Attachment 4
Data Collection Instruments

Form Approval
OMB No. 0925-XXXX
Expires XX/XX/XX

PHYSICIAN SURVEY OF PRACTICES ON DIET, PHYSICAL ACTIVITY, AND WEIGHT CONTROL:

ADULT QUESTIONNAIRE

Conducted by:

NATIONAL® CANCER INSTITUTE

National Institute of Diabetes & Digestive & Kidney Diseases

Office of Behavioral & Social Sciences Research

National Institute of Child Health and Human Development (NICHD)

CDC Department of Health and Human Services Centers for Disease Control and Prevention

INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control – *Adult Questionnaire* is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases, and the Centers for Disease Control and Prevention. It is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians. Your name and contact information were provided to us by the American Medical Association.

This survey asks about the evaluation and guidance you provide to your patients about diet, weight, and physical activity.

The information you provide will remain confidential to the fullest extent of the law. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

INSTRUCTIONS

- **When you answer, include ALL the patients you treat in the age range specified.**
- **Answer the questions regarding your main primary care practice location (i.e., the practice setting where you spend the most hours per week, at which the majority of your patients are seen.)**
- **Use an X or check mark in the box to indicate your answers.**
- **Use the line provided in "Other (specify): _____" if your answer is not adequately represented by available choices**

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

SECTION A: PATIENT POPULATIONS TREATED

A1. Please indicate the patient population(s) you treat. **CHECK ONE IN EACH ROW**

	YES	NO
a. Do you see infants, < 2 years?	☐	☐
b. Do you see children 2-11 years?	☐	☐
c. Do you see adolescents 12-17 years?	☐	☐
d. Do you see adults 18-65 years?	☐	☐
e. Do you see older adults 65+ years?	☐	☐

THOUGH YOU MAY TREAT A WIDE RANGE OF PATIENTS, THE FOLLOWING QUESTIONS FOCUS ON ADULT POPULATIONS YOU TREAT, AGE 18 YEARS AND OLDER.

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

The next questions are about practices involving adult patients 18 years and older.

A2. During routine well-patient physical exams of your adult (18 years and older) patients:

		CHECK ONE IN EACH ROW				
		NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a.	How often do you assess diet, or physical activity?	☐	☐	☐	☐	☐
b.	As a general policy, for your entire adult patient population, how often do you promote:					
	Healthy Diet / Nutrition	☐	☐	☐	☐	☐
	Physical Activity	☐	☐	☐	☐	☐

A3. For your adult patients WITHOUT weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight:

How often do you…:		CHECK ONE IN EACH ROW				
		NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a.	Provide general counseling for changing diet, physical activity, or weight?	☐	☐	☐	☐	☐
b.	Provide specific guidance on:	☐	☐	☐	☐	☐
	Diet/Nutrition (e.g. “Eat more fruits and vegetables” or “Increase your calcium”)?	☐	☐	☐	☐	☐
	Physical Activity (e.g. “Increase your exercise by walking daily”)?	☐	☐	☐	☐	☐
	Weight Control (e.g. “Lose X lbs by cutting calories and exercising”)?	☐	☐	☐	☐	☐
c.	Refer these patients to another health professional or program outside of your practice for further evaluation and/or management?	☐	☐	☐	☐	☐
d.	Systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	☐	☐	☐	☐	☐

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

A4. For your adult patients WITH weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight:

How often do you…:

		CHECK ONE IN EACH ROW				
		NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a.	Provide general counseling for changing diet, physical activity, or weight?	☐	☐	☐	☐	☐
b.	Provide specific guidance on:	☐	☐	☐	☐	☐
	Diet/Nutrition (e.g. "Eat more fruits and vegetables" or "Increase your calcium")?	☐	☐	☐	☐	☐
	Physical Activity (e.g. "Increase your exercise by walking daily")?	☐	☐	☐	☐	☐
	Weight Control (e.g. "Lose X lbs by cutting calories and exercising")?	☐	☐	☐	☐	☐
c.	Refer these patients to another health professional or program outside of your practice for further evaluation and/or management?	☐	☐	☐	☐	☐
d.	Systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	☐	☐	☐	☐	☐

A5. If you assess diet, HOW do you assess it?

☐ Not applicable. I do not assess diet. **GO TO A6.**

		CHECK ONE IN EACH ROW	
		YES	NO
a.	General questions about food groups (e.g., fruits and vegetables)	☐	☐
b.	General questions about dietary patterns (e.g., fast food)	☐	☐
c.	Specific questions about diet components (e.g., calcium, protein)	☐	☐
d.	Standardized diet questionnaire	☐	☐
e.	Other (Please specify) _____	☐	☐

A6. If you assess physical activity, HOW do you assess it?

☐ Not applicable. I do not assess physical activity. **GO TO A7.**

		CHECK ONE IN EACH ROW YES	NO
a.	General questions about amount of physical activity	☐	☐
b.	General questions about amount of sedentary activity (e.g. TV watching)	☐	☐
c.	Specific questions about duration, intensity, and type of physical activity	☐	☐
d.	Standardized physical activity questionnaire	☐	☐
e.	Other (Please specify) _____	☐	☐

A7. How often do you assess the following? CHECK ALL THAT APPLY

	Every well patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (specify)
a. Weight measured on a scale	☐	☐	☐	☐	☐	_____
b. Weight reported by the patient	☐	☐	☐	☐	☐	_____
c. Body mass Index (BMI)	☐	☐	☐	☐	☐	_____
d. Waist circumference	☐	☐	☐	☐	☐	_____
e. Height	☐	☐	☐	☐	☐	_____

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

A8. How often are the following tests utilized in your practice for <u>overweight/obese</u> adult patients?

