are collected.
- This study conforms to the Privacy Rule as mandated by HIPAA, because disclosure of patient data is permitted for public health purposes, the NCHS Research Ethics Review Board has approved NAMCS.
- U.S. Census Bureau employees, who administer the study, have taken an oath to abide by Title 13, U.S. Code, Section 9, which requires them to keep all information about your practice and patients confidential.

A representative of the Census Bureau, acting as our agent, will be calling you to schedule an appointment regarding the details of your participation. If you have any questions regarding your participation, please call a NAMCS representative at 1-800-392-2862. Additional information on the survey may be obtained by visiting the NAMCS participant Web site at www.cdc.gov/namcs/ahcd/namcs_participant.htm.

You may have questions about your rights as a participant in the research study. If so, please call the Research Ethics Review Board at the National Center for Health Statics, toll-free at 1-800-223-8118. Please leave a brief message with your name and phone number. Say that you are calling about Protocol #2010-02. Your call will be returned as soon as possible.

We greatly appreciate your cooperation.

Sincerely,

Edward J. Sondik, PH. D.,
Director

Section I – TELEPHONE SCREENER – Continued

Disclaimer – The following questionnaire is based on a computer-based questionnaire. Thus, the following questions contain the same content of the computer-based questionnaire, though the flow of the paper-questionnaire questions does not necessarily represent the flow of the computer-based questionnaire due to the limitations of a paper questionnaire.

6. Specialty

a. Your specialty is ,
is that right?

- 1 Yes – *SKIP to item 6c*
2 No

Edit

b. What is your specialty (including general practice)?

(Name of specialty)

Code

Refer to the NAMCS-21, pages 3 and 4 for codes.

Edit

c. What is your ethnicity?

- 1 Hispanic or Latino
2 Not Hispanic or Latino

d. What is your race?
Enter (X) one or more.

- 1 White
2 Black/African-American
3 Asian
4 Native Hawaiian/Other Pacific Islander
5 American Indian/Alaska Native

7. Which of the following categories best describes your professional activity – patient care, research, teaching, administration, or something else?

- 1 Patient care
2 Research
3 Teaching
4 Administration
5 Something else – *Specify* ↴

8a. Do you directly care for any ambulatory patients in your work?

- 1 Yes – *SKIP to item 8c*
2 No – does not give direct care [8b PROBE]
3 No longer in practice – *SKIP to item 10 on page 4*

b. PROBE: We include as ambulatory patients, any patients coming to see you for personal health services who are not currently on the premises. Does your work include any such individuals?

- 1 Yes, cares for ambulatory patients
2 No, does not give direct care –*Determine reason, then read item 10 on page 4*

c. Do you work as an employee or a contractor in a federally operated patient care setting or in a hospital emergency or outpatient department?

- 1 Yes
2 No – *SKIP to item 9a on page 4*

d. In addition to working in a federally operated patient care setting, hospital emergency or outpatient department, do you also see any ambulatory patients in another setting?

- 1 Yes
2 No – *SKIP to item 10 on page 4*

If "Yes" to item 8d, all of the following questions are concerned with the private patients.

Section I TELEPHONE SCREENER Continued

9a. We have your address as *(Read address shown in item 1).* **Is that the correct address for your office?**

- 1 Yes – *SKIP to item 12*
 2 No, incorrect address – *Ask item 9b*

b. What is the (correct) address and telephone number of your office?

| | |
|----------------------------------|----------|
| Number and street | |
| City | |
| State | ZIP Code |
| | |
| Telephone (Area code and number) | |

}

SKIP to item 12

10. Has the physician moved out of the United States?

- 1 Yes – *SKIP to CHECK ITEM A on page 7*
 2 No

11. Is the physician retired or deceased?

- 1 Yes – *SKIP to CHECK ITEM A on page 7*
 2 No

12. Thank you, Dr. . . . , but I believe that since you do not (see any ambulatory patients/practice any longer), our questions would not be appropriate for you. I appreciate your time and interest. *(Go to Check Item A on page 7.)*

PROVIDER'S OFFICE SCHEDULE

INSTRUCTION Please complete the office schedule for the week the provider is in sample.

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|------------|--------|---------|-----------|----------|--------|----------|--------|
| A.M. | | | | | | | |
| P.M. | | | | | | | |
| Office No. | | | | | | | |

NOTES

Section II INDUCTION INTERVIEW

Before we begin, I would like to give you a little background about this study.

Systematic information about the characteristics and problems of the people who consult providers in their offices is essential for medical researchers, educators, and others who are concerned with medical education, manpower needs, and the changing nature of health care delivery.

In response to the demand for this information, the Centers for Disease Control and Prevention, in close consultation with representatives of the medical profession, developed the National Ambulatory Medical Care Survey.

Your part in the study is very simple, carefully designed, and should not take much of your time. It consists of your participation during a specified 7-day period. During that time, you would supply a minimal amount of information about patients you see.

Now, before we get to the actual procedures, I have some questions to ask you about your practice. The answers you give will be used only for classification and analysis. Of course, ALL information you provide for this study will be held in strict confidence.

13a. Overall, at how many office locations do you see ambulatory patients? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.

Number of locations ↴

b. In a typical year, about how many weeks do you NOT see any ambulatory patients (e.g., conferences, vacations, etc.)?

Number of weeks ↴

If > 26 weeks ask item 13c.
If = 0, SKIP to item 13d.
If 1 to 26 weeks,
SKIP to item 14a.

c. You typically see patients fewer than half the weeks in each year. Is that correct?

- 1 Yes – SKIP to item 14a
2 No – Please explain ↴

} SKIP to item 14a

d. You typically see patients all 52 weeks of the year. Is that correct?

- 1 Yes
2 No – Please explain ↴

14a. This study will be concerned with the AMBULATORY patients you will see in your office(s) during the week of Monday,

through Sunday, .

Are you likely to see any ambulatory patients in your office(s) during that week?

(For allergists, family practitioners, etc. – if routine care such as allergy shots, blood pressure checks, and so forth will be provided by staff in physician's absence, enter "Yes.")

