Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

Background Questions on Practice Characteristics

(To Be Completed by Office Point of Contact)

Instructions: Please answer the following questions, which will be used to analyze data collected with the *Medical Office Survey on Patient Safety Culture.* If you need assistance in answering any of the questions, please contact [project staff member] by telephone (xxx-xxx-xxxx) or by email (xxxx@xxxxx.xxx).

Name of Office Point-of-Contact: (First)_____ (Last) _____
Job Title:_____
Name of Office:_____
Office Mailing Address: (Street) _____
(City) _____(State) _____(Zip code)_____
Phone: _____
Fax:_____
Email:_____

1a. Does your medical practice have:

☐ 1 One geographic location? → (SKIP TO QUESTION 2)
☐ 2 Multiple geographic locations? → Total number of locations: _____

↓

1b. Is <u>this</u> office location the:

☐ a. Primary/headquarters location?
☐ b. Satellite location (not the primary/ headquarters location)?

2. Which best describes the majority ownership of <u>this</u> medical office/practice?

☐ 1 Provider(s) and/or Physician(s)
☐ 2 Managed Care or Health Maintenance Organization (MCO/HMO)
☐ 3 University or Medical School or Academic Medical Institution
☐ 4 Hospital or health system
☐ 5 Federal, state, or local government, community board, etc.
☐ 6 Other, please specify: _____

3a. Which of the following best describes the type of practice at this office location?

☐ 1 Single specialty
☐ 2 Multispecialty with primary care only (family medicine, internal medicine, pediatrics, OB/GYN, general practice)
☐ 3 Multispecialty with primary and specialty care
☐ 4 Multispecialty with specialty care only

Do Not Write in This Space
Site ID: _____

3b. In Table 3b, check all specialties that apply in your medical office and record the number of providers in each specialty. By provider, we mean physicians (MDs and DOs), physician assistants (PAs), and nurse practitioners (NPs) who diagnose, treat patients, and prescribe medications.

If a provider is certified in more than one specialty, record only the specialty for which the provider spends most of his/her time. See example.

Example: An office with 3 Family Practice providers and 1 doctor certified in both Gastroenterology (works in this area 70% of time) and General Practice (works in this area 30% of time):

	Number of Providers	Specialty
☑9	3	Family Practice / Family Medicine
☐10		Forensic Pathology
☑11	1	Gastroenterology
☐12		General Practice

TABLE 3b (Check specialties and record number of providers in each specialty)

✓	Number of Providers	Specialty	✓	Number of Providers	Specialty
☐1		Allergy/Immunology	☐19		Nephrology
☐2		Anesthesiology	☐20		Neurology
☐3		Cardiology	☐21		Nuclear Medicine
☐4		Child & Adolescent Psychiatry	☐22		OB/GYN or GYN
☐5		Dermatology	☐23		Ophthalmology
☐6		Diagnostic Radiology	☐24		Orthopedics
☐7		Emergency Medicine	☐25		Otolaryngology
☐8		Endocrinology/ Metabolism	☐26		Pathology – Anatomic/Clinical
☐9		Family Practice/Family Medicine	☐27		Pediatrics
☐10		Forensic Pathology	☐28		Physical Medicine & Rehabilitation
☐11		Gastroenterology	☐29		Psychiatry
☐12		General Practice	☐30		Public Health & Rehabilitation
☐13		General Preventive Medicine	☐31		Pulmonary Medicine
☐14		General Surgery	☐32		Radiology
☐15		Geriatrics	☐33		Rheumatology
☐16		Hematology/Oncology	☐34		Surgery (All)
☐17		Internal Medicine	☐35		Urology
☐18		Medical Genetics	☐36		Vascular Medicine
			☐37	_____	Other specialty (Please specify): _____
			☐38	_____	_____
			☐39	_____	_____

4. To what extent has this medical office implemented each of the following electronic (computer-based) tools? (By implemented, we mean the office has the tool capability and is using it.)

	Not implemented & no plans to implement in the next 12 months ▼	Not implemented but implementation planned in the next 12 months ▼	Implementation in process (only partial implementation) ▼	Fully implemented ▼
a) Electronic appointment scheduling	☐1	☐2	☐3	☐4
b) Electronic billing of services	☐1	☐2	☐3	☐4
c) Electronic ordering of medications (with pharmacies capable of processing electronic orders)	☐1	☐2	☐3	☐4
d) Electronic ordering of tests, imaging, or procedures (with test/ imaging centers capable of processing electronic orders)	☐1	☐2	☐3	☐4
e) Electronic access to your patients' test or imaging results	☐1	☐2	☐3	☐4
f) Electronic medical/health records (EMR/EHR)	☐1	☐2	☐3	☐4
g) Other (Please specify): _____	☐1	☐2	☐3	☐4

5. What is the total number of patient visits in a typical week in this medical office location?
_____ total patient visits in a typical week

6. What is the total number of providers (MDs, DOs, PAs, NPs, etc.) working in this medical office location during a typical week?
_____ total number of providers working during a typical week

NOTE:

- **If your medical office is using ID numbers on surveys to track individual response, YOU ARE DONE and you can SKIP question 7 on next page.**
- **If your medical office is administering the survey anonymously (not using ID numbers to track individual response), please answer question 7 on next page.**

7. Please record the total number of staff who will be asked to complete the survey in each of the following categories:

Staff Position	**Number of Individuals**
a. Physician (MD/DO).....	_____
b. Physician Assistant	_____
c. Nurse Practitioner/Clinical Nurse Specialist/Nurse Midwife/Advanced Practice Nurse, etc.	_____
d. Practice Manager/Office Manager/Office Administrator/ Business Manager/Nurse Manager, Lab Manager, Other Manager	_____
e. Administrative or Clerical	_____
Insurance Processor — Medical Records Billing Staff — Receptionist Referral Staff — Scheduler (appt., surgery, etc.) Front Desk — Other administrative or clerical staff	
f. Registered Nurse/LVN/LPN.....	_____
g. Medical Assistant/Nursing Aide.....	_____
h. Other Clinical Staff ..... Technician (all types) Therapist (all types) Other clinical staff	_____
i. Other Positions (Please specify): _____	_____
TOTAL NUMBER OF INDIVIDUALS WHO WILL BE ASKED TO COMPLETE THE SURVEY IN YOUR MEDICAL OFFICE	_____ **Individuals**

YOU ARE DONE!
THANK YOU FOR COMPLETING THESE QUESTIONS ABOUT YOUR MEDICAL OFFICE.
Please email or fax your responses back to XXXXX
Email:
Fax number: