**OMB No.: 0920-0222 Exp. Date: xx/xx/20xx**

Attachment 1: NAMCS: Physician Survey

|  |
| --- |
| **NOTICE -** Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Information Collection Review Office; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).**Assurance of Confidentiality -** All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).  |

NAMCS: Physician Survey

The Physician Survey is an expansion of the National Ambulatory Medical Care Survey (NAMCS). The purpose of the survey is to collect information about physician work environments across many settings. Your participation is greatly appreciated. Your answers are completely confidential. Participation in this survey is voluntary. If you have questions or comments about this survey, please call 866-966-1473.

1. We have your specialty as

|  |
| --- |
|  Is that correct? □1 Yes □2 No → What is your specialty? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Do you do any clinical work (e.g., seeing patients, interpreting lab or imaging results)?

□1 Yes (Continue to Q3) □2 No. I do not do any clinical work. (*Go to Q39)*

|  |
| --- |
| *The next set of questions asks about a normal week of work. We define “normal week” as a week with a normal caseload, with no holidays, vacations, or conferences. If your work varies, provide a normal week by averaging this work.* |
| 1. In a NORMAL WEEK, at how many locations do you do clinical work? \_\_\_\_\_\_\_LOCATIONS
 |
| *The next questions are about your work at* all locations *where you do clinical work.* |
| 1. In a NORMAL WEEK, about how many hours do you work? \_\_\_\_\_\_\_\_\_\_Total hours (all locations)
2. Approximately how many days in a NORMAL WEEK do you work? \_\_\_\_\_\_\_day(s) per week
3. During a NORMAL WEEK of work, approximately how many patients do you care for? \_\_\_\_\_\_\_\_\_ NUMBER OF PATIENTS (all locations)
 |
| 1. During a NORMAL WEEK of work (at all locations), about how many total hours do you spend doing clinical work?

 \_\_\_\_\_\_\_\_\_\_\_ Total clinical work hours (If you answered 3 hours or fewer Go to Q39) |
| 7a. During a NORMAL WEEK of work, what percent of your total clinical work hours is spent on each of the following activities? *Exclude time not providing patient care.*  *Enter “0” for activities you do not spend time on during a normal week.* | Percent |
| 1. Providing in-person evaluation and patient/case management services
 | \_\_\_\_\_\_\_\_\_% |
| 1. Performing procedures (e.g., diagnostic procedures, anesthesia, surgery)
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Providing in-person treatment for patients (e.g., radiation therapy, chemotherapy)
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Interpreting patient diagnostic tests (e.g., imaging studies, biopsies) for the medical record
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Communicate with patients or caregivers by email or telephone
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Communicate with providers about patient management and care coordination
 | \_\_\_\_\_\_\_\_\_% |
| 1. Patient-related clinical administrative tasks (e.g., patient-related office work, billing, or obtaining prior authorizations)
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 | **\_\_\_\_\_\_\_\_\_%** |
| TOTAL | 100% |

|  |
| --- |
| 1. During a NORMAL WEEK (at all locations), approximately how many total hours do you spend doing

non-clinical work (e.g., administration, teaching, research)? \_\_\_\_\_\_\_\_\_\_\_ Total non-clinical work hours  |
| 8a. During a NORMAL WEEK of work (all locations), what percent of your total non-clinical work hours is spent on each of the following activities? *Enter “0” for activities you do not spend time on during a normal week.* | Percent |
| 1. Administrative tasks (e.g., practice or hospital management) not directly related to clinical care
 | \_\_\_\_\_\_\_\_\_% |
| 1. Teaching activities
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Research activities
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Professional activities (e.g., conferences, continuing education)
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 | **\_\_\_\_\_\_\_\_\_%** |
| 1. Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 | **\_\_\_\_\_\_\_\_\_%** |
|  | **100%** |

1. During a TYPICAL MONTH, approximately how many hours do you spend on-call, if any?

 \_\_\_\_\_\_\_\_\_\_HOURS □1 Not on-call during a typical month

1. In a typical year, about how many weeks are you NOT engaged in clinical activities because of such events as conferences, vacations, illness, etc.?