- 1 Yes –SKIP to item 15a on page 6
2 No

b. Why is that? Record verbatim.

(If appropriate, read item 14c below. Otherwise, SKIP to item 16a on page 7.)

c. Since it's very important that we include any ambulatory patients that you might see in your office during that week, I'll check back with your office just before (Starting date) to make sure your plans have not changed.

PLEASE READ BEFORE CONTINUING

Instruction – Even though the physician/provider is not available during the reporting week, continue with item 15a on page 6.

Section II INDUCTION INTERVIEW – Continued

15a. At what office location(s) will you see ambulatory patients during your practice's 7-day reporting period Monday, [] through Sunday, [] ?

Probe – Are there any other office locations at which you will see ambulatory patients during that 7-day reporting period?

Note – Non-Participating Physicians: If refusal record location where ambulatory patients are normally seen.

(2) What is the street address?

(3) In what city is this office located?

(4) In what state is this office?

(5) What is the Zip code for this office?

15b. Looking at FLASHCARD B below, choose ALL of the type(s) of settings that describe each location where you work. For each location enter all setting types that apply. For each location, also enter the appropriate "scope" status. If any even numbered settings are entered, then enter location as out-of-scope.

If FLASHCARD number 3 (free-standing clinic/urgicenter) is entered, ask –

Is this/that clinic in an institutional setting (#8), in an industrial outpatient facility (#10), or operated by the Federal Government (#12)? (If yes – Enter out-of-scope.)

1 Yes 2 No

If FLASHCARD number 11 (family planning clinic) is entered, ask –

Is this/that clinic operated by the Federal Government (If yes – Enter out-of-scope.)

1 Yes 2 No

If in doubt about any clinic/facility/institution, PROBE –

(1) Is this/that (clinic/facility/institution) part of a hospital emergency department or an outpatient department (#2, #4)? (If yes – Enter out-of-scope)

1 Yes 2 No

(2) Is this/that (clinic/facility/institution) operated by the Federal Government (#12)? If yes – Enter out-of-scope)

1 Yes 2 No

Edit

FLASHCARD B

- | | |
|---|---|
| (1) Private solo or group practice | (2) Hospital emergency department |
| (3) Freestanding clinic/urgicenter (not part of a hospital outpatient department) | (4) Hospital outpatient department |
| (5) Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or 'look alike' clinics) | (6) Ambulatory surgicenter |
| (7) Mental health center | (8) Institutional setting (school infirmary, nursing home, prison) |
| (9) Non-federal Government clinic (e.g., state, county, city, maternal and child health, etc.) | (10) Industrial outpatient facility |
| (11) Family planning clinic (including Planned Parenthood) | (12) Federal Government operated clinic (e.g., VA, military, etc.) |
| (13) Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente) | (14) Laser vision surgery |
| (15) Faculty practice plan | |

| Office No. | Office locations (Enter street address) | Circle FLASHCARD number | Mark (X) | |
|------------|--|-------------------------------------|----------------------------|----------------------------|
| | | | In-scope | Out-of-scope |
| 1 | | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 2 | | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 3 | | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 4 | | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

15c. Are there other office locations where you NORMALLY would see patients, even though you will not see any during your 7-day reporting period? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.

1 Yes – SKIP to item 15d
2 No – SKIP to Check Item A on page 7

d. Of these locations where you will not be seeing patients during your 7-day reporting period, how many total office visits did you have during your last week of practice at these locations?

Number of visits

Section II INDUCTION INTERVIEW – Continued

CHECK ITEM A

- 1 All locations listed in 15a are out-of-scope – Read CLOSING STATEMENT below
- 2 All/Some locations listed in 15a are in-scope – Go to item 16a

CLOSING STATEMENT

Thank you, Dr. . . . , your practice is not within the scope of this study. We appreciate your time and interest. (Terminate interview and complete Sections III and IV on pages 20–22.)

Ask item 16a ONCE to obtain total for ALL in-scope locations.

16a. During the week of Monday, [] through Sunday, [] how many days do you expect to see any ambulatory patients? (Only include days at in-scope locations.)

NOTE – NON-PARTICIPATING PHYSICIANS: If refusal (Final=3) or unavailable (Final=4), enter the number of days in a normal week.

Estimated Number of Days →

Enter street name or town of in-scope location(s).

NOTE: Keep the location numbers the same as the office numbers in item 15a.

| | | | | Office location No. | | | |
|---|---|---|---|---------------------|----|----|----|
| | | | | #1 | #2 | #3 | #4 |
| <input style="width: 50px; height: 20px;" type="text"/> | <input style="width: 50px; height: 20px;" type="text"/> | <input style="width: 50px; height: 20px;" type="text"/> | <input style="width: 50px; height: 20px;" type="text"/> | | | | |

b. During your last normal week of practice, approximately how many office visit encounters did you have at each office location?

NOTE: If physician is in group practice, only include the visits to sampled physician.

| | | | | |
|------------------|---|---|---|---|
| Number of visits | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> |
|------------------|---|---|---|---|

c. During the week of Monday, [] through Sunday [], do you expect to have about the same number of visits as you saw during your last normal week in each office taking into account time off, holidays, and conferences?

NOTE: Enter (X) response. If answer is "Yes", transcribe the number in 16b to 16d for that office location. If answer is "No" then ASK item 16d for that office location.

| | | | | |
|-----------|----------------------------|----------------------------|----------------------------|----------------------------|
| Yes . . . | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| No . . . | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |

d. Approximately how many ambulatory visits do you expect to have at this office location?

| | | | | |
|------------------|---|---|---|---|
| Number of visits | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> |
|------------------|---|---|---|---|

e. Tally of estimated number of visits

NOTE: To obtain the total number of estimated visits, add the estimate for each office location in 16d.

Number of visits →

Answer 17a–21a for the in-scope location/practice with the most visits.

Now, I'm going to ask about your practice at (in-scope location).

17a. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way (at this/that in-scope location)?

| Office Location | #1 | #2 | #3 | #4 |
|-----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Solo 1 | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| If Solo, SKIP to item 17d. | | | | |
| Nonsolo 2 | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |

b. How many physicians are associated with you (at this/that in-scope location)?

