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**1. Physician's address:**

**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.

FORM **NAMCS-1A**  
(4-1-2013)

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  
2013 PANEL**

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

<b>Office 1</b>	Telephone		<b>Office 2</b>	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			

## 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. We intend to conduct additional health care research by linking your National Provider Identifier (NPI) and Federal Tax ID 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 and 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 (800)–392–2862. Additional information on the survey may be obtained by visiting the NAMCS participant Web site at [http://www.cdc.gov/nchs/ahcd/namcs\\_participant.htm](http://www.cdc.gov/nchs/ahcd/namcs_participant.htm).

You may have questions about your rights as a participant in this research study. If so, please call the Research Ethics Review Board at the National Center for Health Statistics, 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**

**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 12 on page 4*

**b. PROBE: We include as ambulatory patients, individuals receiving health services without admission to a hospital or other facility. 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 12 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 12 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 13*  
 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 13*

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

- 1  Yes – *SKIP to CHECK ITEM A on page 5*  
 2  No

**11. Is the physician retired or deceased?**

- 1  Yes – *SKIP to CHECK ITEM A on page 5*  
 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 5.)*

**13. I would like to arrange an appointment with you within the next week or so to discuss the study. It will take about 30 minutes. What would be a good time for you, before Friday, \_\_\_\_\_ (last Friday before the assigned reporting week)?**

Weekday	Month	Day	Year	Time
				a.m.
				p.m.

Physician refused to participate --Go to the top of page 5.

**Thank you, Dr. . . . I'll see you then.** *(Go to Check Item A on the bottom of page 5.)*

**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.							

**Section I TELEPHONE SCREENER Continued**

**FR, PLEASE READ BEFORE CONTINUING**

FR Instruction – COMPLETE QUESTIONS BELOW FOR ALL IN-SCOPE PHYSICIANS WHO HAVE REFUSED TO PARTICIPATE.

**I appreciate that you choose not to participate in the study, but I would like to ask a few short questions about your practice so we can make sure responding physicians do not differ from nonresponding physicians.**

<p><b>14a. At how many different office locations, do you see ambulatory patients? Do not include settings such as EDs, outpatient departments, surgicenters, and Federal clinics.</b></p>	<p>Number of office locations <input type="text"/></p>
<p><b>b. In a typical year, about how many weeks do you NOT see ambulatory patients (e.g., conferences, vacations, etc.)?</b></p>	<p>Number of weeks <input type="text"/> ↘                  If &gt; 26 weeks, ask item 14c.                  If = 0, SKIP to item 14d.                  If 1 to 26 weeks, SKIP to item 14e.</p>
<p><b>c. You typically see patients fewer than half the weeks in each year. Is that correct?</b></p>	<p>1 <input type="checkbox"/> Yes – SKIP to item 14e.                  2 <input type="checkbox"/> No – Please explain ↘  <input type="text"/> } SKIP to item 14e</p>
<p><b>d. You typically see patients all 52 weeks of the year. Is that correct?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No – Please explain ↘  <input type="text"/></p>
<p><b>e. During your last normal week of practice, how many patient visits did you have at all office locations?</b></p>	<p>Number of patient visits <input type="text"/></p>
<p><b>f. During your last normal week of practice, how many hours of direct patient care did you provide?</b>  <b>NOTE – Direct patient care includes: Seeing patients, reviewing tests, preparing for and performing surgery/procedures, providing other related patient care services. Do not include hours from EDs, outpatient departments, surgicenters, or Federal clinics.</b></p>	<p>Number of weekly hours <input type="text"/></p>
<p><b>g. At the office location where you see the most ambulatory patients:</b>  <b>(1) How many physicians are associated with you?</b></p>	<p>Number of physicians <input type="text"/>                  If number of other physicians is 0, SKIP to item 14g(3).</p>
<p><b>(2) Is this a single- or multi-specialty group practice?</b></p>	<p>1 <input type="checkbox"/> Multi-specialty practice                  2 <input type="checkbox"/> Single-specialty practice</p>
<p><b>(3) Are you a full- or part-owner, employee, or an independent contractor?</b></p>	<p>1 <input type="checkbox"/> Full-owner                  2 <input type="checkbox"/> Part-owner                  3 <input type="checkbox"/> Employee                  4 <input type="checkbox"/> Contractor</p>
<p><b>(4) Who owns the practice?</b>   <b>REFER TO FLASHCARD A.</b></p>	<p>1 <input type="checkbox"/> Physician or physician group                  2 <input type="checkbox"/> Insurance company, health plan, or HMO                  3 <input type="checkbox"/> Community Health Center                  4 <input type="checkbox"/> Medical/Academic health center                  5 <input type="checkbox"/> Other hospital                  6 <input type="checkbox"/> Other health care corporation                  7 <input type="checkbox"/> Other – Specify ↘  <input type="text"/></p>