CHECK ALL THAT APPLY

	Not Applicable (Do not utilize)	Every 2 years	Annually	Every 6 months	More than twice a year	Other (Specify):
a. <u>Random</u> blood glucose						
Patients **<u>with</u>** additional risk factors	☐	☐	☐	☐	☐	_____
Patients **<u>without</u>** additional risk factors	☐	☐	☐	☐	☐	_____
b. <u>Fasting</u> blood glucose						
Patients **<u>with</u>** additional risk factors	☐	☐	☐	☐	☐	_____
Patients **<u>without</u>** additional risk factors	☐	☐	☐	☐	☐	_____

A9. Have you ever, or are you currently…

CHECK <u>TWO</u> FOR EACH ROW

	EVER		CURRENTLY	
	Yes	No	Yes	No
a. Prescribing pharmacological treatments for weight control to any of your patients?	☐	☐	☐	☐
b. Referring any of your patients for surgical treatment for obesity?	☐	☐	☐	☐

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

A10. When you treat each of the following conditions, do you address diet/nutrition, physical activity or weight control?

		CHECK ALL THAT APPLY			
		Do Not Treat this Condition	**Diet**	**Physical Activity**	**Weight Control**
a.	Abnormal body weight/BMI	☐	☐	☐	☐
b.	Abnormal lipid profile	☐	☐	☐	☐
c.	Hypertension	☐	☐	☐	☐
d.	Eating disorders such as anorexia or bulimia	☐	☐	☐	☐
e.	Asthma	☐	☐	☐	☐
f.	Diabetes mellitus (Type II)	☐	☐	☐	☐
g.	Coronary heart disease	☐	☐	☐	☐
h.	Cancer	☐	☐	☐	☐
i.	Arthritis	☐	☐	☐	☐
j.	Sleep apnea	☐	☐	☐	☐
k.	Chronic obstructive lung disease	☐	☐	☐	☐
l.	Back pain/problems/injury	☐	☐	☐	☐
m.	Family history of diabetes mellitus	☐	☐	☐	☐
n.	Family history of heart disease	☐	☐	☐	☐
o.	Family history of cancer	☐	☐	☐	☐
p.	Other, specify:_____	☐	☐	☐	☐

SECTION B: BARRIERS TO PATIENT ASSESSMENT, EVALUATION, and MANAGEMENT

B1. Which of the following are the TOP 3 BARRIERS to evaluating and/or managing your patients' diet/nutrition, physical activity, and weight in your practice?

		CHECK THE TOP 3 BARRIERS
a.	Not enough time	☐
b.	Not part of my role	☐
c.	I am not adequately trained in this area	☐
d.	Too difficult to evaluate and manage	☐
e.	Inadequate reimbursement	☐
f.	Lack of adequate referral services for diet, physical activity and weight	☐
g.	Patients are not interested in improving their diet, physical activity, or weight levels	☐
h.	Fear of offending the patient	☐
i.	Too difficult for patients to change their behavior	☐
j.	Lack of effective tools and information to give to patients.	☐
k.	Lack of effective treatment options	☐
l.	Other (specify): _____	☐

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

B2. Relative to your current practice, what are the TOP 3 improvements that could assist you in reducing patients' health issues related to diet, physical activity, and weight?

CHECK THE TOP 3 IMPROVEMENTS

a.	Ways to more easily **identify** problems with diet, physical activity, and weight	☐
b.	Easy-to-understand patient management **guidelines**	☐
c.	Better **reimbursement** for counseling	☐
d.	Better **tools to communicate** diet, physical activity, or weight problems to patient or family	☐
e.	Better **counseling tools** to guide patients toward lifestyle modification	☐
f.	More **training** for your **staff** in evaluating and managing patient diet, physical activity, and weight	☐
g.	More **training** for **you** in evaluating and managing patient diet, physical activity, and weight	☐
h.	Better **information systems** to **document and track goals** in the medical record	☐
i.	Better **information systems** to identify appropriate **referral services**	☐
j.	Better mechanism to connect patient to specific referral services	☐
k.	Other (specify): _____	☐

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

PERSONAL BELIEFS

B3. Please indicate how strongly you agree with each of the following statements.

CHECK ONE IN EACH ROW

	Strongly Disagree	Disagree Somewhat	Neither Agree nor Disagree	Agree Somewhat	Strongly Agree
a. Physicians have a responsibility to promote the following with their patients:					
eat a healthy diet.	☐	☐	☐	☐	☐
be adequately physically active.	☐	☐	☐	☐	☐
maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
b. Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so.	☐	☐	☐	☐	☐
c. There are effective strategies and/or tools to help patients:					
eat a healthy diet.	☐	☐	☐	☐	☐
be adequately physically active.	☐	☐	☐	☐	☐
maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
d. I am confident in my ability to counsel my patients:					
eat a healthy diet.	☐	☐	☐	☐	☐
to be adequately physically active.	☐	☐	☐	☐	☐
maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
e. I am effective at helping my patients					
eat a healthy diet.	☐	☐	☐	☐	☐
be adequately physically active.	☐	☐	☐	☐	☐
maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
f. In order to effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself.	☐	☐	☐	☐	☐
g. Specifically, a physician will be able to provide more credible and effective counseling if he/she:					
eats a healthy diet.	☐	☐	☐	☐	☐
is adequately physically active.	☐	☐	☐	☐	☐
maintains a healthy weight or loses weight.	☐	☐	☐	☐	☐

B4. According to current guidelines, at what BMI level are adult patients (18 years or older) considered to be…

CHECK ONE IN EACH ROW

		≥ 20 kg/m^2	≥ 25 kg/m^2	≥ 30 kg/m^2	≥ 35 kg/m^2	Don't Know
a.	Overweight?	☐	☐	☐	☐	☐
b.	Obese?	☐	☐	☐	☐	☐

B5. According to current guidelines, in what BMI percentile range are children or adolescents (2-17 years) considered to have healthy weight? CHECK ONE

- ☐ 5th - 65th percentile
- ☐ 5th - 75th percentile
- ☐ 5th - 85th percentile
- ☐ 5th - 95th percentile
- ☐ Other, specify _____
- ☐ DON'T KNOW

B6. According to current guidelines, for adults, 18 and older, how much moderate physical activity is recommended (on most days of the week) for general health and prevention of chronic diseases? CHECK ONE

- ☐ 20 minutes
- ☐ 30 minutes
- ☐ 40 minutes
- ☐ 60 minutes
- ☐ 90 minutes
- ☐ Other, specify _____
- ☐ DON'T KNOW

B7. According to current guidelines, <u>for adults</u>, 18 and older, how many servings of fruits and vegetables should a person have in a day? CHECK <u>ONE</u>

- ☐ 3 servings
- ☐ 5 servings
- ☐ 7 servings
- ☐ It depends on daily calorie intake
- ☐ Other, specify _____
- ☐ DON'T KNOW

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

SECTION C: YOUR PERSONAL HEALTH STATUS / HEALTH BEHAVIORS

C1. In general, would you say your health is: **CHECK ONE**

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

C2. These questions are about the foods you ate or drank during the PAST MONTH, that is, the past 30 days. Please include meals and snacks eaten at home, at work or school, in restaurants, and any place else.

