OMB No. 0920-0234: Approval expires 08/31/2009

1. Physician's address:

FORM **NAMCS-1**
(11-15-2006)

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 2007 PANEL

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

Office 1	Telephone	
	FAX	
Office 2	Telephone	
	FAX	

3. Field Representative information

Telephone screener	Code
Induction interview	Code

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

4. Record of telephone calls

Call	Date	Time	Results
1			
2			
3			
4			
5			
6			
7			

FR INSTRUCTION *If interview is with a CHC provider, start with Section II on page 7, but remember to complete the office hours on page 5. If CHC provider refuses to complete the survey, obtain answers to item 13 in Section I, on page 6.*

5a. Has the physician moved out of the United States?

1 ☐ Yes – *SKIP to CHECK ITEM A on page 6*
2 ☐ No

b. Is the physician retired or deceased?

1 ☐ Yes – *SKIP to CHECK ITEM A on page 6*
2 ☐ No

6. Introduction

Hello, Dr. _____ , I am *(Your name)***. I'm calling for the Centers for Disease Control and Prevention regarding their study of ambulatory care. You should have received a letter from the Director of the National Center for Health Statistics, explaining the study.** *(Pause)* **You've probably also received a letter from the Census Bureau. We are acting as data collection agents for the study.**

IF DOCTOR DOES NOT REMEMBER NCHS LETTER; THE LETTER STATES:

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 one-page questionnaire on a sample of about 30 patient encounters during a randomly assigned one-week reporting period. Additionally, there is a short interview (approximately 30 minutes) with you about the nature of your practice. Participation is voluntary. 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 www.cdc.gov/namcs. We greatly appreciate your cooperation.

Section I TELEPHONE SCREENER Continued

7. Specialty

a. Your specialty is _____, is that right?

1 ☐ Yes – *SKIP to item 8*
2 ☐ No

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

(Name of specialty)

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

FR INSTRUCTION *Do not classify cases solely on the basis of specialty. Complete all items on the NAMCS-1 and have the physician fill out PRFs if appropriate.*

8. 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*

9a. Do you directly care for any ambulatory patients in your work?

1 Yes – *SKIP to item 9c*
2 No – does not give direct care *[9b PROBE]*
3 ☐ No longer in practice – *SKIP to item 11 on page 4*

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

1 ☐ Yes, cares for ambulatory patients
2 ☐ No, does not give direct care –*Determine reason, then read item 11 on page 4*

c. Are you employed by the Federal Government or do you work in a hospital emergency or outpatient department?

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

d. In addition to working in any of these settings, do you also see any ambulatory patients?

1 ☐ Yes
2 ☐ No – *SKIP to item 11 on page 4*

If "Yes" to item 9d, all of the following questions are concerned with the private patients.

Section I TELEPHONE SCREENER Continued

10a. **We have your address as** *(Read address shown in item 1).* **Is that the correct address for your office?**

1 ☐ Yes – *SKIP to item 12*
2 ☐ No, incorrect address – *Ask item 10b*

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

Number and street

City

Telephone *(Area code and number)*

SKIP to item 12

11. **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 6.)*

12. **I would like to arrange an appointment with you within the next week or so to discuss the study. It will take about 15 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.

Verify office location, if appropriate:

☐ Physician refused to participate –*Go to the top of page 6.*

Thank you, Dr. _____ . I'll see you then. *(Go to Check Item A on the bottom of page 6.)*

NOTES

FR, PLEASE READ **BEFORE** CONTINUING

FR Instruction – *If you have made it to this point, it appears the physician will be cooperative. Please remember to show the physician the Data Use Agreement and remind them they need to keep this document for six years. If the physician or their staff are unwilling to complete the Patient Record forms themselves and request you to abstract the information, please remember that an Accounting Document must be placed in each of the medical records from which information has been abstracted. This document must also be kept for six years. If necessary, please show the physician the IRB approval.*

PROVIDER'S OFFICE SCHEDULE

FR 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.

13a. At how many different office locations do you see ambulatory patients?

Number of office locations ↙

_____

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

Number of weeks ↙

_____

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

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

1 ☐ Yes – *SKIP to item 13e.*
2 ☐ *No – Please explain* ↙

_____ } *SKIP to item 13e*

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

1 ☐ Yes
2 ☐ No – *Please explain* ↙

_____

e. During your last normal week of practice how many patient visits did you have at all office locations?

Number of patient visits ↙

_____

f. At the office location where you see the most ambulatory patients:

(1) How many physicians are associated with you?