**CHECK ITEM A Final outcome of screening**

1  Appointment MADE or Physician unavailable during reporting period – Go to Section II, page 6  
 2  In-scope, but REFUSED – Complete item 14, then go to Section III, page 21  
 3  Out-of-Scope/Other – Go to Section III, page 21

**▶ CHECK ITEM A MUST BE COMPLETED BEFORE CONTINUING ◀**

Edit

**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.

**15a. 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 15c.  
If = 0, SKIP to item 15d.  
If 1 to 26 weeks,  
SKIP to item 16a.

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

- 1  Yes – SKIP to item 16a  
2  No – Please explain ↴

} SKIP to item 16a

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

- 1  Yes  
2  No – Please explain ↴

**16a. 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 17a on page 7  
2  No

**b. Why is that? Record verbatim.**

(If appropriate, read item 16c below. Otherwise, SKIP to item 17a 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 17a on page 7.



**Section II INDUCTION INTERVIEW – Continued**

**17a. At what office location(s) will you see ambulatory patients during your practice's 7-day reporting period Monday, \_\_\_\_\_ through Sunday, \_\_\_\_\_?**

**(1) Are there any other office locations at which you will see ambulatory patients during that 7-day reporting period?**  
 \_\_\_\_\_

**(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?**  
 \_\_\_\_\_

**17b. 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.)

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

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

*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**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><b>(1) Private solo or group practice</b></li> <li><b>(3) Freestanding clinic/urgicenter (not part of a hospital outpatient department)</b></li> <li><b>(5) Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or 'look alike' clinics)</b></li> <li><b>(7) Mental health center</b></li> <li><b>(9) Non-federal Government clinic (e.g., state, county, city, maternal and child health, etc.)</b></li> <li><b>(11) Family planning clinic (including Planned Parenthood)</b></li> <li><b>(13) Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente)</b></li> <li><b>(15) Faculty practice plan</b></li> </ul> | <ul style="list-style-type: none"> <li><b>(2) Hospital emergency department</b></li> <li><b>(4) Hospital outpatient department</b></li> <li><b>(6) Ambulatory surgicenter</b></li> <li><b>(8) Institutional setting (school infirmary, nursing home, prison)</b></li> <li><b>(10) Industrial outpatient facility</b></li> <li><b>(12) Federal Government operated clinic (e.g., VA, military, etc.)</b></li> <li><b>(14) Laser vision surgery</b></li> </ul> |
|---|--|

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

**17c. 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 17d
- 2  No – SKIP to Check Item B on page 8

**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 B**

- 1  All locations listed in 17a are out-of-scope – *Read CLOSING STATEMENT below*
- 2  All/Some locations listed in 17a are in-scope – *Go to item 18a*

**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 21–24.)

Ask item 18a ONCE to obtain total for ALL in-scope locations.

**18a. 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 17a.

	Office location No.			
	#1	#2	#3	#4
[ ]				
[ ]				
[ ]				
[ ]				

**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

[ ]	[ ]	[ ]	[ ]
-----	-----	-----	-----

**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 18b to 18d for that office location. If answer is "No" then ASK item 18d for that office location.

Yes . . . .  
No . . . .

1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
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

[ ]	[ ]	[ ]	[ ]
-----	-----	-----	-----

**e. Tally of estimated number of visits**

**NOTE:** To obtain the total number of estimated visits, add the estimate for each office location in 18d.

Number of visits →

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

**19a. 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 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<b>If Solo, SKIP to item 19d.</b>				
Nonsolo . . . . . 2 <input type="checkbox"/>	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"/>	1 <input type="checkbox"/>
Single . . . . . 2 <input type="checkbox"/>	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
<b>19d. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with you (at this/that in-scope location)?</b>	How many → <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>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 19f.</b>	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"/>
<b>f. Give FLASHCARD A (p.14 Flashcard Booklet) and ask:  Who owns the practice (at this/that in-scope location)?</b>	Physician or physician group . . . . 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	Insurance company, health plan, or 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"/>
<b>g. Does your practice have the ability to perform any of the following on site (at this/that in-scope location)?</b>				
<b>1. EKG/ECG</b>	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
<b>2. Lab testing</b>	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
<b>3. Spirometry</b>	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
<b>4. Ultrasound</b>	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
<b>5. X-Ray</b>	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
<b>h. Do you see patients in the office during the evening or on weekends?</b>	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
<b>i. What is your National Provider Identifier (NPI) at each office location?</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>j. What is your Federal Tax ID at each office location?</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Notes

