

Section II INDUCTION INTERVIEW – Continued

Office Location		#1	#2	#3	#4	
18d. 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)? <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"/>	
f. Give FLASHCARD B (p.16 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. Give FLASHCARD C (p.17 Flashcard Booklet) and ask: Does your practice have the ability to perform any of the following on site (at this/that in-scope location)?	CT 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"/>
	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

22. 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 21b, last column, any component(s) turned off.

2 No
3 Unknown

23. 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

Give FLASHCARD D (p.18 Flashcard Booklet) and 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.

24a. 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 ↘

%

%

%

%

%

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

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 25a*
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

<p>29a. Roughly, what percent of your daily visits are same day appointments?</p>	<p><input type="text"/> %</p>
<p>b. Does your practice set time aside for same day appointments?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>
<p>c. On average, about how long does it take to get an appointment for a routine medical exam?</p>	<p>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</p>
<p><i>Item 30 should only be asked of GFP, IM, PD, OB/GYN, physicians and all providers at community health centers. Otherwise SKIP to item 31.</i></p>	
<p>30a. Does your practice currently recommend the Human Papillomavirus (HPV) vaccine?</p>	<p>1 <input type="checkbox"/> Yes – <i>SKIP to item 30c</i> 2 <input type="checkbox"/> No – <i>Go to item 30b</i></p>
<p>b. Does your practice plan on recommending the HPV vaccine?</p>	<p>1 <input type="checkbox"/> Yes – <i>Go to item 30c</i> 2 <input type="checkbox"/> No – <i>SKIP to item 30e</i></p>
<p>c. Which HPV vaccine does your practice recommend using?</p>	<p>1 <input type="checkbox"/> Gardasil (quadrivalent vaccine) 2 <input type="checkbox"/> Cervarix (bivalent vaccine) 3 <input type="checkbox"/> Both 4 <input type="checkbox"/> Don't know</p>
<p>d. What age group(s) does your practice recommend patients get the HPV vaccine? <i>Mark (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> Females 9–12 years of age 2 <input type="checkbox"/> Females 13–26 years of age 3 <input type="checkbox"/> Females 27 years of age and older 4 <input type="checkbox"/> Males 9–12 years of age 5 <input type="checkbox"/> Males 13–26 years of age 6 <input type="checkbox"/> Males 27 years of age and older</p> <p align="right">} <i>SKIP to item 31</i></p>
<p><i>Give FLASHCARD F (p.20 Flashcard Booklet) and ask:</i></p>	
<p>e. Please indicate the reason(s) why your practice does NOT plan on recommending the HPV vaccine. <i>Mark (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> Not a large proportion of recommended age group in my practice 2 <input type="checkbox"/> Concern that it encourages sexual promiscuity 3 <input type="checkbox"/> Not wanting to convince parents/patients to accept vaccine 4 <input type="checkbox"/> Awkwardness of conversation that HPV is sexually transmitted 5 <input type="checkbox"/> Concern about safety of the vaccine 6 <input type="checkbox"/> Concern about failure of vaccine to prevent all cervical cancer 7 <input type="checkbox"/> Concern about thiomersal in vaccine 8 <input type="checkbox"/> Concern about decreased efficiency in a population that has been exposed to HPV (i.e., sexually active) 9 <input type="checkbox"/> Concern that the office schedule is too crowded to accommodate additional visits 10 <input type="checkbox"/> Insurance reimbursement issues 11 <input type="checkbox"/> Up-front costs to purchase vaccine 12 <input type="checkbox"/> Concern regarding the storage and administration protocol of vaccine 13 <input type="checkbox"/> Other – <i>Specify</i> <input type="text"/></p>
<p><i>Ask of all physicians/providers</i></p>	
<p>31. Do you offer any type of cervical cancer screening?</p>	<p>1 <input type="checkbox"/> Yes – <i>Leave a NAMCS-CCS only if physician's speciality is GFP, IM, OB/GYN or provider works at a community health center. Please specify e-mail address</i> <input type="text"/> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>
<p>CHECK ITEM C Is provider part of the community health center sample? 1 <input type="checkbox"/> Yes – <i>Ask item 32</i> 2 <input type="checkbox"/> No – <i>SKIP to FR INSTRUCTION on page 15</i></p>	

Section II INDUCTION INTERVIEW - Continued

33b. 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 16a.

Office No.	Location (Enter street name)	Name	Position
1	RECORD ON CONTROL CARD		
2	RECORD ON CONTROL CARD		
3	RECORD ON CONTROL CARD		
4	RECORD ON CONTROL CARD		

FR NOTE –Explain to the physician and to anyone helping the physician that you would like to review some of the questions found on the Patient Record form. Go to page 17.