CHECK ONE IN EACH ROW

	Never	1-3 times last month	1-2 times per week	3-4 times per week	5-6 times per week	1 time per day	2 times per day	3 or more times per day	4 or more times per day	5 or more times per day
a. How often did you drink 100% FRUIT Juice, such as orange, mango, apple, or grape juices? Do NOT include fruit drinks	☐	☐	☐	☐	☐	☐	☐	☐		
b. How often did you eat FRUIT? INCLUDE fresh, frozen or canned fruit. Do NOT include juices.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. How often did you eat FRENCH FRIES, or home fries, or hash brown potatoes?	☐	☐	☐	☐	☐	☐	☐	☐		
d. How often did you eat other POTATOES? INCLUDE baked, boiled, mashed or potato salad.	☐	☐	☐	☐	☐	☐	☐	☐		
e. Not including potatoes (and not counting rice), how often did you eat OTHER VEGETABLES?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

Physical Activity

C3. Moderate physical activities make you breathe somewhat harder than normal. During the last 7 days, did you do any moderate physical activities for at least 10 minutes? Think about activities such as bicycling, swimming, brisk walking, dancing or gardening.

☐ NO ➔GO TO C4
☐ YES
↓

a. On how many of the past 7 days did you do moderate physical activities? *

|___| DAYS

b. In the past 7 days, on a typical day in which you did moderate physical activities, how much time did you spend doing them? *

|___|___|___| MINUTES PER DAY

C4. Vigorous activities make you breathe much harder than normal. Now think about vigorous activities you did that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming. During the last 7 days, did you do any vigorous physical activities in your free time for at least 10 minutes?

☐ NO ➔GO TO C5
☐ YES
↓

a. On how many of the past 7 days did you do vigorous physical activities?

|___| DAYS

b. In the past 7 days, on a typical day in which you did vigorous physical activities, how much time did you spend doing them?

|___|___|___| MINUTES PER DAY

C5. Now think about activities specifically designed to STRENGTHEN your muscles, such as lifting weights or other strength-building exercises. Include all such activities even if you have included them before. During the last 7 days, did you do activities to strengthen your muscles?

☐ NO ➔GO TO C6
☐ YES

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

Height and Weight Status

C6. How tall are you without shoes?

|___| FEET |___|___| INCHES

IF YOU ARE FEMALE AND CURRENTLY PREGNANT, GO TO C7a.
OTHERWISE GO TO C7.

C7. How much do you weigh without shoes?

|___|___|___| POUNDS

C7a. If you are currently pregnant, how much did you weigh before your pregnancy?

|___|___|___| POUNDS

C8. Are you currently trying to: CHECK ONE

- ☐ Lose weight
- ☐ Gain weight
- ☐ Maintain weight
- ☐ Not trying to make a change

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

PHYSICIAN CHARACTERISTICS

C9. When were you born?

| 1 | 9 | __ | __| YEAR

C10. Are you… CHECK ONE

- ☐ Female
- ☐ Male

C11. Do you consider yourself to be Hispanic or Latino/a? CHECK ONE

- ☐ YES
- ☐ NO

C12. What do you consider to be your race? CHECK ONE OR MORE

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

C13. During a typical month, approximately what percent of your professional time do you spend in the following activities?

		Percent of professional time
a.	Providing Primary Care	____ ____ **%**
b.	Providing Subspecialty Care Please specify: _____	____ ____ **%**
c.	Research	____ ____ **%**
d.	Teaching	____ ____ **%**
e.	Administration	____ ____ **%**
f.	Other *(specify)*: _____	____ ____ **%**
	TOTAL	**1 0 0 %**

Physician Survey of Practices on Diet, Physical Activity, and Weight Control: Adult Questionnaire

PRACTICE CHARACTERISTICS

C14. Which of the following categories best describes your main primary care practice location? Are you a…

		CHECK ALL THAT APPLY
a.	Full- or part-owner of a physician practice	☐
b.	Employee of a physician-owned practice	☐
c.	Employee of a large medical group or health care system	☐
d.	Employee of a staff or group model HMO	☐
e.	Employee of a university hospital or clinic	☐
f.	Employee of a hospital or clinic not associated with a university (including community health clinics)	☐
g.	Other (specify): _____	☐

C15. Please estimate the number of patient visits that you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled clinical activity):

|___|___|___| Number of Patient Visits

☐ DON'T KNOW

C16. Approximately what percentage of the patients you treat is female?

|___|___|___| %

☐ DON'T KNOW

C17. Approximately what percentage of the patients you treat is Hispanic or Latino?….(PLEASE GIVE YOUR BEST ESTIMATE)

		CHECK ONE
a.	0-5%	☐
b.	6-25%	☐
c.	26-50%	☐
d.	51-75%	☐
e.	76-100%	☐
f.	DON'T KNOW	☐

C18. Approximately what percentage of the patients you treat is….(PLEASE GIVE YOUR BEST ESTIMATE)

		PERCENTAGE OF PATIENTS
a.	White	___ ___ ___ %
b.	Black or African-American	___ ___ ___ %
c.	Asian	___ ___ ___ %
d.	Native Hawaiian or Other Pacific Islander	___ ___ ___ %
e.	American Indian or Alaska Native	___ ___ ___ %
	T O T A L	**1 0 0 %**

C19. Within a practice, there may be multiple clinical sites at which medical care is delivered.