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**Section II INDUCTION INTERVIEW – Continued**

**20a. 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

  
  
  
  


*The next set of questions pertain to characteristics of the sampled physician's healthcare workforce, including physicians and other allied health care providers.*

**IF ONE LOCATION LISTED IN NAMCS-1A DISPLAY THE FOLLOWING:**

**21. How many physicians, including you, are associated with this practice? Please include physicians at [fill address of sampled location], and physicians at any other locations of this practice.**

- 1  1 physician
- 2  2-3 physicians
- 3  4-10 physicians
- 4  11-50 physicians
- 5  51-100 physicians
- 6  More than 100 physicians

**IF TWO OR MORE LOCATIONS LISTED IN NAMCS-1A, DISPLAY THE FOLLOWING TEXT AND QUESTION:**

**The next questions are about the location where you have the most office visits.**

**21. How many physicians, including you, are associated with that practice? Please include physicians at [fill address of location with the most office visits based on NAMCS-1A], and physicians at any other locations of that practice.**

- 1  1 physician
- 2  2-3 physicians
- 3  4-10 physicians
- 4  11-50 physicians
- 5  51-100 physicians
- 6  More than 100 physicians

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**22. Is your practice certified as a patient-centered medical home?**

- a  Yes – By whom
- 1  The Accreditation Association for Ambulatory Health (AAAH)
  - 2  The Joint Commission
  - 3  The National Committee for Quality Assurance (NCQA)

**What is the level of certification for the NCQA?**

- (a)  Level 1
- (b)  Level 2
- (c)  Level 3

- 4  Utilization Review Accreditation Commission (URAC)

- 5  Other – Specify

- 6  Unknown

- b  No
- c  Unknown

**23. Give FLASHCARD H (p. 22 Flashcard Booklet) and ask: How many of the following full-time and part-time providers are on staff at the office location where you have the most office visits? NOTE: Please include the sampled provider in the total count of staff below. Full-time is 30 or more hours per week. Part-time is less than 30 hours per week. Please provide the total number of full-time and part-time providers.**

Type of Provider	Number Full-time (≥ 30 hours)	Number Part-time (<30 hours)
Physicians (MD and DO)	<input type="text"/>	<input type="text"/>
<b>Non-Physician Clinicians</b>		
Physician Assistant (PA)	<input type="text"/>	<input type="text"/>
Nurse Practitioner (NP)	<input type="text"/>	<input type="text"/>
Certified Nurse Midwife (CNM)	<input type="text"/>	<input type="text"/>
<b>Other Nursing Care</b>		
Registered nurse (RN) (not an NP or CNM)	<input type="text"/>	<input type="text"/>
Licensed Practical Nurse (LPN)	<input type="text"/>	<input type="text"/>
Certified Nursing Assistant/Aide (CNA)	<input type="text"/>	<input type="text"/>
<b>Allied Health</b>		
Medical Assistant (MA)	<input type="text"/>	<input type="text"/>
Radiology Technician (RT)	<input type="text"/>	<input type="text"/>
Laboratory Technician(LT)	<input type="text"/>	<input type="text"/>
Physical Therapist (PT)	<input type="text"/>	<input type="text"/>
Pharmacist (Ph)	<input type="text"/>	<input type="text"/>
Dietitian/Nutritionist (DN)	<input type="text"/>	<input type="text"/>
<b>Other</b>		
Mental Health Provider (MH)	<input type="text"/>	<input type="text"/>
Health Educator/ Counselor (HEC)	<input type="text"/>	<input type="text"/>
Case Manager (not an RN)/Certified Social Worker (CSW)	<input type="text"/>	<input type="text"/>
Community Health Worker (CHW)	<input type="text"/>	<input type="text"/>