Number of physicians ↙

_____

If number of other physicians is 0, SKIP to item 13f(3).

(2) Is this a single- or multi-specialty group practice?

1 ☐ Multi-specialty practice
2 ☐ Single-specialty practice

(3) Are you a full- or part-owner, employee, or an independent contractor?

1 ☐ Owner – *Automatically mark "Physician or physician group" in item 13f(4)*
2 ☐ Employee
3 ☐ Contractor

(4) Who owns the practice?

REFER TO FLASHCARD B.

1 ☐ Physician or physician group
2 ☐ HMO
3 ☐ Community Health Center
4 ☐ Medical/Academic health center
5 ☐ Other hospital
6 ☐ Other health care corporation
7 ☐ Other – *Specify* ↙

_____

Final outcome of screening

1 ☐ Appointment MADE or Physician unavailable during reporting period –*Go to Section II, page 7*
2 ☐ Inscope, but REFUSED –*Complete item 13, then go to Section III, page 19*
3 ☐ Out-of-Scope/Other –*Go to Section III, page 19*

CHECK ITEM A MUST BE COMPLETED BEFORE CONTINUING

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.

14a. Overall, at how many office locations do you see ambulatory patients?

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 14c.
If = 0, SKIP to item 14d.
If 1 to 26 weeks, SKIP to item 15a.

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

1 ☐ Yes – *SKIP to item 15a*
2 ☐ *No – Please explain* ↙

_____ } *SKIP to item 15a*

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

1 ☐ Yes
2 ☐ No – *Please explain* ↙

_____

15a. 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, mark "Yes.")

1 ☐ Yes –*SKIP to item 16a on page 8*
2 ☐ No

b. Why is that? *Record verbatim.*

_____

c. Since it's very important that we include any ambulatory patients that you might see in your office during that week, I'll leave forms with you – just in case your plans change. I'll check back with your office just before *(Starting date)* **to make sure, and if necessary I can explain them in detail then.**

Give the doctor the folio and enter the folio number on page 17. Then continue with item 16a on page 8.

FR, PLEASE READ **BEFORE** CONTINUING

FR Instruction – *Even if the physician is not available during the reporting week, continue with item 16a on page 8.*

Section II INDUCTION INTERVIEW – Continued

16a. **At what office location(s) will you see ambulatory patients during your practice's 7-day reporting period Monday, _____ through Sunday, _____ ?**

PROBE: **Are there any other office locations at which you will see ambulatory patients during that 7-day report period?**

NOTE – NON-PARTICIPATING PHYSICIANS: If refusal (Final=3) or unavailable (Final=4), record locations where ambulatory patients are normally seen.

16b. *Give FLASHCARD A (p. 14 Flashcard Booklet) and ask* ***Looking at this list, choose ALL of the type(s) of settings that describe each location where you work.*** *For each location mark all setting types that apply. For each location also mark the appropriate "scope" status. If any even numbered settings are marked, then mark location as out-of-scope.*

If FLASHCARD number 3 (free-standing clinic/urgicenter) is marked, 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 – *Mark out-of-scope.)*

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

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

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

Edit

Office No.	Office locations *(Enter street address)*	Circle FLASHCARD number	Mark (X) In-scope	Mark (X) Out-of-scope
1		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
2		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
3		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐
4		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	1 ☐	2 ☐

FLASHCARD A

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

16c. **Are there other locations where you NORMALLY would see patients, even though you will not see any during your 7-day reporting period?**

1 ☐ Yes – *SKIP to item 16d*
2 ☐ No – *SKIP to item 17a on page 9*

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

1 ☐ All locations listed in 16a are out-of-scope – *Read CLOSING STATEMENT below*
2 ☐ All/Some locations listed in 16a are in-scope – *Go to item 17a*

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 19–21.)*

Section II INDUCTION INTERVIEW – Continued

Ask item 17a ONCE to obtain total for ALL in-scope locations.

17a. 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. Edit **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 16a.*

	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. Edit

	Number of visits				
		#1	#2	#3	#4
		_____	_____	_____	_____

c. During the week of Monday, _____ through Sunday _____, do you expect to see 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: Mark (X) response. If answer is "Yes", transcribe the number in 17b to 17d for that office location. If answere is "No" then ASK item 17d for that office location.