How many →

c. Is this a single- or multi-specialty (group) practice (at this/that in-scope location)?

| | | | | |
|------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Multi | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| Single | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Section II INDUCTION INTERVIEW - Continued

| Office Location | #1 | #2 | #3 | #4 |
|--|--|--|--|--|
| 17d. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with you (at this/that in-scope location)? | How many → <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| e. Are you a full- or part-owner, employee, or an independent contractor (at this/that in-scope location)? If "Owner" is marked then automatically mark "Physician or physician group" in item 17f. | Owner 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| | Employee 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| | Contractor 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| f. Give FLASHCARD A (p.15 Flashcard Booklet) and ask: Who owns the practice (at this/that in-scope location)? | Physician or physician group 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| | HMO 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| | Community Health Center 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| | Medical/ Academic health center 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| | Other hospital 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| | Other health care corp 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| | Other 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> |
| g. Does your practice have the ability to perform any of the following on site (at this/that in-scope location)? | | | | |
| 1. EKG/ECG | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| 2. Lab testing | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| 3. Spirometry | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| 4. Ultrasound | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| 5. X-Ray | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| h. Do you see patients in the office during the evening or on weekends? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK |
| i. What is your National Provider Identifier (NPI) at each office location? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Notes

Section II INDUCTION INTERVIEW – Continued

18a. During your last normal week of practice, how many hours of direct patient care did you provide?

NOTE – Direct patient care includes: Seeing patients, reviewing tests, preparing for and performing surgery/procedures, providing other related patient care services.

Number of weekly hours

b. During your last normal week of practice, about how many encounters of the following type did you make with patients:

- (1) Nursing home visits
- (2) Other home visits
- (3) Hospital visits
- (4) Telephone consults
- (5) Internet/e-mail consults

Number of encounters per week ↘

Answer ALL remaining questions for the in-scope location/practice with the most visits.

19a. Does your practice submit any claims electronically (electronic billing)?

- 1 Yes
- 2 No
- 3 Unknown

b. Do you or your staff verify an individual patient's insurance eligibility electronically?

- 1 Yes – Go to 19c
- 2 No
- 3 Unknown } SKIP to 20a

c. How do you or your staff electronically verify an individual patient's insurance eligibility? Is it through an EHR/EMR system, a stand-alone practice management system, or some other electronic system?

- 1 Stand-alone practice management system
- 2 EHR/EMR system
- 3 Another electronic system
- 4 Unknown

d. When you electronically verify a patient's insurance eligibility, do you usually get results back before the patient leaves the office?

- 1 Yes
- 2 No
- 3 Unknown

20a. Does your practice use an electronic health record (EHR) or electronic medical record (EMR) system? Do not include billing record systems.

- 1 Yes, all electronic } Go to Question 20b
- 2 Yes, part paper and part electronic }
- 3 No } SKIP to Question 21a on page 10
- 4 Unknown }

b. In which year did your practice install your EHR/EMR system?

 Year

c. What is the name of your practice's current EHR/EMR system?

Enter (X) only one box.

- 1 Allscripts
- 2 Cerner
- 3 eClinicalWorks
- 4 Epic
- 5 GE/Centricity
- 6 Greenway Medical
- 7 McKesson/Practice Partner
- 8 NextGen
- 9 Sage/Vitera
- 10 Other ↘
- 11 Unknown

d. At your practice, are there plans for installing a new EHR/EMR system within the next 18 months?

- 1 Yes
- 2 No
- 3 Maybe
- 4 Unknown

Section II INDUCTION INTERVIEW – Continued

21a. Medicare and Medicaid offer incentives to practices that demonstrate "meaningful use of health IT." At your practice, are there plans to apply for these incentive payments?

- 1 Yes, we already applied – *Go to 21b*
- 2 Yes, we intend to apply – *Go to 21c*
- 3 Uncertain if we will apply
- 4 No, we will not apply

b. When did you first apply?

- 1 2011
- 2 2012
- 3 Unknown

c. When do you intend to first apply?

- 1 2012
- 2 2013 or later
- 3 Unknown

Notes

Notes section with multiple horizontal lines for text entry. A large watermark is overlaid diagonally across the page: "INFORMATIONAL COPY Not to be used as a data collection tool".

Section II INDUCTION INTERVIEW – Continued

22. Give FLASHCARD C-1 (p.17 Flashcard booklet) and ask:
Please indicate whether your practice has each of the following computerized capabilities and how often these capabilities are used.
 Enter (X) only one per row.

| Yes, used routinely | Yes, but NOT used routinely | Yes, but turned off or not used | No | Unknown |
|---------------------|-----------------------------|---------------------------------|----|---------|
|---------------------|-----------------------------|---------------------------------|----|---------|

a. Recording patient history and demographic information?

| | | | | |
|--|--|---|---|---|
| 1 <input type="checkbox"/> Go to 22a(1) | 2 <input type="checkbox"/> Go to 22a(1) | 3 <input type="checkbox"/> Skip to 22b | 4 <input type="checkbox"/> Skip to 22b | 5 <input type="checkbox"/> Skip to 22b |
|--|--|---|---|---|

If Yes, ask – (1) Does this include a patient problem list?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

b. Recording and charting vital signs?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

c. Recording patient smoking status?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

d. Recording clinical notes?

| | | | | |
|--|--|---|---|---|
| 1 <input type="checkbox"/> Go to 22d(1) | 2 <input type="checkbox"/> Go to 22d(1) | 3 <input type="checkbox"/> Skip to 22e | 4 <input type="checkbox"/> Skip to 22e | 5 <input type="checkbox"/> Skip to 22e |
|--|--|---|---|---|

If Yes, ask – (1) Do the notes include a list of the patient's medications and allergies?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

e. Ordering prescriptions?

| | | | | |
|--|--|---|---|---|
| 1 <input type="checkbox"/> Go to 22e(1) | 2 <input type="checkbox"/> Go to 22e(1) | 3 <input type="checkbox"/> Skip to 22f | 4 <input type="checkbox"/> Skip to 22f | 5 <input type="checkbox"/> Skip to 22f |
|--|--|---|---|---|