**Section II INDUCTION INTERVIEW – Continued**

24. At the office location where you have the most office visits, which type of provider most commonly performs the following tasks? <i>Mark (X) all that apply.</i>	Mark (X) all that apply.			
	Yes	No	Unknown	Task is not performed in this office
Based on the staff selected in <b>Question 23</b> , a drop-down list will be made available for each of the following questions <b>a–m</b> , but will only contain those selected providers as well as "Unknown" and "Task is not performed in this office" if needed.				
<b>a. Records body measurements (such as height and weight) and vital signs (such as BP, temperature, heart rate)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>b. Performs office-based testing such as EKG and hearing/vision testing (do not include laboratory testing)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>c. Draws blood for lab testing</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>d. Provides immunizations (includes both childhood and adult)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>e. Conducts cancer screenings (such as breast, cervical, and prostate screenings)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>f. Provides behavioral health screenings (such as depression, alcohol and substance abuse)</b>	1 <input checked="" type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>g. Provides counseling services (such as diet/nutrition, weight reduction, tobacco cessation, stress management)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>h. Manages the routine care of patients with chronic conditions (such as hypertension, asthma, diabetes)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>i. Writes refill prescriptions for medications</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>j. Enters patient information into medical/billing records</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>k. Performs imaging tests (such as X-rays and ultrasounds)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>l. Makes referrals (for example, to specialty care, or to community-based services)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>m. Contacts patients, who are transitioning from hospital or nursing home back to the community</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>25. The following questions concern the mid-level providers practicing at the location where you have the most office visits.</b>	Yes, always	Yes, sometimes	No	Unknown/ Not applicable
<b>a. Physician Assistant</b>				
(1) Are PA(s) supervised by someone on-site? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(2) Do you sign-off on the medical records of the patients the PA(s) see(s)? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(3) Do the PA's patients have a separate log from your patients? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(4) Is your approval required before the PA(s) prescribe(s) medication? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>b. Nurse Practitioner</b>				
(1) Are NP(s) supervised by someone on-site? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(2) Do you sign-off on the medical record of the patients the NP(s) see(s)? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(3) Do the NP's patients have a separate log from your patients? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(4) Is your approval required before the NP(s) prescribe(s) medication? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(5) Do/does the NP(s) bill for services using their own NPI number? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>c. Certified Nurse Midwife</b>				
(1) Are CNM(s) supervised by someone on-site? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(2) Do you sign-off on the medical record of the patients the CNM(s) see(s)? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(3) Do the CNM's patients have a separate log from your patients? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(4) Is your approval required before the CNM(s) prescribe(s) medication? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(5) Do/does the CNM(s) bill for services using their own NPI number? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

**The remaining questions are to be answered for the practice that is associated with the location where the physician has the most office visits. When defining this location, include only in-scope locations previously listed.**