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 Take Every (**TE**) and Start With (**SW**) numbers follow these instructions. Read down the "Estimated visits for week" column to the line that corresponds to the total entry in **ITEM 17e**. Then, read across the "Days physician will see patients that week" line to the column that corresponds to the entry in **ITEM 17a**. Circle the appropriate number. This number is the physician's Take Every number for all office locations. Then transcribe this number below, and onto the front of the folio, and to the Patient Visit Worksheet if it is used.

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

INSTRUCTIONS – Continued

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 patient has cancer, indicate stage. If none of the conditions listed apply, then mark "None of the above."

Items 5c, Enrollment in Disease Management Program – Indicate the status of enrollment in a disease management program for any of the conditions listed in 5b. A disease management program is designed to improve a patient's health by working more directly with them and their physicians on their treatment plans regarding diet, adherence to medicine schedules and other self-management techniques.

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 12, Visit Disposition – "No show" and "Left without being seen" should only be marked in those cases when the patient was scheduled to see the sampled physician/CHC provider and the PRF was completed ahead of time, but for one of the two reasons the visit did not take place. Optimally, visits that fall into these categories should not be sampled.

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.

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

34a. CLOSING STATEMENT

Thank you for your time and cooperation Dr. . . . I will call you on Monday, _____ to see if (everything is all right/your plans have changed). If you have any questions (Hand doctor your business card) please feel free to call me. My telephone number is also written in the folio.

FR INSTRUCTION

If applicable, complete Sections III through V before returning completed materials to office.

34b. CLOSING STATEMENT

Thank you for your time and cooperation Dr. . . . The information you provided will improve the accuracy of the NAMCS in describing office-based patient care in the United States.

FR INSTRUCTION

Complete Sections III through IV before returning completed materials to office.

Section III NONINTERVIEW - Continued

38. Why is provider unavailable or not in practice?

*SKIP to
item 40 on
page 21*

39a. What is the provider's new address?

Number and street

RECORD ON CONTROL CARD

City, State, ZIP Code

RECORD ON CONTROL CARD

Telephone

RECORD ON CONTROL CARD

b. Name of Field Representative

RO

PSU

Date transferred

RECORD ON CONTROL CARD

*Continue
with item
40 on
page 21*

NOTES

Section V PATIENT RECORD FORM CHECK

CHECK ITEM D

1. Who answered the questions in the Physician Induction Interview?

Mark (X) all that apply.

- 1 Sampled provider
2 Office staff

3 Other – *Specify* ↗

2. Who completed the Patient Record forms?

Mark (X) all that apply.

- 1 Sampled provider
2 Office staff
3 FR – abstraction

4 Other – *Specify* ↗

3. Did the sampled provider accept the Data Use Agreement?

- 1 Yes
2 No

4. If the FR abstracted the PRFs, were the Accounting Documents placed in each of the medical records used for abstraction?

- 1 Yes
2 No – *Explain* ↗

5. Did sampled provider (or staff) request to see the IRB approval?

- 1 Yes
2 No

43. Verify that all items on the Patient Record form check have been answered. DO NOT call the sampled provider regarding missing information on Patient Record form unless instructed by your supervisor or the FR Manual.

Mark (X) when completed

Field Representative check list (a)	Office check list (b)
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a. Check for missing Patient Record forms (e.g., if the last completed Patient Record is number 1500051, do you have 1500001 through 1500050). *List missing Patient Record forms in Section VI, Part I of chart.*

b. Item 1a – Date of visit recorded on each Patient Record form – If missing, complete 1 and 2 below.

(1) Determine date of visit by referring to Patient Record forms immediately before and after. For example, if 1550087 through 1550092 are dated "1/12/2007" and the date on 1550088 is missing, enter "1/12/2007" in item 1a.

(2) If the exact date of the patient visit cannot be determined, estimate the date and enter "EST" next to the entry.

c. Items 1–13 –Verify that each of these items has been answered on the Patient Record form. List missing information in Section VI, Part 3 of chart on page 24.

d. Check the sample provider’s office schedule against the dates on the Patient Record forms for **survey week days with no completed Patient Record forms**. Do the **dates** on the Patient Record forms include **every day** during the survey week that the sample provider’s office scheduled appointments?

- Yes No –*List missing days in Section VI, Part 2 of chart on page 24.*

NOTES

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

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)

45. Was provider/office staff contacted for any reason during the editing process?
 Yes No

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

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

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

NOTES