	CHECK ONE	
Does this practice have more than one clinical site?	☐ YES	☐ NO

C20. About how many physicians, nurse practitioners, and physician assistants provide care in all of the clinical sites within this practice? CHECK ONE

- ☐ 1
- ☐ 2 – 5
- ☐ 6 – 20
- ☐ More than 20 and fewer than 100
- ☐ More than 100
- ☐ DON'T KNOW

C21. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?

CHECK ONE

- ☐ I prefer paper and pencil
- ☐ I prefer a web-based questionnaire
- ☐ I have no preference
- ☐ Other (please specify): _____

C22. We would like to obtain additional information about aspects of the practice that support disease prevention activities. However, we know your time is limited, so we'd like to send your office administrator a short questionnaire of about 20 questions related to the structure of your practice and the roles of different staff that work there. Please give us the name of your office administrator, or indicate whether it would be better for us to send the brief questionnaire to you.

Check one: ☐ **Dr.** ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

First Name: |___|___|___|___|___|___|___|

Last Name: |___|___|___|___|___|___|___|___|___|___|___|

☐ **The office administrator in my practice is less familiar with the clinical roles of my staff; I am the best person to answer questions about my practice.**

If you have any comments about the questionnaire, individual questions, or the burden, please make them here. We appreciate your participation and feedback.

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PHYSICIAN SURVEY OF PRACTICES ON DIET, PHYSICAL ACTIVITY, AND WEIGHT CONTROL

CHILD/ADOLESCENT QUESTIONNAIRE

Conducted by:

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National Institute of Diabetes & Digestive & Kidney Diseases

Office of Behavioral & Social Sciences Research

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CDC Department of Health and Human Services Centers for Disease Control and Prevention

INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control – Child/Adolescent Questionnaire is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases and the Centers for Disease Control and Prevention. It is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians. Your name and contact information were provided to us by the American Medical Association.

This survey asks about the evaluation and guidance you provide to your patients about diet, weight, and physical activity.

The information you provide will remain confidential to the fullest extent of the law. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

INSTRUCTIONS

- **When you answer, include ALL the patients you treat in the age range specified.**
- **Answer the questions regarding your main primary care practice location (i.e., the practice setting where you spend the most hours per week, at which the majority of your patients are seen.)**
- **Use an X or check mark in the box to indicate your answers.**
- **Use the line provided in "Other (specify): _____" if your answer is not adequately represented by available choices**

SECTION A: PATIENT POPULATIONS TREATED

A1. Please indicate the patient population(s) you treat. **CHECK ONE IN EACH ROW**

	YES	NO
a. Do you see infants, < 2 years?	☐	☐
b. Do you see children 2-11 years?	☐	☐
c. Do you see adolescents 12-17 years?	☐	☐
d. Do you see adults 18-65 years?	☐	☐
e. Do you see older adults 65+ years?	☐	☐

Though you may treat a wide range of patients, this survey focuses on your practices involving your child/adolescent patients (age 2-17).

The next questions are about practices involving child/adolescent patients (age 2-17).

A2. During routine well-patient physical exams of your child/adolescent patients (age 2-17):

		CHECK ONE IN EACH ROW				
		NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a.	How often do you assess diet, or physical activity?	☐	☐	☐	☐	☐
b.	As a general policy for your entire child/adolescent patient population, how often do you promote:					
	Healthy Diet / Nutrition?	☐	☐	☐	☐	☐
	Physical Activity?	☐	☐	☐	☐	☐

A3. For your child/adolescent patients who have unhealthy diet, are insufficiently active, are overweight, or are at risk for weight-related chronic disease:

		CHECK ONE IN EACH ROW				
		NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a.	How often do you provide general counseling for changing diet, physical activity, or weight?	☐	☐	☐	☐	☐
b.	How often do you provide specific guidance on:					
	Diet/Nutrition (e.g. “Eat more fruits and vegetables” or “Increase your calcium”)?	☐	☐	☐	☐	☐
	Physical Activity (e.g. “Increase your exercise by walking daily”)?	☐	☐	☐	☐	☐
	Weight Control (e.g. “Lose X lbs by cutting calories and exercising”)?	☐	☐	☐	☐	☐
c.	How often do you refer these patients to another health professional or program outside of your practice for further evaluation and/or management?	☐	☐	☐	☐	☐
d.	How often do you systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	☐	☐	☐	☐	☐

A4. When you assess <u>diet</u> in patients 2-17 years, HOW do you assess it?

☐ Not applicable. I do not assess diet. **GO TO A5**

		CHECK ONE IN EACH ROW YES	NO
a.	General questions about food groups (e.g., fruits and vegetables)	☐	☐
b.	General questions about dietary patterns (e.g., fast food)	☐	☐
c.	Specific questions about diet components (e.g., calcium, protein)	☐	☐
d.	Standardized diet questionnaire	☐	☐
e.	Other (Please specify) _____	☐	☐

A5. When you assess <u>physical activity</u> in patients 2-17 years, HOW do you assess it?

☐ Not applicable. I do not assess physical activity. **GO TO A6**

		CHECK ONE IN EACH ROW YES	NO
a.	General questions about amount of physical activity	☐	☐
b.	General questions about amount of sedentary activity (e.g. TV watching)	☐	☐
c.	Specific questions about duration, intensity, and type of physical activity	☐	☐
d.	Standardized physical activity questionnaire	☐	☐
e.	Other (Please specify) _____	☐	☐

A6. How often do you assess or review the following in <u>children or adolescents</u> (ages 2-17)?

CHECK <u>ALL</u> THAT APPLY

	Every well patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Specify)
a. Weight measured in office	☐	☐	☐	☐	☐	_____
b. Height measured in office	☐	☐	☐	☐	☐	_____
c. Body Mass Index	☐	☐	☐	☐	☐	_____
d. Waist circumference or waist-to-hip ratio	☐	☐	☐	☐	☐	_____
e. Weight-for-age growth charts	☐	☐	☐	☐	☐	_____
f. Stature-for-age growth charts	☐	☐	☐	☐	☐	_____
g. BMI-for-age growth chart	☐	☐	☐	☐	☐	_____

A7. How often do you assess or review the following in <u>infants</u> (ages <2)?