<p><b>26. Is it possible within your practice to access patient medical records 24-hours a day?</b></p>	<p>a <input type="checkbox"/> Yes – <b>Is this access available to physicians only, or is it also available to other non-physician clinicians?</b></p> <p>1 <input type="checkbox"/> Physicians (MD/DO) only                  2 <input type="checkbox"/> All Physicians and Non-physician Clinicians                  3 <input type="checkbox"/> Unknown</p> <p>b <input type="checkbox"/> No                  c <input type="checkbox"/> Unknown</p>
<p><b>27. What is the primary method by which your practice receives information about patients in your practice when they have been seen in the emergency department or hospitalized? Mark (X) all that apply.</b></p>	<p>a <input type="checkbox"/> Electronic transmission (i.e., EHR or EMR)                  b <input type="checkbox"/> Fax                  c <input type="checkbox"/> Email – <i>If yes</i> – <b>Was this email sent over a secure network?</b></p> <p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p> <p>d <input type="checkbox"/> Telephone or in-person communication with provider                  e <input type="checkbox"/> Paper copy                  f <input type="checkbox"/> Other</p>
<p><b>28. Is someone in your practice responsible for assisting patients to safely transition back to the community within 72 hours of being discharged from a hospital or nursing home?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input checked="" type="checkbox"/> Unknown</p>
<p><b>29. Does your practice report any quality measures or quality indicators to either payers or to organizations that monitor health care quality?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input checked="" type="checkbox"/> No</p>
<p><b>30. Do all other locations or offices associated with this practice use the same Federal Tax Identification Number, or do any locations or offices associated with this practice use a different Federal Tax Identification Number?</b></p>	<p>1 <input type="checkbox"/> All use the same Federal Tax ID                  2 <input type="checkbox"/> Some use a different Federal Tax ID                  3 <input checked="" type="checkbox"/> Unknown</p>
<p><b>Answer ALL remaining questions for the in-scope location with the most visits.</b></p>	
<p><b>31. Does the reporting location submit any claims electronically (electronic billing)?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>
<p><b>32a. Does the reporting location use an electronic health record (EHR) or electronic medical record (EMR) system? Do not include billing record systems.</b></p>	<p>1 <input type="checkbox"/> Yes, all electronic                  2 <input type="checkbox"/> Yes, part paper and part electronic                  3 <input type="checkbox"/> No                  4 <input type="checkbox"/> Unknown</p> <p>} Go to Question 32b                  } SKIP to Question 33 on page 14</p>
<p><b>b. In which year did you install your EHR/EMR system?</b></p>	<p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year</p>
<p><b>c. Does your current system meet meaningful use criteria as defined by the Department of Health and Human Services?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Unknown</p>
<p><b>d. What is the name of your current EHR/EMR system?</b></p> <p><i>Enter (X) only one box.</i></p>	<p>1 <input type="checkbox"/> Allscripts                  2 <input type="checkbox"/> Amazing Charts                  3 <input type="checkbox"/> Athenahealth                  4 <input type="checkbox"/> Cerner                  5 <input type="checkbox"/> eClinicalWorks                  6 <input type="checkbox"/> e-MDs                  7 <input type="checkbox"/> Epic                  8 <input type="checkbox"/> GE/Centricity</p> <p>9 <input type="checkbox"/> Greenway Medical                  10 <input type="checkbox"/> McKesson/Practice Partner                  11 <input type="checkbox"/> NextGen                  12 <input type="checkbox"/> Practice Fusion                  13 <input type="checkbox"/> Sage/Vitera                  14 <input type="checkbox"/> Other <input type="text"/></p> <p>15 <input type="checkbox"/> Unknown</p>