	#1	#2	#3	#4
Yes . .	1 ☐	1 ☐	1 ☐	1 ☐
No . . .	2 ☐	2 ☐	2 ☐	2 ☐

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

	Number of visits			
	#1	#2	#3	#4
	_____	_____	_____	_____

e. Tally of estimated number of visits

NOTE: To obtain the total number of estimated visits add the estimate for each office location in 17d.

Number of visits → _____

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

Office Location	#1	#2	#3	#4
18a. 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)**?**				
Solo	1 ☐	1 ☐	1 ☐	1 ☐
Nonsolo	2 ☐	2 ☐	2 ☐	2 ☐
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 ☐	1 ☐	1 ☐	1 ☐
Single	2 ☐	2 ☐	2 ☐	2 ☐

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 →				
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 18f.*	Owner	1 ☐	1 ☐	1 ☐	1 ☐
		Employee	2 ☐	2 ☐	2 ☐	2 ☐
		Contractor	3 ☐	3 ☐	3 ☐	3 ☐
f.	**Who owns the practice** (at this/that in-scope location)**?**	Physician or physician group . . .	1 ☐	1 ☐	1 ☐	1 ☐
		HMO	2 ☐	2 ☐	2 ☐	2 ☐
		Community Health Center	3 ☐	3 ☐	3 ☐	3 ☐
	REFER TO FLASHCARD B.	Medical/ Academic health center	4 ☐	4 ☐	4 ☐	4 ☐
		Other hospital . . .	5 ☐	5 ☐	5 ☐	5 ☐
		Other health care corp	6 ☐	6 ☐	6 ☐	6 ☐
		Other	7 ☐	7 ☐	7 ☐	7 ☐
g.	**Does your practice have the ability to perform any of the following on site** (at this/that in-scope location)**?**	CT scan	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Chemotherapy	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
	REFER TO FLASHCARD C.	Colonoscopy	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		EKG/ECG	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Lab testing	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Mammography	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		MRI	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		PET scan	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Radiation therapy	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Sigmoidoscopy	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Spirometry	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		Ultrasound	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐
		X-Ray	Yes 1 ☐	1 ☐	1 ☐	1 ☐
			No 2 ☐	2 ☐	2 ☐	2 ☐
			DK 3 ☐	3 ☐	3 ☐	3 ☐

Section II INDUCTION INTERVIEW – Continued

18h. Do you see patients in the office during the evening or on weekends?

Office Location	#1	#2	#3	#4
	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK	1 ☐ Yes 2 ☐ No 3 ☐ DK

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

Number of encounters per week

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

20. Does your practice submit claims electronically (Electronic billing)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Don't know

21a. Does your practice use electronic MEDICAL RECORDS (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Don't know

b. Does your practice have a computerized system for –

	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Does this include patient problem lists?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are there warnings of drug interactions or contraindictions provided?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions set electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Viewing Lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are out of range levels highlighted?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing Imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are electronic images returned?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Do they include medical history and follow up notes?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐

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

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 –

Percent of patient care revenue ↙

(1) Medicare? _____ %

(2) Medicaid? _____ %

(3) Private insurance? _____ %

(4) Patient payments? _____ %

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

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.**

1 ☐ None – *SKIP to item 25a*

2 ☐ Less than 3

3 ☐ 3 to 10

4 ☐ More than 10

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.

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 ↙

_____ %

25a. **Which of the following factors are taken into account for your patient care compensation (e.g., base pay, bonuses, or withholds)?**

(1) Your productivity (e.g., number of cases seen per time period)?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(2) Patient satisfaction (e.g., results of patient surveys)?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(3) Quality of care (e.g., rates of preventive care services)?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(4) Practice profiling (patterns of using certain services, e.g., laboratory tests, imaging, referrals, etc.)?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know

If yes to any item in 25a, then ask item 25b. Otherwise, SKIP to item 26.

b. **Are performance measures on your practice available to the public?**

1 ☐ Yes
2 ☐ No
3 ☐ Don't know

26. **What percent of your patient care revenue is based on bonuses, returned witholds, or other performance-based payments?**

_____ %

27. **Roughly, what percent of your patient care revenue comes from each of the following methods of payment?**

Percent of patient care revenue ↙

(1) Usual, customary and reasonable fee-for-service?	_____ %
(2) Discounted fee for service?	_____ %
(3) Capitation?	_____ %
(4) Case rates (e.g., package pricing/episode of care)?	_____ %
(5) Other?	_____ %

REFER TO FLASHCARD E.

FR NOTE – Categories should sum close to 100%.