CHECK <u>ALL</u> THAT APPLY

	Every well patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Specify)
a. Weight measured in office	☐	☐	☐	☐	☐	_____
b. Length measured in office	☐	☐	☐	☐	☐	_____
c. Growth chart	☐	☐	☐	☐	☐	_____
d. Weight-for-length growth charts	☐	☐	☐	☐	☐	_____
e. Weight-for-age growth charts	☐	☐	☐	☐	☐	_____
f. Length-for-age growth chart	☐	☐	☐	☐	☐	_____

A8. For your overweight/obese child/adolescent patients (ages 2-17), at what age do you begin performing the following tests?

If you DO NOT perform these tests, please check "N/A".

	CHECK ONE IN EACH ROW	
	N/A	**Age in Years**
a **Random blood glucose testing**		
Patients **with** risk factors or family history	☐	_____
Patients **without** risk factors or family history	☐	_____
b **Fasting blood glucose testing**		
Patients **with** risk factors or family history	☐	_____
Patients **without** risk factors or family history	☐	_____

A9. How often are the following tests utilized in your practice for overweight/obese children/adolescent patients (ages 2-17)?

If you DO NOT perform these tests, please check "N/A".

	CHECK ALL THAT APPLY					
	N/A	**Every 2 years**	**Annually**	**Every 6 months**	**More than twice a year**	**Other (Specify):**
a. **Random blood glucose**						
Patients **with** additional risk factors	☐	☐	☐	☐	☐	_____
Patients **without** additional risk factors	☐	☐	☐	☐	☐	_____
b. **Fasting blood glucose**						
Patients **with** additional risk factors	☐	☐	☐	☐	☐	_____
Patients **without** additional risk factors	☐	☐	☐	☐	☐	_____

A10. When you treat each of the following conditions for your child/adolescent patients (ages 2-17), do you address diet/nutrition, physical activity or weight control?

		CHECK ALL THAT APPLY			
		Do Not Treat this Condition	**Diet**	**Physical Activity**	**Weight Control**
a.	Abnormal body weight/BMI	☐	☐	☐	☐
b.	Elevated blood pressure	☐	☐	☐	☐
c.	Abnormal lipid profile	☐	☐	☐	☐
d.	Eating disorders such as anorexia or bulimia	☐	☐	☐	☐
e.	Asthma	☐	☐	☐	☐
f.	Diabetes mellitus (Type II)	☐	☐	☐	☐
g.	Family history of diabetes mellitus	☐	☐	☐	☐
h.	Family history of heart disease	☐	☐	☐	☐
i.	Family history of cancer	☐	☐	☐	☐
j.	Other, specify:_____	☐	☐	☐	☐

SECTION B: BARRIERS TO PATIENT ASSESSMENT, EVALUATION, and MANAGEMENT

B1. Which of the following are the TOP 3 BARRIERS to evaluating and/or managing your patients' diet/nutrition, physical activity, and weight in your practice?

		CHECK THE TOP 3 BARRIERS
a.	Not enough time	☐
b.	Not part of my role	☐
c.	I am not adequately trained in this area	☐
d.	Too difficult to evaluate and manage	☐
e.	Inadequate reimbursement	☐
f.	Lack of adequate referral services for diet, physical activity and weight	☐
g.	Patients are not interested in improving their diet, physical activity, or weight levels	☐
h.	Fear of offending the patient	☐
i.	Too difficult for patients to change their behavior	☐
j.	Lack of effective tools and information to give to patients.	☐
k.	Lack of effective treatment options	☐
l.	Other (specify): _____	☐

B2. Relative to your current practice, what are the TOP 3 improvements that could assist you in reducing patients' health issues related to diet, physical activity, and weight?

CHECK THE TOP 3 IMPROVEMENTS

a.	Ways to more easily **identify** problems with diet, physical activity, and weight	☐
b.	Easy-to-understand patient management **guidelines**	☐
c.	Better **reimbursement** for counseling	☐
d.	Better **tools to communicate** diet, physical activity, or weight problems to patient or family	☐
e.	Better **counseling tools** to guide patients toward lifestyle modification	☐
f.	More **training** for your **staff** in evaluating and managing patient diet, physical activity, and weight	☐
g.	More **training** for **you** in evaluating and managing patient diet, physical activity, and weight	☐
h.	Better **information systems** to **document and track goals** in the medical record	☐
i.	Better **information systems** to identify appropriate **referral services**	☐
j.	Better mechanism to connect patient to specific referral services	☐
k.	Other (specify): _____	☐

PERSONAL BELIEFS

B3. Please indicate how strongly you agree with each of the following statements.

		CHECK ONE IN EACH ROW				
		Strongly Disagree	Disagree Somewhat	Neither Agree nor Disagree	Agree Somewhat	Strongly Agree
a.	**Physicians have a responsibility to promote the following with their patients:**					
	eat a healthy diet.	☐	☐	☐	☐	☐
	be adequately physically active.	☐	☐	☐	☐	☐
	maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
b.	**Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so.**	☐	☐	☐	☐	☐
c.	**There are effective strategies and/or tools to help patients:**					
	eat a healthy diet.	☐	☐	☐	☐	☐
	be adequately physically active.	☐	☐	☐	☐	☐
	maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
d.	**I am confident in my ability to counsel my patients:**					
	eat a healthy diet.	☐	☐	☐	☐	☐
	be adequately physically active.	☐	☐	☐	☐	☐
	maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
e.	**I am effective at helping my patients**					
	eat a healthy diet.	☐	☐	☐	☐	☐
	be adequately physically active.	☐	☐	☐	☐	☐
	maintain a healthy weight or lose weight.	☐	☐	☐	☐	☐
f.	**In order to effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself.**	☐	☐	☐	☐	☐
g.	**Specifically, a physician will be able to provide more credible and effective counseling if he/she:**					
	eats a healthy diet.	☐	☐	☐	☐	☐
	is adequately physically active.	☐	☐	☐	☐	☐
	maintains a healthy weight or loses weight.	☐	☐	☐	☐	☐

B4. According to current guidelines, at what BMI level are <u>adult</u> patients (18 years or older) considered to be…