**Section II INDUCTION INTERVIEW - Continued**

<p><b>33. At the reporting location, are there plans for installing a new EHR/EMR system within the next 18 months?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> Maybe                  4 <input type="checkbox"/> Unknown</p>				
<p><b>34a. Medicare and Medicaid offer incentives to practices that demonstrate "meaningful use of health IT." At the reporting location, are there plans to apply for these incentive payments?</b></p>	<p>1 <input type="checkbox"/> Yes, we already applied } <i>Go to 34b</i>                  2 <input type="checkbox"/> Yes, we intend to apply }                  3 <input type="checkbox"/> Uncertain if we will apply } <i>SKIP to Question 35</i>                  4 <input type="checkbox"/> No, we will not apply }</p>				
<p><b>b. When did you first apply or when do you first intend to apply?</b></p>	<p>1 <input type="checkbox"/> 2011                  2 <input type="checkbox"/> 2012                  3 <input type="checkbox"/> 2013                  4 <input type="checkbox"/> 2014 or later                  5 <input type="checkbox"/> Unknown</p>				
<p><b>35. Give FLASHCARD C-1 (p.16 Flashcard booklet) and ask: Please indicate whether the ambulatory reporting location has each of the following computerized capabilities and how often these capabilities are used. Enter (X) only one per row.</b></p> <p><b>a. Recording patient history and demographic information?</b> .....</p> <p><i>If Yes, ask – (1) Does this include a patient problem list?</i></p> <p><b>b. Recording and charting vital signs?</b> .....</p> <p><b>c. Recording patient smoking status?</b> .....</p> <p><b>d. Recording clinical notes?</b> .....</p> <p><i>If Yes, ask – (1) Do the notes include a list of the patient's medications and allergies?</i></p> <p><b>e. Reconciling lists of patient medications to identify the most accurate list?</b> .....</p> <p><b>f. Ordering prescriptions?</b> .....</p> <p><i>If Yes, ask – (1) Are prescriptions sent electronically to the pharmacy?</i></p> <p><i>If Yes, ask – (2) Are warnings of drug interactions or contraindications provided?</i></p> <p><b>g. Providing reminders for guideline-based interventions or screening tests?</b> .....</p> <p><b>h. Ordering lab tests?</b> .....</p> <p><i>If Yes, ask – (1) Are orders sent electronically?</i></p> <p><b>i. Viewing lab results?</b> .....</p> <p><i>If Yes, ask – (1) Can the EHR/EMR automatically graph a specific patient's lab results over time?</i></p>	<p>Yes, used routinely</p>	<p>Yes, but NOT used routinely</p>	<p>Yes, but turned off or not used</p>	<p>No</p>	<p>Unknown</p>
<p>1 <input type="checkbox"/> <i>Go to 35a(1)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35a(1)</i></p>	<p>3 <input type="checkbox"/> <i>Skip to 35b</i></p>	<p>4 <input type="checkbox"/> <i>Skip to 35b</i></p>	<p>5 <input type="checkbox"/> <i>Skip to 35b</i></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/> <i>Go to 35d(1)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35d(1)</i></p>	<p>3 <input type="checkbox"/> <i>Skip to 35e</i></p>	<p>4 <input type="checkbox"/> <i>Skip to 35e</i></p>	<p>5 <input type="checkbox"/> <i>Skip to 35e</i></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/> <i>Go to 35f(1)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35f(1)</i></p>	<p>3 <input type="checkbox"/> <i>Skip to 35g</i></p>	<p>4 <input type="checkbox"/> <i>Skip to 35g</i></p>	<p>5 <input type="checkbox"/> <i>Skip to 35g</i></p>	
<p>1 <input type="checkbox"/> <i>Go to 35f(2)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35f(2)</i></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/> <i>Go to 35h(1)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35h(1)</i></p>	<p>3 <input type="checkbox"/> <i>Skip to 35i</i></p>	<p>4 <input type="checkbox"/> <i>Skip to 35i</i></p>	<p>5 <input type="checkbox"/> <i>Skip to 35i</i></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	
<p>1 <input type="checkbox"/> <i>Go to 35i(1)</i></p>	<p>2 <input type="checkbox"/> <i>Go to 35i(1)</i></p>	<p>3 <input type="checkbox"/> <i>Skip to 35j</i></p>	<p>4 <input type="checkbox"/> <i>Skip to 35j</i></p>	<p>5 <input type="checkbox"/> <i>Skip to 35j</i></p>	
<p>1 <input type="checkbox"/></p>	<p>2 <input type="checkbox"/></p>	<p>3 <input type="checkbox"/></p>	<p>4 <input type="checkbox"/></p>	<p>5 <input type="checkbox"/></p>	



**Section II INDUCTION INTERVIEW – Continued**

<b>35. Please indicate whether the ambulatory reporting location has each of the following computerized capabilities and how often these capabilities are used.</b> <i>Enter (X) only one per row.</i>	Yes, used routinely	Yes, but NOT used routinely	Yes, but turned off or not used	No	Unknown
<b>j. Viewing imaging results?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>k. Identifying educational resources for patients' specific conditions?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>l. Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>m. Generating lists of patients with particular health conditions?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>n. Electronic reporting to immunization registries?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>o. Providing patients with clinical summaries for each visit?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>p. Exchanging secure messages with patients?</b> ...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input checked="" type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>q. Providing patients with an electronic copy of their health information?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>r. Providing patients the ability to view online, download, or transmit information from their medical record?</b> .....	1 <input checked="" type="checkbox"/>	2 <input checked="" type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**The next questions are about sharing (either sending or receiving) patient health information.**

<b>36a. Do you share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?</b>	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to Question 38a on page 16
<b>b. How do you electronically share patient health information?</b> <i>Enter (X) all that apply.</i>	1 <input type="checkbox"/> EHR/EMR 2 <input type="checkbox"/> Web portal (separate from EHR/EMR) 3 <input type="checkbox"/> Other electronic method – Specify ↴ <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>

<b>37. Give FLASHCARD C-2 (p.17 Flashcard Booklet) and ask: Please indicate which types of health data you share electronically (not fax) with the health care providers listed.</b> <i>Enter all that apply.</i>	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
<b>a. Lab results?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>b. Imaging reports?</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>c. Patient problem lists</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>d. Medication lists</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>e. Medication allergy lists</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>f. Do you share any of the previously mentioned types of information using a "Summary Care Record"?</b> [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			