28a. **Are you currently accepting "new" patients into your practice(s)** (at in-scope locations)**?**

1 ☐ Yes
2 ☐ No – *SKIP to item 29*
3 ☐ Don't know – *SKIP to item 29*

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

(1) Private insurance –	
(a) Capitated?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(b) Non-capitated?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(2) Medicare?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(3) Medicaid?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(4) Workers compensation?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(5) Self-pay?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know
(6) No charge?	1 ☐ Yes 2 ☐ No 3 ☐ Don't know

Section II INDUCTION INTERVIEW – Continued

29a. 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 ☐ Within 1 week
2 ☐ 1–2 weeks
3 ☐ 3–4 weeks
4 ☐ 1–2 months
5 ☐ 3 or more months
6 ☐ Do not provide routine medical exams
7 ☐ Don't know

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.

30a. Does your practice currently recommend the new Human Papillomavirus (HPV) vaccine?

1 ☐ Yes – *SKIP to item 30c*
2 ☐ No – *Go to item 30b*

b. Does your practice plan on recommending the HPV vaccine?

1 ☐ Yes – *Go to item 30c*
2 ☐ No – *SKIP to item 30d*

c. What age group(s) does your practice recommend patients get the HPV vaccine?
Mark (X) all that apply.

1 ☐ Females 9–12 years of age
2 ☐ Females 13–26 years of age
3 ☐ Females 27 years of age and older
4 ☐ Males 9–12 years of age
5 ☐ Males 13–26 years of age
6 ☐ Males 27 years of age and older

} *SKIP to item 31*

d. Please indicate the reason(s) why your practice does NOT plan on recommending the HPV vaccine.
Mark (X) all that apply.

REFER TO FLASHCARD F.

1 ☐ Not a large proportion of recommended age group in my practice
2 ☐ Concern that it encourages sexual promiscuity
3 ☐ Not wanting to convince parents/patients to accept vaccine
4 ☐ Awkwardness of conversation that HPV is sexually transmitted
5 ☐ Concern about safety of the vaccine
6 ☐ Concern about failure of vaccine to prevent all cervical cancer
7 ☐ Concern about thiomersal in vaccine
8 ☐ Concern about decreased efficiacy in a population that has been exposed to HPV (i.e., sexually active)
9 ☐ Concern that the office schedule is too crowded to accommodate additional visits
10 ☐ Insurance reimbursement issues
11 ☐ Up-front costs to purchase vaccine
12 ☐ Concern regarding the storage and administration protocol of vaccine
13 ☐ Other – *Specify*

Ask of all physicians/providers

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

1 ☐ Yes – ***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

2 ☐ No
3 ☐ Don't know

Is provider part of the community health center sample?

1 ☐ Yes – *Ask item 32*
2 ☐ No – *SKIP to FR INSTRUCTION on page 15*

Section II INDUCTION INTERVIEW – Continued

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?

REFER TO FLASHCARD G.

1 ☐ MD
2 ☐ DO
} *Go to item 32f*

3 ☐ Nurse practitioner
4 ☐ Physician assistant
5 ☐ Nurse midwife
6 ☐ Other
} *SKIP to FR INSTRUCTION on page 15.*

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 ☐☐☐

i. What is your secondary board certification?

Board certification _____ Code ☐☐☐

j. What year did you graduate medical school?

☐☐☐☐ Year

k. Did you graduate from a foreign medical school?

1 ☐ Yes
2 ☐ No

FR INSTRUCTION *If physician unavailable during reporting period, SKIP to item 34b on page 18.*

33a. During the period Monday, _____ through Sunday, _____ will ANYONE be available to help you fill out the patient record forms for this study (at in-scope locations)**?**

1 ☐ Yes
2 ☐ No – *Go to page 16*

FR NOTE – Explain to the physician that you would like to review some of the questions found on the patient record form.

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			
2			
3			
4			

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

START WITH NUMBER

To determine the Start With (SW) number read down the "If Take Every Number is" column and find the Take Every Number. The number to the right is the Start With Number. Transcribe this number onto line at the right, and to the front of the folio, and to the Patient Visit Worksheet if it is used.

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

Start With Number _____

Office number	Edit	Folio Number	**OFFICE USE ONLY** Number of PRFs completed
1			
2			
3			
4			
Additional folio for Office #			

INSTRUCTIONS

GIVE THE PHYSICIAN A FOLIO AND A COPY OF THE SAMPLE PATIENT RECORD FORM (NAMCS-73), AND EXPLAIN HOW TO COMPLETE THE FORMS.