CHECK <u>ONE</u> IN EACH ROW

		≥ 20 kg/m^2	≥ 25 kg/m^2	≥ 30 kg/m^2	≥ 35 kg/m^2	Don't Know
a.	Overweight?	☐	☐	☐	☐	☐
b.	Obese?	☐	☐	☐	☐	☐

B5. According to current guidelines, in what BMI percentile range are <u>children or adolescents</u> (2-17 years) considered to have <u>healthy</u> weight? CHECK <u>ONE</u>

- ☐ 5th - 65th percentile
- ☐ 5th - 75th percentile
- ☐ 5th - 85th percentile
- ☐ 5th - 95th percentile
- ☐ Other, specify _____
- ☐ DON'T KNOW

B6. According to current guidelines, <u>for adults</u>, 18 and older, how much moderate physical activity is recommended (on most days of the week) for general health and prevention of chronic diseases? CHECK <u>ONE</u>

- ☐ 20 minutes
- ☐ 30 minutes
- ☐ 40 minutes
- ☐ 60 minutes
- ☐ 90 minutes
- ☐ Other, specify _____
- ☐ DON'T KNOW

B7. According to current guidelines, <u>for adults</u>, 18 and older, how many servings of fruits and vegetables should a person have in a day? CHECK <u>ONE</u>

- ☐ 3 servings
- ☐ 5 servings
- ☐ 7 servings
- ☐ It depends on daily calorie intake
- ☐ Other, specify _____
- ☐ DON'T KNOW

SECTION C: YOUR PERSONAL HEALTH STATUS / HEALTH BEHAVIORS

C1. In general, would you say your health is: **CHECK ONE**

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

C2. These questions are about the foods you ate or drank during the PAST MONTH, that is, the past 30 days. Please include meals and snacks eaten at home, at work or school, in restaurants, and any place else.

CHECK ONE IN EACH ROW

	Never	1-3 times last month	1-2 times per week	3-4 times per week	5-6 times per week	1 time per day	2 times per day	3 or more times per day	4 or more times per day	5 or more times per day
a. How often did you drink 100% FRUIT Juice, such as orange, mango, apple, or grape juices? Do NOT include fruit drinks	☐	☐	☐	☐	☐	☐	☐	☐		
b. How often did you eat FRUIT? INCLUDE fresh, frozen or canned fruit. Do NOT include juices.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. How often did you eat FRENCH FRIES, or home fries, or hash brown potatoes?	☐	☐	☐	☐	☐	☐	☐	☐		
d. How often did you eat other POTATOES? INCLUDE baked, boiled, mashed or potato salad.	☐	☐	☐	☐	☐	☐	☐	☐		
e. Not including potatoes (and not counting rice), how often did you eat OTHER VEGETABLES?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Physical Activity

C3. Moderate physical activities make you breathe somewhat harder than normal. During the last 7 days, did you do any moderate physical activities for at least 10 minutes? Think about activities such as bicycling, swimming, brisk walking, dancing or gardening.

☐ NO ➔GO TO C4
☐ YES
↓

a. On how many of the past 7 days did you do moderate physical activities?

|___| DAYS

b. In the past 7 days, on a typical day in which you did moderate physical activities, how much time did you spend doing them?*

|___|___|___| **MINUTES PER DAY**

C4. Vigorous activities make you breathe much harder than normal. Now think about vigorous activities you did that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming. During the last 7 days, did you do any vigorous physical activities in your free time for at least 10 minutes?

☐ NO ➔GO TO C5
☐ YES
↓

a. On how many of the past 7 days did you do vigorous physical activities?

|___| **DAYS**

b. In the past 7 days, on a typical day in which you did vigorous physical activities, how much time did you spend doing them?

|___||___||___| **MINUTES PER DAY**

C5. Now think about activities specifically designed to STRENGTHEN your muscles, such as lifting weights or other strength-building exercises. Include all such activities even if you have included them before. During the last 7 days, did you do activities to strengthen your muscles?

☐ NO ➔GO TO C6
☐ YES

Height and Weight Status

C6. How tall are you without shoes?

|___| **FEET** |___|___| **INCHES**

IF YOU ARE FEMALE AND CURRENTLY PREGNANT, GO TO C7a.
OTHERWISE GO TO C7.

C7. How much do you weigh without shoes?

|___|___|___| **POUNDS**

C7a. If you are currently pregnant, how much did you weigh before your pregnancy?

|___|___|___| **POUNDS**

C8. Are you currently trying to: CHECK ONE

- ☐ Lose weight
- ☐ Gain weight
- ☐ Maintain weight
- ☐ I am not trying to do anything about my weight

PHYSICIAN CHARACTERISTICS

C9. When were you born?

| 1 | 9 | __ | __ | **YEAR**

C10. Are you… CHECK ONE

- ☐ Female
- ☐ Male

C11. Do you consider yourself to be Hispanic or Latino/a? CHECK ONE

- ☐ YES
- ☐ NO

C12. What do you consider to be your race? CHECK ONE OR MORE

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

C13. During a typical month, approximately what percent of your professional time do you spend in the following activities?

		Percent of professional time
a.	Providing Primary Care	____ ____ **%**
b.	Providing Subspecialty Care Please specify: _____	____ ____ **%**
c.	Research	____ ____ **%**
d.	Teaching	____ ____ **%**
e.	Administration	____ ____ **%**
f.	Other *(specify)*: _____	____ ____ **%**
	TOTAL	**1 0 0 %**

PRACTICE CHARACTERISTICS

C14. Which of the following categories best describes your main primary care practice location? Are you a…

		CHECK ALL THAT APPLY
a.	Full- or part-owner of a physician practice	☐
b.	Employee of a physician-owned practice	☐
c.	Employee of a large medical group or health care system	☐
d.	Employee of a staff or group model HMO	☐
e.	Employee of a university hospital or clinic	☐
f.	Employee of a hospital or clinic not associated with a university (including community health clinics)	☐
g.	Other (specify): _____	☐

C15. Please estimate the number of patient visits that you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled clinical activity):

|___|___|___| Number of Patient Visits

☐ DON'T KNOW

C16. Approximately what percentage of the patients you treat is female?

