



















**Section II – INDUCTION INTERVIEW – Continued**

		Office Location	#1	#2	#3	#4
<b>18d. Is this a single- or multi-specialty (group) practice</b> (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"/>
<b>e. Are you a full- or part-owner, employee, or an independent contractor</b> (at this/that in-scope location)? <i>If "Owner" is marked then automatically mark "Physician or physician group" in item 18f.</i>	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. Who owns the practice</b> (at this/that in-scope location)?  <b>REFER TO FLASHCARD B.</b>	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"/>
	<b>g. Does your practice have the ability to perform any of the following on site</b> (at this/that in-scope location)?  <b>REFER TO FLASHCARD C.</b>	CT scan	Yes	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"/>
DK			3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Chemotherapy		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"/>
		DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Colonoscopy		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"/>
		DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
EKG/ECG		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"/>
		DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Lab testing		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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
Mammography	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
MRI	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
PET scan	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
Radiation therapy	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
Sigmoidoscopy	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
Spirometry	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
Ultrasound	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
X-Ray	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"/>	
	DK	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	



**Section II – INDUCTION INTERVIEW – Continued**

**23. Are there any of the above features of your system that you do NOT use or have turned off?**

1  Yes – *Please specify* ↘

**FR NOTE** – Indicate in item 22b, last column, any component(s) turned off.

2  No  
3  Unknown

**24. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?**

1  Yes  
2  No  
3  Maybe  
4  Unknown

*Ask items 25–28 ONCE for ALL in-scope locations.*

**I would like to ask a few questions about your practice revenue and contracts with managed care plans.**

**25a. Roughly, what percent of your patient care revenue comes from –**

**(1) Medicare?**.....

**(2) Medicaid?**.....

**(3) Private insurance?** .....

**(4) Patient payments?** .....

**(5) Other?** –(including charity, research, CHAMPUS, VA, etc.)

Percent of patient care revenue ↘

%

%

%

%

%

**REFER TO FLASHCARD D.**

**FR NOTE** – Categories should sum close to 100%.

**b. Roughly, how many managed care contracts does this practice have such as HMOs, PPOs, IPAs, and point-of-service plans?**

*If necessary read:* **Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan.**

**FR NOTE** – Include Medicare managed care and Medicaid managed care, but not traditional Medicare and Medicaid. Include any private insurance managed care plans. Be sure the response is about contracts and not patients.

Include all the different plans an insurance provider may have and for which the physician has a contract. For example, the physician may have a contract for each of the plans Aetna may offer: a PPO, IPA, and point-of-service plan. This would equal 3 contracts, not 1 contract. It may be necessary to obtain information from the billing office of the practice.

1  None – *SKIP to item 26a*  
2  Less than 3  
3  3 to 10  
4  More than 10

**c. Roughly, what percentage of the patient care revenue received by this practice comes from (these) managed care contracts?**

Percent of revenue from managed care ↘

%

Edit



**Section II - INDUCTION INTERVIEW - Continued**

30. On a 4-point scale from a lot of difficulty, some, little, or no difficulty, in the last 12 months, has your practice experienced any difficulty in referring patients with the following types of health insurance for specialty consultations?	A lot of difficulty	Some difficulty	Little difficulty	No difficulty	Don't know	Not Applicable
(a) Medicaid .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
(b) Medicare .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
(c) Private insurance .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
(d) Uninsured .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

**31. Do you offer any type of cervical cancer screening?**

1  Yes – Leave a NAMCS-CCS if physician's specialty is GFP, IM, OB/GYN, or provider works at a Community Health Center. Please specify e-mail address.

2  No

3  Don't know

**CHECK ITEM C** Is provider part of the community health center sample?

1  Yes – Ask item 32

2  No – SKIP to FR INSTRUCTION on page 15

**32. Provider demographics -**

**a. What is your year of birth?**

**b. What is your sex?**

1  Male

2  Female

**c. What is your ethnicity?**

1  Hispanic or Latino

2  Not Hispanic or Latino

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

1  White

2  Black/African-American

3  Asian

4  Native Hawaiian/Other Pacific Islander

5  American Indian/Alaska Native

**e. What is your highest medical degree?**

1  MD } Ask items 32f

2  DO }

3  Nurse practitioner } SKIP to FR INSTRUCTION on page 15.

4  Physician assistant }

5  Nurse midwife }

6  Other }

**REFER TO FLASHCARD F.**

**f. What is your primary specialty?**

Name of specialty Code

**g. What is your secondary specialty?**

Name of specialty Code

**h. What is your primary board certification?**

Board certification Code



