Cover following points —

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

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

(2) Show doctor instruction card in folio pocket and go over Patient Record item by item, paying particular attention to —

Item 2, Injury/Poisoning/Adverse Effect – If any part of this visit was related to an injury or poisoning or adverse effect of medical or surgical care or an adverse effect of medicinal drug, then mark the appropriate box. If this visit was not related to any of these, then mark the last option, "None of the above."

Item 3, Reason for Visit – To be recorded in patient's own words. We want the patient's own complaint here, not the physician's diagnosis. If the patient has no complaint, the physician should enter the reason for the visit.

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

35. 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

1 ☐ Refused/Breakoff –*SKIP to item 37a*
2 ☐ Non-office based
3 ☐ Sees no ambulatory patients
} *SKIP to item 36*
4 ☐ Retired
5 ☐ Deceased
} *SKIP to item 40 on page 21*
6 ☐ Temporarily not practicing –*SKIP to item 38 on page 20*
7 ☐ Can't locate
8 ☐ Not licensed
9 ☐ Moved out of U.S.A.
} *SKIP to item 40 on page 21*
10 ☐ Other out-of-scope –*SKIP to item 36*
11 ☐ Unavailable during reporting period –*SKIP to item 38 on page 20*
12 ☐ Moved out of PSU –*SKIP to item 39a on page 20*

36. 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 40 page 21*

37a. At what point in the interview did the refusal/break-off occur?

(Mark (X) one.)

1 ☐ During telephone screening
2 ☐ During induction interview
} *Make sure item 13 has been completed*
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?

(Mark (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 ☐☐☐☐

e. Conversion attempt result

1 ☐ No conversion attempt
2 ☐ Sampled provider refused
} *SKIP to item 40 on page 21*
3 ☐ Sampled provider agreed to see Field Representative – *Complete Section II*

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

City, State, ZIP Code

Telephone

b. Name of Field Representative

RO	PSU	Date transferred

Continue with item 40 on page 21

NOTES

Section IV DISPOSITION AND SUMMARY

40. FINAL DISPOSITION

(a) Eligible physician/provider

1 ☐ **Completed Patient Record forms** →

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

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

(b) Unused CHC NAMCS-1

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

(c) Transfer cases

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

41. CASE SUMMARY

1. Number of patient visits during reporting week . . . . . ☐☐☐

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

3. Number of patient record forms completed . . . . . ☐☐☐

NOTE – *For items 41(1) and 41(3), see FR instruction below.* ↙

☐☐

Item 41(1) – Accurate determination of "Number of patient visits during reporting week" is **EXTREMELY IMPORTANT**! This count is to include any days the provider may have skipped or not participated. This information may be obtained from either the office staff or from the PRF Folio cover.

Item 41(3) – If the number of Patient Record forms completed is less than 20 or greater than 40, then explain why in the NOTES section below.

Items 17e and 41(1) – If applicable, record explanation of why items 17e and 41(1) differ significantly and any other information regarding this case which may help to understand it at a later date.

42. Final disposition for Cervical Cancer Screening Supplement (CCS)

(a) Physician/Provider Eligible for the CCS

1 ☐ **Completed Paper**
2 ☐ **Completed Web**
3 ☐ **Refused**
4 ☐ **Does not perform screening**

(b) Other

5 ☐ **Physician/Provider is ineligible for the CCS (i.e., not a CHC provider or a physician with a specialty of GFP, IM, OB/GYN.)**
6 ☐ **Other –** *Specify (e.g., unable to locate)*

CCS web user ID: _____

CCS web password: _____

☐

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)
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.*		

Section VI MISSING INFORMATION CHART

Part 1 — Missing Patient Record Forms

44a. Enter 7-digit Patient Record number(s) for missing forms.

b. Contact provider regarding missing forms. Enter results of missing forms follow-up below:

☐ Forms/information obtained
☐ Forms/information not obtained – *Explain why*

Section VI MISSING INFORMATION CHART – Continued

Part 2 — Missing Days or Blocks of Time

*List day(s) and blocks of time not reported, and check with the provider's office for the reason. (If patients were seen during day(s)/hours not reported, arrange to obtain missing data. If not possible to obtain missing data, ask for the **number of patients** seen during day(s)/hours not reported.)*

Not reported		Reason	Will physician's office provide missing data? *(Mark X)* (d)		Number of patients seen
Day(s) (a)	Blocks of time (b)	(c)	Yes	No	(e)

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