If Yes, ask – (1) Are prescriptions sent electronically to the pharmacy?

| | | | | |
|--|--|--|--|--|
| 1 <input type="checkbox"/> Go to 22e(2) | 2 <input type="checkbox"/> Go to 22e(2) | 3 <input type="checkbox"/> Go to 22e(2) | 4 <input type="checkbox"/> Skip to 22e(3) | 5 <input type="checkbox"/> Skip to 22e(3) |
|--|--|--|--|--|

If Yes, ask – (2) When orders for prescriptions are submitted electronically, are they submitted by the prescribing practitioner, or by someone else? Enter all that apply.

| | | |
|---|---|------------------------------------|
| 1 <input type="checkbox"/> Prescribing practitioner | 2 <input type="checkbox"/> Someone else | 3 <input type="checkbox"/> Unknown |
|---|---|------------------------------------|

If Yes, ask – (3) Are warnings of drug interactions or contraindications provided?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

f. Providing reminders for guideline-based interventions or screening tests?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

g. Providing standard order sets related to a particular condition or procedure?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

h. Ordering lab tests?

| | | | | |
|--|--|---|---|---|
| 1 <input type="checkbox"/> Go to 22h(1) | 2 <input type="checkbox"/> Go to 22h(1) | 3 <input type="checkbox"/> Skip to 22i | 4 <input type="checkbox"/> Skip to 22i | 5 <input type="checkbox"/> Skip to 22i |
|--|--|---|---|---|

If Yes, ask – (1) Are orders sent electronically?

| | | | | |
|--|--|--|---|---|
| 1 <input type="checkbox"/> Go to 22h(2) | 2 <input type="checkbox"/> Go to 22h(2) | 3 <input type="checkbox"/> Go to 22h(2) | 4 <input type="checkbox"/> Skip to 22i | 5 <input type="checkbox"/> Skip to 22i |
|--|--|--|---|---|

If Yes, ask – (2) When orders for lab tests are submitted electronically, are they submitted by the prescribing practitioner, or by someone else? Enter all that apply.

| | | |
|---|---|------------------------------------|
| 1 <input type="checkbox"/> Prescribing practitioner | 2 <input type="checkbox"/> Someone else | 3 <input type="checkbox"/> Unknown |
|---|---|------------------------------------|

i. Viewing lab results?

| | | | | |
|--|--|---|---|---|
| 1 <input type="checkbox"/> Go to 22i(1) | 2 <input type="checkbox"/> Go to 22i(1) | 3 <input type="checkbox"/> Skip to 22j | 4 <input type="checkbox"/> Skip to 22j | 5 <input type="checkbox"/> Skip to 22j |
|--|--|---|---|---|

If Yes, ask – (1) Can the EHR/EMR automatically graph a specific patient's lab results over time?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

j. Viewing imaging results?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

k. Viewing data on quality of care measures?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

l. Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

Section II INDUCTION INTERVIEW – Continued

22. Please indicate whether your practice has each of the following computerized capabilities and how often these capabilities are used.
Enter (X) only one per row.

| Yes, used routinely | Yes, but NOT used routinely | Yes, but turned off or not used | No | Unknown |
|---------------------|-----------------------------|---------------------------------|----|---------|
|---------------------|-----------------------------|---------------------------------|----|---------|

m. Generating lists of patients with particular health conditions?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

n. Electronic reporting to immunization registries?

| | | | | |
|---|---|--|--|--|
| 1 <input type="checkbox"/> <i>Go to 22n(1)</i> | 2 <input type="checkbox"/> <i>Go to 22n(1)</i> | 3 <input type="checkbox"/> <i>Skip to 22o</i> | 4 <input type="checkbox"/> <i>Skip to 22o</i> | 5 <input type="checkbox"/> <i>Skip to 22o</i> |
|---|---|--|--|--|

If Yes, ask – (1) Is the electronic reporting to immunization registries reported in standards specified by Meaningful Use criteria?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

o. Providing patients with clinical summaries for each visit?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

p. Exchanging secure messages with patients? ...

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

q. Providing patients with an electronic copy of their health information?

| | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

23a. Do you share any patient health information electronically, (not fax) with other providers, including hospitals, ambulatory providers, or electronically (not fax) labs?

| | |
|--------------------------------|-------------------------------|
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
|--------------------------------|-------------------------------|

b. How do you electronically share patient health information?

| | | |
|------------------------------------|---|---|
| 1 <input type="checkbox"/> EHR/EMR | 2 <input type="checkbox"/> Web portal (separate from EHR/EMR) | 3 <input type="checkbox"/> Other electronic method – <i>Specify</i> ↴ |
| | | |

24. Give FLASHCARD C-2 (p.18 Flashcard Booklet) and ask: Please indicate which types of health data you share electronically (not fax) with the health care providers listed. Enter all that apply.

| Hospitals with which you are affiliated | Ambulatory providers inside your office/group | Hospitals with which you are not affiliated | Ambulatory providers outside your office/group |
|---|---|---|--|
|---|---|---|--|

a. Lab results?

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|

b. Imaging reports?