**Section II INDUCTION INTERVIEW – Continued**

<b>38a. Do you refer any of your patients to providers outside of your office or group?</b>	1 <input type="checkbox"/> Yes – Go to Question 38b 2 <input type="checkbox"/> No – SKIP to Question 39a
<b>b. Do you receive a report back from the other provider with results of the consultation?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 39a
<b>c. Do you receive it <u>electronically</u> (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No
<b>39a. Do you see any patients referred to you by providers outside of your office or group?</b>	1 <input type="checkbox"/> Yes – Go to Question 39b 2 <input type="checkbox"/> No – SKIP to Question 40a
<b>b. Do you receive notification of both the patient's history and reason for consultation?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 40a
<b>c. Do you receive them <u>electronically</u> (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No
<b>40a. Do you take care of patients after they are discharged from an inpatient setting?</b>	1 <input type="checkbox"/> Yes – Go to Question 40b 2 <input type="checkbox"/> No – SKIP to Question 41
<b>b. Do you receive all of the information you need to continue managing the patient?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 41
<b>c. Is the information available when needed?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No – SKIP to Question 41
<b>d. Do you receive it <u>electronically</u> (not fax)?</b>	1 <input type="checkbox"/> Yes, routinely 2 <input type="checkbox"/> Yes, but not routinely 3 <input type="checkbox"/> No

*Please remind physician/provider that the remaining questions refer to all offices that were determined to be in-scope.*

Give FLASHCARD D (p. 18 Flashcard Booklet) and ask:  
**The following questions are about your practice revenue and contracts with managed care plans.**

<b>41. Roughly, what percent of your patient care revenue comes from –</b>	Percent of patient care revenue ↴
<b>(1) Medicare?</b> .....	<input type="text"/> %
<b>(2) Medicaid?</b> .....	<input type="text"/> %
<b>(3) Private insurance?</b> .....	<input type="text"/> %
<b>(4) Patient payments?</b> .....	<input type="text"/> %
<b>(5) Other?</b> – (including charity, research, Tricare, VA, etc.) .....	<input type="text"/> %
	<b>FR NOTE</b> – Categories should sum close to 100%. Do not leave blank or use dash to indicate 0 percent, include value.
<b>42. Roughly, what percentage of the patient care revenue received by this practice comes from managed care contracts?</b>	Percent of revenue from managed care ↴ <input type="text"/> %

**Section II INDUCTION INTERVIEW - Continued**

**43.** Give FLASHCARD E (p.19 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.

**44a.** Are you currently accepting "new" patients into your practice(s) (at in-scope locations)?

- 1  Yes - Go to 44b  
 2  No  
 3  Don't know } SKIP to item 45

**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 |

**45.** 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

**46.** 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 (X) 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

**47a.** 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**

**49. 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 17a.

Office No.	Location (Enter street name)	Name	Position
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			

**NOTE –** We will review some of the questions found on the Patient Record form. Go to page 20 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 18e) with the "Days physician will see patients that week" line (based on the entry in ITEM 18a).

**TAKE EVERY NUMBER**

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

**Take Every Number**





**Section III NONINTERVIEW**

**51.** 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 53a*
- 2  Non-office based
- 3  Sees no ambulatory patients
- 4  Retired
- 5  Deceased
- 6  Temporarily not practicing – *SKIP to item 54*
- 7  Can't locate
- 8  Not licensed
- 9  Moved out of U.S.A.
- 10  Other out-of-scope – *Go to item 52*
- 11  Unavailable during reporting period – *SKIP to item 54 on page 22*
- 12  Moved out of PSU – *SKIP to item 55a on page 22*

**52.** 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 58 on page 24*

**53a.** 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**

**54.** Why is provider unavailable or not in practice?

SKIP to  
item 58 on  
page 24

**55a.** 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  
58 on  
page 24

**NOTES**

INFORMATIONAL COPY  
Not to be used as a data collection tool



**Section IV DISPOSITION AND SUMMARY**

**58. FINAL DISPOSITION**

**(a) Eligible physician/provider**

- 1  **Completed Patient Record forms** →
- 2  **Out-of-scope** (Item 51, codes 2, 3, 4, 5, 6, 8, 9, or 10)
- 3  **Refused-Breakoff** (Item 51, code 1)
- 4  **Unavailable during reporting period** (Item 51, code 11)
- 5  **Moved out of PSU** (Item 51, code 12-final)
- 6  **Can't locate** (Item 51, code 7)

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

**(b) Transfer cases**

- Moved out of PSU** (Item 51, code 12-pending)

**59. 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** .....

Edit

Edit

Notes

Notes section with multiple horizontal lines for text entry.