|___|___|___| **%**

☐ **DON'T KNOW**

C17. Approximately what percentage of the patients you treat is Hispanic or Latino?….(PLEASE GIVE YOUR BEST ESTIMATE)

		CHECK ONE
a.	0-5%	☐
b.	6-25%	☐
c.	26-50%	☐
d.	51-75%	☐
e.	76-100%	☐
f.	DON'T KNOW	☐

C18. Approximately what percentage of the patients you treat is...(PLEASE GIVE YOUR BEST ESTIMATE)

		PERCENTAGE OF PATIENTS
a.	White	___ ___ ___ %
b.	Black or African-American	___ ___ ___ %
c.	Asian	___ ___ ___ %
d.	Native Hawaiian or Other Pacific Islander	___ ___ ___ %
e.	American Indian or Alaska Native	___ ___ ___ %
	T O T A L	**1 0 0 %**

C19. Within a practice, there may be multiple clinical sites at which medical care is delivered.

	CHECK ONE
Does this practice have more than one clinical site?	☐ YES ☐ NO

C20. About how many physicians, nurse practitioners, and physician assistants provide care in all of the clinical sites within this practice? CHECK ONE

- ☐ 1
- ☐ 2 – 5
- ☐ 6 – 20
- ☐ More than 20 and fewer than 100
- ☐ More than 100
- ☐ DON'T KNOW

C21. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?

CHECK ONE

- ☐ I prefer paper and pencil
- ☐ I prefer a web-based questionnaire
- ☐ I have no preference
- ☐ Other (please specify): _____

C22. We would like to obtain additional information about aspects of the practice that support disease prevention activities. However, we know your time is limited, so we'd like to send your office administrator a short questionnaire of about 20 questions related to the structure of your practice and the roles of different staff that work there. Please give us the name of your office administrator, or indicate whether it would be better for us to send the brief questionnaire to you.

Check one: ☐ **Dr.** ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

First Name: |___|___|___|___|___|___|___|___|

Last Name: |___|___|___|___|___|___|___|___|___|___|___|___|

☐ **The office administrator in my practice is less familiar with the clinical roles of my staff; I am the best person to answer questions about my practice.**

If you have any comments about the questionnaire, individual questions, or the burden, please make them here. We appreciate your participation and feedback.

Form Approval
OMB No. 0925-XXXX
Expires XX/XX/XX

Physician Survey of Practices on Diet, Physical Activity and Weight Control

ADMINISTRATOR QUESTIONNAIRE

Conducted by:

National Cancer Institute

National Institute of Diabetes & Digestive & Kidney Diseases

Office of Behavioral & Social Sciences Research

National Institute of Child Health and Human Development (NICHD)

CDC Department of Health and Human Services Centers for Disease Control and Prevention

INTRODUCTION AND INSTRUCTIONS

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases and the Centers for Disease Control and Prevention. Obesity, poor diet, and lack of physical activity are recognized as major public health problems in the United States. The Administrator Questionnaire asks about factors that could facilitate or hinder physician's practices intended to address these problems.

The survey is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians, and their associated administrators. The following doctor in your office has participated in the physician portion of the survey:

Please provide answers to the survey questions based on the patient characteristics, clinical guidelines, and financial arrangements related to the clinical site listed above, which should be the location at which the doctor practices medicine. You may need to obtain information from multiple members of the clinic team.

The information you provide in this survey will remain confidential to the fullest extent of the law. Your answers will be combined with those of other respondents in reports to NCI and anyone else.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

- **Use an X in the boxes to indicate your answers.**
- **Use the line provided in "Other (Specify): _____" if your answer is not adequately represented by available choices.**
- If you are not sure of an answer give your best estimate.

Section A. Practice Characteristics

A1. **Is this doctor's office part of a…**

CHECK ONE BOX

- ☐ Solo practice➔ GO TO A5
- ☐ Group practice
- ☐ Medical School
- ☐ Hospital
- ☐ Clinic or Community Health Center
- ☐ Other (Specify) _____

A2. **Is this doctor's office a…**

CHECK ONE BOX

- ☐ Single specialty practice
- ☐ Multi-specialty practice, where physicians from more than one specialty provide services
- ☐ Other (Specify) _____

A3. **Who owns this doctor's office?**

CHECK ONE BOX

- ☐ One or more physicians or a physician owned corporation
- ☐ A health system or integrated delivery system
- ☐ A health plan or insurance company
- ☐ Federal, state or local government
- ☐ A medical school, hospital, or related organization
- ☐ Other (Specify) _____

A4. **About how many part time and full time <u>physicians</u>, <u>nurse practitioners, and physician assistants</u> work in this office?**

CHECK <u>ONE</u> BOX

|___|___|___|	Number of part time and full time physicians, nurse practitioners and physician assistants
|___|___|___|	Number of physician, nurse practitioner and physician's assistant full time equivalents (FTEs)

A5. **Which of the following types of healthcare professionals work in this office?**

PLACE AN "X" FOR <u>ALL</u> THAT APPLY

a.	Nurse Practitioners or Clinical Nurse Specialist	☐
b.	Physician Assistants	☐
c.	Nurses (e.g., RN, LPN, LVN)	☐
d.	Dieticians/Nutritionists	☐
e.	Health Educator	☐
f.	Occupational/Physical therapists	☐
g.	Social workers	☐
h.	Psychologists	☐
i.	Medical Assistants	☐
k.	Other (Specify) _____	☐

A6. **Where is this office located?**

CHECK <u>ONE</u> BOX

- ☐ Large City (Population over 500,000)
- ☐ Medium City (Population 100,000-500,000)
- ☐ Small City (Population under 100,000)
- ☐ Rural Community
- ☐ Other (Specify) _____

A7. **At this office, approximately how many patient visits with physicians, nurse practitioners, or physician assistants occur during a typical week?**

PLEASE GIVE YOUR BEST ESTIMATE

|___|___|___| Number of patient visits per week

A8. **In this office, approximately what percentage of the patients is…**

PLEASE GIVE YOUR BEST ESTIMATE

	0-5%	6-25%	26-50%	51-75%	76-100%	Don't Know
a. Uninsured	☐	☐	☐	☐	☐	☐
b. Privately Insured	☐	☐	☐	☐	☐	☐
c. Medicare Insured	☐	☐	☐	☐	☐	☐
d. Medicaid Insured	☐	☐	☐	☐	☐	☐

Section B. Clinical Policies and Procedures

B1. In this office, who usually performs the following for patients?