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|

c. Patient problem lists

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|

d. Medication lists

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|

e. Medication Allergy lists

| | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
|----------------------------|----------------------------|----------------------------|----------------------------|

f. Do you share any of the previously mentioned types of information using a "Summary Care Record"? [A Summary Care Record is an electronic file that contains the previously mentioned health data in a standardized format.]

| | | |
|--------------------------------|-------------------------------|------------------------------------|
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Unknown |
|--------------------------------|-------------------------------|------------------------------------|

Notes

Section II INDUCTION INTERVIEW – Continued

| | Yes, routinely | Yes, but NOT routinely | No | Does not apply |
|--|--|--|---|---|
| 25a. When you refer your patient to a provider outside of your office or group, do you receive a report back from the other provider with results of the consultation? | 1 <input type="checkbox"/> Go to 25b | 2 <input type="checkbox"/> Go to 25b | 3 <input type="checkbox"/> Skip to 25c | 4 <input type="checkbox"/> Skip to 25c |
| b. Do you receive it electronically (not fax)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. When you see a patient referred to you by a provider outside of your office or group, do you receive notification of both the patient's history and reason for consultation? | 1 <input type="checkbox"/> Go to 25d | 2 <input checked="" type="checkbox"/> Go to 25d | 3 <input type="checkbox"/> Skip to 26 | 4 <input type="checkbox"/> Skip to 26 |
| d. Do you receive them electronically? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 26. When your patient is discharged from an inpatient setting, do you receive all of the information you need to continue managing the patient? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| a. Is the information timely, available when needed? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b. Do you receive it electronically (not fax)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Give FLASHCARD D (p. 19 Flashcard Booklet) and ask: The following questions are about your practice revenue and contracts with managed care plans. | | | | |
| 27. Roughly, what percent of your patient care revenue comes from – | Percent of patient care revenue ↴ | | | |
| (1) Medicare? | <input type="text"/> % | | | |
| (2) Medicaid? | <input type="text"/> % | | | |
| (3) Private insurance? | <input type="text"/> % | | | |
| (4) Patient payments? | <input type="text"/> % | | | |
| (5) Other? – (including charity, research, Tricare, VA, etc.) | <input type="text"/> % | | | |
| FR NOTE – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value. | | | | |
| 28. Roughly, what percentage of the patient care revenue received by this practice comes from managed care contracts? | Percent of revenue from managed care ↴ <input type="text"/> % | | | |

Edit

Section II INDUCTION INTERVIEW – Continued

29. Give FLASHCARD E (p.20 Flashcard Booklet) and ask:
Roughly, what percent of your patient care revenue comes from each of the following methods of payment?

(a) Fee-for-service?

(b) Capitation?

(c) Case rates (e.g., package pricing/episode of care)?

(d) Other?

Percent of patient care revenue ↘

| | |
|--|---|
| | % |
| | % |
| | % |
| | % |

FR NOTE – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value.

30a. Are you currently accepting "new" patients into your practice(s) (at in-scope locations)?

- 1 Yes – Go to 30b
 2 No
 3 Don't know } **SKIP to item 31**

b. From those "new" patients, which of the following types of payment do you accept (at in-scope locations)?

- (1) Capitated private insurance?
- (2) Non-capitated private insurance?
- (3) Medicare?
- (4) Medicaid?
- (5) Workers compensation?
- (6) Self-pay?
- (7) No charge?

- | | | |
|--------------------------------|-------------------------------|---------------------------------------|
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |

31. Which of the following methods best describes your basic compensation?

- 1 Fixed salary
 2 Share of practice billings or workload
 3 Mix of salary and share of billings or other measures of performance (e.g., your own billings, practice's financial performance, quality measures, practice profiling)
 4 Shift, hourly or other time-based payment
 5 Other

32. Clinical practices may take various factors into account in determining the compensation (salary, bonus, pay rate, etc.) paid to the physicians in the practice. Please indicate whether the practice explicitly considers each of the following factors in determining your compensation.

Enter all that apply.

- 1 Factors that reflect your own productivity
 2 Results of satisfaction surveys from your own patients
 3 Specific measures of quality, such as rates of preventive services for your patients
 4 Results of practice profiling, that is, comparing your pattern of using medical resources with that of other physicians
 5 The overall financial performance of the practice

33a. Roughly, what percent of your daily visits are same day appointments?

 %

b. Does your practice set time aside for same day appointments?

- 1 Yes
 2 No
 3 Don't know

c. On average, about how long does it take to get an appointment for a routine medical exam?

- | | |
|--|---|
| 1 <input type="checkbox"/> Within 1 week | 5 <input type="checkbox"/> 3 or more months |
| 2 <input type="checkbox"/> 1–2 weeks | 6 <input type="checkbox"/> Do not provide routine medical exams |
| 3 <input type="checkbox"/> 3–4 weeks | 7 <input type="checkbox"/> Don't know |
| 4 <input type="checkbox"/> 1–2 months | |

Section II INDUCTION INTERVIEW – Continued

34. Do you see any patients for whom you provide asthma diagnosis, education and/or ongoing clinical management?

- 1 Yes – If yes, asthma supplement will be left with the respondent.
 2 No

Note – Respondents are to answer all items (1 – 9); even if answering "No" for one item, one must still complete the remaining items

35. Give FLASHCARD H (p. 23 Flashcard Booklet) and Ask: The following questions are about complementary and alternative medicine, or "CAM," and how you may utilize it in your medical practice. Some CAM therapies are now commonly used, and you may think of them as mainstream.

a. During the past 12 months, did you recommend any of the following therapies or practices to patients? Please select "Yes" or "No" for each.

1. Herbs and other non-vitamin supplements
2. Mind-body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]
3. Chiropractic or osteopathic manipulation
4. Acupuncture
5. Naturopathic treatment
6. Massage therapy
7. Homeopathic treatment
8. Biofeedback or hypnosis
9. Yoga

| Yes <i>Go to 35b for that item</i> | No <i>Skip to 35f for that item</i> |
|--|---|
| 1 <input type="checkbox"/> | 2 <input checked="" type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input checked="" type="checkbox"/> |
| 1 <input checked="" type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input checked="" type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Note – The following CAM questions are only asked of the first four therapies/practices. Respondents are to answer all items (1 – 4); even if answering "Never," "Don't know," or "Refusal" for one item, one must still complete the remaining items

b. During the past 12 months, how often did each of the following therapies arise in conversation between you and your patients? Would you say –

1. Herbs and other non-vitamin supplements
2. Mind-body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]
3. Chiropractic or osteopathic manipulation
4. Acupuncture

| Rarely <i>Go to 35c for that item</i> | Sometimes <i>Go to 35c for that item</i> | Often <i>Go to 35c for that item</i> | Never <i>Skip to 35d for that item</i> | Don't know <i>Skip to 35d for that item</i> | Refusal <i>Skip to 35d for that item</i> |
|---|--|--|--|---|--|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |

Notes

Section II INDUCTION INTERVIEW – Continued

35c. Thinking back to these conversations, who brought up the topic of the following therapies most often?