 \_\_\_\_\_\_\_\_\_\_ weeks

|  |
| --- |
| The next questions are about the primary practice location, which is the location you spend the most time engaged in clinical work. Your primary practice location may differ from the medical organization that employs you. |

|  |  |
| --- | --- |
| 1. Which of the following settings describes your primary practice location? CHECK ONE ONLY

□1 Office or clinic physically located within a larger medical facility or campus□2 Office or clinic located in the community (not in a larger medical facility or campus)□3 Other outpatient facility (ambulatory or surgical center) □4 Hospital setting (inpatient ward, emergency department, surgical suite, radiological facility)□5 Long-term or post-acute care setting**□**6 Other setting (*Please describe*): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**1. During your last *normal* week, approximately how many patient visits did you have at the *primary practice location*? *Note: Include visits where you personally saw the patient. MARK Not Applicable, if you do not see patients.*

\_\_\_\_\_\_\_\_\_\_ patient visits □0 Not applicable | 1. Overall, how would you rate the quality of teamwork among the clinicians at your primary practice location that provide care for your patients?

□1 Excellent□2 Very good□3 Good□4 Fair□5 Poor□6 N/A -No other clinicians in my primary practice1. What is the degree of electronic health record acquisition or implementation at the primary practice location?

□1 We have implemented an EHR system □2 We are in the process of implementing an EHR□3 We plan to acquire an EHR system in the next 12 months□4 We plan to acquire an EHR system in the next 13-to 24 months□5 We have no plans to acquire an EHR system |
| 1. Do you share any patient health information electronically (not fax) with any other providers, including hospitals, ambulatory providers, or labs?

□1 Yes □2 No □3 Unknown □4 Not applicable, I do not have an EHR system | 1. Does your EHR at your primary practice location have the capability to electronically send health information to another provider whose EHR system is different from your own?

□1 Yes □2 No □3 Unknown □4 Not applicable, I do not have an EHR system |

| 1. Does the primary practice location have the computerized capabilities listed below? CHECK NO MORE THAN ONE BOX PER ROW. If you do not perform task mark Not Applicable.
 | Yes | Yes, but turned off | No | Unknown | Not Applicable |
| --- | --- | --- | --- | --- | --- |
| 1. Identifying patients due for preventive or follow-up care in order to send patients reminders?
 | □1 | □2 | □3 | □5 | □6 |
| 1. Providing reminders for guideline-based interventions or screening tests?
 | □1 | □2 | □3 | □5 | □6 |
| 1. Ordering lab tests?
 | □1 | □2 | □3 | □5 | □6 |
| 1. Ordering radiology tests?
 | □1 | □2 | □3 | □5 | □6 |
| 1. Generating lists of patients with particular health conditions?
 | □1 | □2 | □3 | □5 | □6 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Do you think the following are major problems, minor problems, or not problems affecting your ability to provide high quality care?
 | **Not a Problem** | **Minor Problem** | **Major Problem** | Not applicable |
| a. Not enough time to spend with patients during visits | □1 | □2 | □3 | □0 |
| b. Too many clinical reminders from my electronic health record | □1 | □2 | □3 | □0 |
| c. Lack of timely information about patients I see who have been cared for by other physicians | □1 | □2 | □3 | □0 |
| e. Lack of access to research evidence to guide my clinical decisions | □1 | □2 | □3 | □0 |
| f. Not enough resources (e.g., time, staff, decision aides) to provide patients with balanced information about treatment options. | □1 | □2 | □3 | □0 |
| g. Not enough resources (e.g., time, staff, decision aids) to incorporate patient preferences into the medical plan | □1 | □2 | □3 | □0 |
| h. Difficulty obtaining specialized diagnostic tests, treatments, or specialist referrals for my patients in a timely manner. | □1 | □2 | □3 | □0 |
| i. Patient difficulty paying for needed care | □1 | □2 | □3 | □0 |

|  |  |
| --- | --- |
| 1. How many of the following types of staff are associated with the primary practice location? If none, mark box provided. Include yourself in the applicable physician category.
 | Number of staff at the primary practice |
|  Specialist physicians | \_\_\_\_\_\_\_\_□**None** |
|  Primary care physicians | \_\_\_\_\_\_\_\_□**None** |
|  Physician assistants | \_\_\_\_\_\_\_\_□**None** |
|  Advanced practice nurses | \_\_\_\_\_\_\_\_□**None** |
|  Registered nurses | \_\_\_\_\_\_\_\_□**None** |
|  Licensed practical nurse/medical assistant | \_\_\_\_\_\_\_\_□**None** |
|  Other licensed health professionals | \_\_\_\_\_\_\_\_□**None** |
|  Number of administrative staff | \_\_\_\_\_\_\_\_□**None** |