PLACE AN "X" FOR ALL THAT APPLY IN EACH ROW AND EACH COLUMN

		Measuring weight and height	Assessing diet and physical activity	Counseling about, diet, physical activity, and weight control
a.	Physician	☐	☐	☐
b.	Nurse practitioner or physician assistant	☐	☐	☐
c.	Other staff (Specify): _____	☐	☐	☐
c.	No one does this	☐	☐	☐
e.	Don't know	☐	☐	☐

B2. In this office, is there a standard protocol that requires that each patient have the following assessed?

PLACE AN "X" IN EACH COLUMN AND EACH ROW

		Diet		Physical Activity		Weight	
a.	At each visit	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b.	At new patient visit	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c.	Annually	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
d.	Other timeframe (Specify) _____	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
e.	A standard protocol is implemented ONLY for high risk patients	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

B3. **Does this office provide preventive medicine/well patient visits?**

- ☐ YES, this site provides preventive/well patient visits

B3a. If yes, do these visits include counseling for diet, physical activity, and weight management?

- ☐ YES
- ☐ NO

- ☐ No, this office does NOT provide preventive/well patient visits
- ☐ I don't know

B4. What type of medical record system does this office use?

CHECK ONE BOX

- ☐ Paper charts
- ☐ Partial electronic medical records (e.g., lab results available electronically, but patient history on paper)
- ☐ In transition from paper to full electronic medical records
- ☐ Full electronic medical records

B5. Which of the following mechanisms does this office have to follow up with patients who have received counseling <u>within the practice</u> on diet, physical activity, or weight management?

CHECK ALL THAT APPLY

Verbal reminder from the physician or other staff during an office visit	☐
Reminder by US Mail, telephone, or e-mail	☐
Personalized Web page or other mechanism (Specify) _____	☐
None of these	☐
Don't Know	☐

B6. Which of the following mechanisms does this office have to follow up with patients who are <u>referred out</u> from your practice for counseling on diet, physical activity, or weight management?

CHECK ALL THAT APPLY

Verbal reminder from the physician or other staff during an office visit	☐
Reminder by US Mail, telephone, or e-mail	☐
Personalized Web page or other mechanism (Specify) _____	☐
None of these	☐
Don't Know	☐

Section C. Information Resources

C1. Please indicate which of the following information resources on diet, physical activity or weight control are available in the waiting or exam rooms.

CHECK ALL THAT APPLY

a.	Brochures, pamphlets	☐
b.	Video	☐
c.	Flyers for related programs or services (e.g., weight loss or exercise program)	☐
d.	Books/ Journal articles	☐
e.	Magazines	☐
f.	No materials are available for diet, physical activity, or weight control	☐

C2. Does the office have a newsletter that goes out to patients?

☐ Yes → GO TO C2a

☐ No → GO TO C3

C2a. In the past 12 months, did any of the newsletters provide information about:

CHECK ALL THAT APPLY

☐ Diet/Nutrition

☐ Physical Activity

☐ Weight Control

C3. Does the office have a website?

☐ Yes → **GO TO C3a**

☐ No → **GO TO D1**

C3a. If yes, in the past 12 months, did the website provide information about:

CHECK ALL THAT APPLY

☐ Diet/Nutrition

☐ Physical Activity

☐ Weight Control

Section D Billing and Reimbursement

D1. Do you review or work with billing data on a regular basis?

☐ Yes → **GO TO D2**

☐ No. → **GO TO SECTION E, PAGE 10**.

D2. About what percentage of the office's revenue is derived from the following sources?

☐ **Don't know**

	FILL IN PERCENTAGE FOR EACH ROW. TOTAL MUST EQUAL 100%	**PERCENTAGE OF REVENUE**
a.	Fee-for-Service	___ ___ ___ %
b.	Capitation	___ ___ ___ %
c.	Other (Specify) _____	___ ___ ___ %
	T O T A L	**1 0 0 %**

D3. In this office, what types of coverage do your <u>insured</u> patients have? (If no patients have insurance, please indicate N/A)

☐ **Don't know**

		PLACE AN "X" IN <u>ONE</u> BOX IN <u>EACH</u> ROW					
		0-5%	**6-25%**	**26-50%**	**51-75%**	**76-100%**	**N/A**
a.	Managed Care (HMO/POS)	☐	☐	☐	☐	☐	☐
b.	Managed Care (PPO)	☐	☐	☐	☐	☐	☐
c.	Other (specify): _____	☐	☐	☐	☐	☐	☐

D4. Does this office bill for visits that involve counseling for diet, physical activity, and weight control? (Under some systems, services are provided under capitation and are not billed).

- ☐ Yes, billed as treatment for a chronic or acute condition
- ☐ Yes, billed as part of preventive medicine/well patient visit
- ☐ No, not billed
- ☐ Don't know

D5. Do physicians working in this office receive any incentive payments to engage in the following?

PLACE AN "X" IN ONE BOX IN EACH ROW

		Yes	No	Don't Know
a.	Diabetes screening	☐	☐	☐
b.	Cancer screening	☐	☐	☐
c.	Heart disease screening	☐	☐	☐
d.	Diet counseling	☐	☐	☐
e.	Physical activity counseling	☐	☐	☐
f.	Weight counseling	☐	☐	☐

Section E Personal Characteristics

E1. What is your position or title?

_____

E2. How long have you been with the practice?

| ____ | ____ | Month or Years (Circle One)

E3. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?

CHECK ONE

- ☐ I prefer paper and pencil
- ☐ I prefer a web-based questionnaire
- ☐ I have no preference
- ☐ Other (please specify): _____

Please add any comments in the space provided. We appreciate your participation and feedback.

_____

_____

_____

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