1. Herbs and other non-vitamin supplements
2. Mind-body therapies [Such as guided imagery, meditation, and progressive muscle relaxation (does not include prayer)]
3. Chiropractic or osteopathic manipulation
4. Acupuncture

| | Patients | Physician | About equal |
|---|----------------------------|---------------------------------------|----------------------------|
| 1 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 2 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 3 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 4 | 1 <input type="checkbox"/> | 2 <input checked="" type="checkbox"/> | 3 <input type="checkbox"/> |

d. Did you recommend (Therapy) to patients for any of the following reasons? Please select "Yes" or "No" for each.

1. For physical symptoms, such as pain
2. For emotional symptoms, such as stress or anxiety
3. For general health maintenance and wellbeing
4. Because the patient asked for it
5. OTHER reasons

| | Yes | No |
|---|---------------------------------------|---------------------------------------|
| 1 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 2 | 1 <input checked="" type="checkbox"/> | 2 <input checked="" type="checkbox"/> |
| 3 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 4 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 5 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

e. Which of the following factors influenced your decision to recommend (Therapy) to patients? Please select "Yes" or "No" for each.

1. Personal experience
2. Patient reports
3. Colleague recommendation
4. Evidence in peer-reviewed literature
5. OTHER reasons

| | Yes | No |
|---|----------------------------|----------------------------|
| 1 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 2 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 3 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 4 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 5 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

f. Which of the following factors prevented you from recommending (Therapy) to patients? Please select "Yes" or "No" for each.

1. Limited health insurance coverage
2. Lack of affordability for the patient
3. Lack of information sources
4. Lack of places/providers to refer patients
5. Patient's lack of interest or openness to (Therapy)
6. Lack of perceived benefit
7. OTHER reasons

| | Yes | No |
|---|----------------------------|----------------------------|
| 1 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 2 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 3 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 4 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 5 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 6 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 7 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Notes

Section II INDUCTION INTERVIEW – Continued

36. Provider demographics –

a. What is your year of birth?

| | | | | |
|---|---|--|--|--|
| 1 | 9 | | | |
|---|---|--|--|--|

b. What is your sex?

- 1 Male
 2 Female

**c. Give FLASHCARD G (p. 22 Flashcard Booklet) and ask:
 What is your highest medical degree?**

- 1 MD } Go to item 36d
 2 DO }
 3 Nurse practitioner }
 4 Physician assistant } SKIP to item 37
 5 Nurse midwife }
 6 Other }

d. What is your primary specialty?

| | | | | |
|-------------------|---|--|--|--|
| | <table border="1"> <tr> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> </tr> </table> | | | |
| | | | | |
| Name of specialty | Code | | | |

e. What is your secondary specialty?

| | | | | |
|-------------------|---|--|--|--|
| | <table border="1"> <tr> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> </tr> </table> | | | |
| | | | | |
| Name of specialty | Code | | | |

f. What is your primary board certification?

| |
|---------------------|
| |
| Board certification |

g. What is your secondary board certification?

| |
|---------------------|
| |
| Board certification |

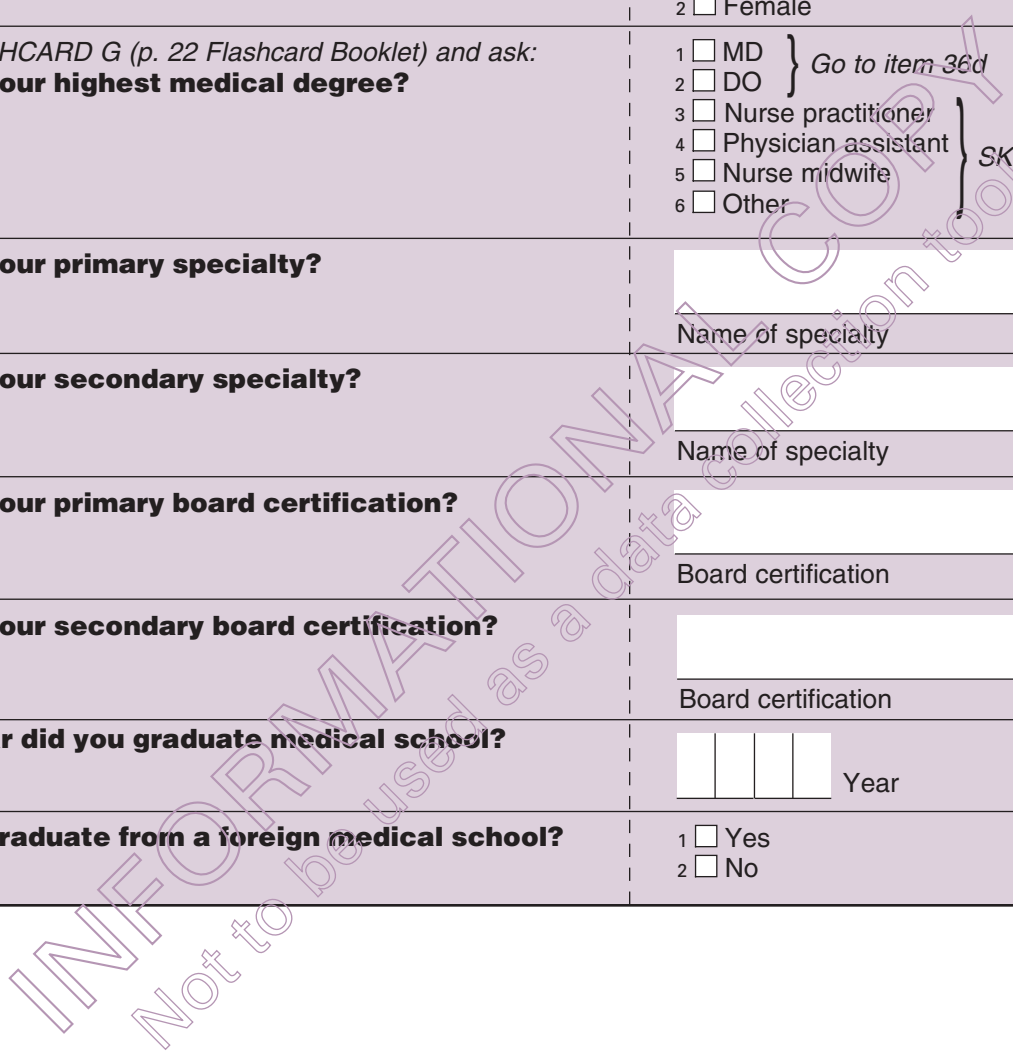
h. What year did you graduate medical school?

| | | | | | | | |
|------|--|--|--|--|--|--|--|
| | | | | | | | |
| Year | | | | | | | |

i. Did you graduate from a foreign medical school?

- 1 Yes
 2 No

NOTES



Section II INDUCTION INTERVIEW - Continued

37. Who will be helping you at each location? (Below enter the location and person's name and position.)

NOTE: Keep the location numbers the same as the office numbers in item 15a.

| Office No. | Location (Enter street name) | Name | Position |
|------------|---------------------------------|------|----------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

NOTE - We will review some of the questions found on the Patient Record form. Go to page 19 for instructions.

Visit Sampling

To select a sample of patient visits, the physician's office will need to know where to start sampling (**Start With**) and how to select subsequent patient visits (**Take Every**).

To determine the Take Every (**TE**) number, the system automatically calculates the intersection of the "Estimated visits for week" column (corresponding to the total entry in ITEM 16e) with the "Days physician will see patients that week" line (based on the entry in ITEM 16a).

TAKE EVERY NUMBER

| Estimated Visits for Week | Days physician will see patients that week | | | | | | |
|---------------------------|--|----------|----------|----------|----------|----------|----------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 0-12 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 13-24 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| 25-39 | 3 | 2 | 1 | 1 | 1 | 1 | 1 |
| 40-44 | 4 | 2 | 2 | 1 | 1 | 1 | 1 |
| 45-49 | 4 | 2 | 2 | 2 | 2 | 2 | 2 |
| 50-64 | 5 | 3 | 2 | 2 | 2 | 2 | 2 |
| 65-74 | 10 | 3 | 2 | 2 | 2 | 2 | 2 |
| 75-89 | 10 | 4 | 3 | 2 | 2 | 2 | 2 |
| 90-104 | 10 | 4 | 3 | 3 | 3 | 3 | 3 |
| 105-114 | 10 | 5 | 3 | 3 | 3 | 3 | 3 |
| 115-129 | 10 | 5 | 4 | 3 | 3 | 3 | 3 |
| 130-134 | 15 | 10 | 4 | 3 | 3 | 3 | 3 |
| 135-154 | 15 | 10 | 4 | 4 | 4 | 4 | 4 |
| 155-174 | 15 | 10 | 5 | 4 | 4 | 4 | 4 |
| 175-194 | 15 | 10 | 5 | 5 | 5 | 5 | 5 |
| 195-209 | 20 | 10 | 10 | 5 | 5 | 5 | 5 |
| 210-219 | 20 | 10 | 10 | 10 | 5 | 5 | 5 |
| 220-254 | 20 | 10 | 10 | 10 | 10 | 10 | 10 |
| 255-319 | 25 | 15 | 10 | 10 | 10 | 10 | 10 |
| 320-364 | 30 | 15 | 10 | 10 | 10 | 10 | 10 |
| 365+ | 30 | 30 | 30 | 30 | 30 | 30 | 30 |

Take Every Number

Section II INDUCTION INTERVIEW – Continued

38. START WITH NUMBER

The system automatically determines the Start With (SW) number based on the previously calculated Take Every number. Based on the Take Every number, a corresponding Start With number is assigned, as shown in the table to the right.

| If the Take Every Number is: | Then the Start With Number is: |
|------------------------------|--------------------------------|
| 1 | 1 |
| 2 | 1 |
| 3 | 2 |
| 4 | 3 |
| 5 | 2 |
| 10 | 8 |
| 15 | 10 |
| 20 | 14 |
| 25 | 21 |
| 30 | 15 |

Start With Number

INSTRUCTIONS

(1) Who to list/who not to list on the Patient Visit Worksheet found in the back of the NAMCS-26

- List every ambulatory patient visit to all in-scope locations during the reporting period.
- INCLUDE patients the physician doesn't see but who receive care from an assistant, nurse, nurse practitioner, physician assistant, etc.
- EXCLUDE patients who do not seek care or services (e.g., they come to pay a bill or leave a specimen).
- EXCLUDE telephone contacts with patients.

Items 5a(1), Provider's Primary Diagnosis for this Visit – Can be tentative or provisional or expressed as a problem. Physician should not record "Rule Out" diagnosis (R.O.). Enter any other diagnosis related to the visit (e.g., depression, obesity, asthma, etc.) in items 5a(2) and 5a(3).

Items 5b, Chronic Disease Checklist – Mark all chronic diseases that the patient has, regardless of entry in item 5a. This item supplements the diagnoses reported in item 5a. If none of the conditions listed apply, then mark "None of the above."

Item 6, Vital Signs – When possible, record specific values for the 4 vital signs. For height and weight, enter the value on the line next to the type or measurement system used. If height was not measured at this visit and patient is 21 years of age or over, enter the most recent height recorded.

Item 8, Health Education – Mark all services ordered or provided at this visit.

Item 9, Non-Medication Treatment – Mark and/or list all non-medical treatment including surgical or non-surgical procedures ordered or provided at this visit.

Item 10, List medication/immunization names – Record up to 8 medications that were ordered, supplied, administered or told to continue at the visit. Include Rx and OTC medications, immunizations, allergy shots, anesthetics, chemotherapy, and dietary supplements. Use SPECIFIC BRAND OR GENERIC DRUG NAMES as entered on prescription or medical records. Do NOT enter broad drug classes such as "pain medication." Record if the medication/immunization was new or continued.

Item 13, Time Spent with Provider – Best estimate of time spent in face-to-face contact with the patient and the sampled provider. The answer may be zero (0), if the patient was attended entirely by a registered nurse or technician and did not see the sampled physician/CHC provider.

Item 14, Laboratory Test Results – If applicable please make sure provider is aware of items on back of PRF, and completes information about tests drawn within last 12 months. If primary medical specialty is listed in Appendix E in the NAMCS-26 Instruction Booklet, physician should complete Item 14.

(2) Explain to the provider, where appropriate, that the receptionist, nurse, or assistant can list patients on the Patient Visit Worksheet as they enter the office. They may also complete items 1–4 on the Patient Record form.

(3) Instruct provider to enter number of patients seen and number of PRF's completed on front of folio – at the end of each day.

Section III NONINTERVIEW

39. What is the reason the provider did not participate in this study?

Explanations for noninterview codes 6 and 11 –

- Temporarily not practicing –Refers to duration of 3 months or more
- Unavailable during reporting period –Absence must be for duration of LESS than 3 months

Edit

- 1 Refused/Breakoff – *SKIP to item 41a*
- 2 Non-office based
- 3 Sees no ambulatory patients
- 4 Retired
- 5 Deceased
- 6 Temporarily not practicing – *SKIP to item 42 on page 21*
- 7 Can't locate
- 8 Not licensed
- 9 Moved out of U.S.A.
- 10 Other out-of-scope – *SKIP to item 40*
- 11 Unavailable during reporting period – *SKIP to item 42 on page 21*
- 12 Moved out of PSU – *SKIP to item 43a on page 21*

40. Check all that apply to describe provider's practice or medical activities which define him/her as ineligible or out-of-scope.

- 1 Federally employed
- 2 Radiology, anesthesiology or pathology specialist
- 3 Administrator
- 4 Work in institutional setting
- 5 Work in hospital emergency department or outpatient department
- 6 Work in industrial setting
- 7 Other – *Specify* ↴

SKIP to item 44 page 22

41a. At what point in the interview did the refusal/break-off occur?

(Enter (X) one.)

- 1 During telephone screening
- 2 During induction interview
- 3 After induction but prior to assigned reporting days
- 4 At reminder call
- 5 During assigned reporting days or mid-week calls
- 6 At follow-up contact

b. By whom?

(Enter (X) one.)

- 1 Sampled provider
- 2 Sampled provider through nurse
- 3 Nurse/Secretary
- 4 Receptionist
- 5 Office manager/Administrator
- 6 Other office staff – *Specify* ↴

c. What reason was given? *(Verbatim)*

d. Date refusal/breakoff was reported to supervisor

| | | |
|---|---|---|
| Month | Day | Year |
| <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> |

e. Conversion attempt result

- 1 No conversion attempt
- 2 Sampled provider refused
- 3 Sampled provider agreed to see Field Representative – *Complete Section II*

Section III NONINTERVIEW - Continued

42. Why is provider unavailable or not in practice?

SKIP to
item 44 on
page 22

43a. What is the provider's new address?

Number and street

City, State, ZIP Code

Telephone

b. Name of Field Representative

RO

PSU

Date transferred

Continue
with item
44 on
page 22

NOTES

INFORMATIONAL COPY
Not to be used as a data collection tool

Section IV DISPOSITION AND SUMMARY

44. FINAL DISPOSITION

(a) Eligible physician/provider

- 1 **Completed Patient Record forms** →
- 2 **Out-of-scope** (Item 35, codes 2, 3, 4, 5, 6, 8, 9, or 10)
- 3 **Refused-Breakoff** (Item 35, code 1)
- 4 **Unavailable during reporting period** (Item 35, code 11)
- 5 **Moved out of PSU** (Item 35, code 12-final)
- 6 **Can't locate** (Item 35 code 7)

End of Interview
 -Make certain all items are accurately completed before returning materials to the office.

(b) Unused CHC NAMCS-1

- 7 **Less than 3 providers sampled**
- 8 **Parent CHC Out-of-scope**
- 9 **Parent CHC Refused to participate**

(c) Transfer cases

- Moved out of PSU** (Item 35, code 12 -pending)

Edit Edit

45. CASE SUMMARY

1. Number of patient visits during reporting week

2. Number of days during reporting week on which patients were seen

3. Number of patient record forms completed

NOTE - For items 45(1) and 45(3), see instruction below. ↗

PLEASE READ BEFORE CONTINUING

Item 45(1) - Accurate determination of "Number of patient visits during reporting week" is **EXTREMELY IMPORTANT!** This count is to include any days the provider may have skipped or not participated. This information may be obtained from either the office staff or from the PRF Folio cover. Only include visits to sampled provider and NOT the total number of visits to entire practice or clinic.

Item 45(3) - If the number of Patient Record forms completed is less than 20 or greater than 40, then explain why in the NOTES section below.

Items 17e and 45(1) - If applicable, record explanation of why items 17e and 45(1) differ significantly and any other information regarding this case which may help to understand it at a later date.

Notes

Part 3 — Missing Patient Record Form Items (1-13)

46. List missing items, and refer to the FR manual for guidelines on retrieving missing information.

| Patient Record number (a) | Item number(s) (b) | Comments (c) |
|------------------------------|-----------------------|-----------------|
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47. Was provider/office staff contacted for any reason during the editing process?

Yes No

48. For all Final = 1 cases, transfer information from front of Patient Record Folio.

| | | | | | | |
|-----------|-------------|---|---|-----------|---|---|
| WEEK OF – | FROM | Month <input type="text"/> <input type="text"/> | Day <input type="text"/> <input type="text"/> | TO | Month <input type="text"/> <input type="text"/> | Day <input type="text"/> <input type="text"/> |
| | | | | | | |

| SURVEY WEEK | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun. | Total |
|---|------|-------|------|-------|------|------|------|-------|
| Complete a Patient Record for patient SW <input type="text"/> and every TE <input type="text"/> <i>nth</i> patient thereafter. | | | | | | | | |
| Number of patient visits | | | | | | | | |
| Number of records completed | | | | | | | | |

NOTES