1. Of all of your patients, what percentage do you provide primary care?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ % of patients

|  |
| --- |
|  *If you provide primary care for 10% or more of your patients, continue to Q20a* *If you provide primary care for less than 10% of your patients, skip to Q21.* |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **20a. How often can the patients you provide primary care to….**  | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** | **Uncertain** |
| i. ...see you each time they visit? | □1 | □2 | □3 | □4 | □5 | □6 |
|  ii. …reach you when they have a question? | □1 | □2 | □3 | □4 | □5 | □6 |
| iii. …communicate with you by email about clinical issues? | □1 | □2 | □3 | □4 | □5 | □6 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **20b. How often is the primary practice location….**  | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** | **Uncertain** |
|  i. ...open for patient visits after normal business hours, such as weekday nights or weekends? | □1 | □2 | □3 | □4 | □5 | □6 |
| ii. …able to see sick patients that same day? | □1 | □2 | □3 | □4 | □5 | □6 |
| iii. …able to provide timely advice to patients either over the phone or by email as needed? | □1 | □2 | □3 | □4 | □5 | □6 |

|  |  |  |  |
| --- | --- | --- | --- |
| 20c. Can patients get the following services on-site at your primary practice location? | Yes | No | Unknown |
| a. Nutrition counseling | □1 | □2 | □5 |
| b. Immunizations | □1 | □2 | □5 |
| c. Family planning or birth control services | □1 | □2 | □5 |
| d. Counseling for behavior or mental health problems | □1 | □2 | □5 |
| e. Treatment of a minor laceration | □1 | □2 | □5 |

 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **20d. If a patient for whom you provide primary care presents with new onset low back pain, how likely is it that you will do each of the following?** | **Very Likely** | **Somewhat Likely** | **Somewhat Unlikely** | **Very Unlikely** |
|  Conduct needed history and physical exam for initial assessment | □1 | □2 | □3 | □4 |
|  Order and interpret the necessary diagnostic tests | □1 | □2 | □3 | □4 |
|  Initiate treatment | □1 | □2 | □3 | □4 |
|  Refer the patient to a different health professional | □1 | □2 | □3 | □4 |
| **20e. If a patient for whom you provide primary care presents with amenorrhea, how likely is it that you will do each of the following?** | **Very Likely** | **Somewhat Likely** | **Somewhat Unlikely** | **Very Unlikely** |
|  Conduct needed history and physical exam for initial assessment | □1 | □2 | □3 | □4 |
|  Order and interpret the necessary diagnostic tests | □1 | □2 | □3 | □4 |
|  Initiate treatment | □1 | □2 | □3 | □4 |
|  Refer the patient to a different health professional | □1 | □2 | □3 | □4 |
| **20f. If a patient for whom you provide primary care presents with depression symptoms, how likely is it that you will do each of the following?** | **Very Likely** | **Somewhat Likely** | **Somewhat Unlikely** | **Very Unlikely** |
|  Conduct needed history and physical exam for initial assessment | □1 | □2 | □3 | □4 |
|  Order and interpret the necessary diagnostic tests | □1 | □2 | □3 | □4 |
|  Initiate treatment | □1 | □2 | □3 | □4 |
|  Refer the patient to a different health professional | □1 | □2 | □3 | □4 |
| **20g. If a patient for whom you provide primary care presents with diabetes symptoms, how likely is it that you will do each of the following?** | **Very Likely** | **Somewhat Likely** | **Somewhat Unlikely** | **Very Unlikely** |
|  Conduct needed history and physical exam for initial assessment | □1 | □2 | □3 | □4 |
|  Order and interpret the necessary diagnostic tests | □1 | □2 | □3 | □4 |
|  Initiate treatment | □1 | □2 | □3 | □4 |
|  Refer the patient to a different health professional | □1 | □2 | □3 | □4 |
| **20h. If a patient for whom you provide primary care presents with sore throat symptoms, how likely is it that you will do each of the following?** | **Very Likely** | **Somewhat Likely** | **Somewhat Unlikely** | **Very Unlikely** |
|  Conduct needed history and physical exam for initial assessment | □1 | □2 | □3 | □4 |
|  Order and interpret the necessary diagnostic tests | □1 | □2 | □3 | □4 |
|  Initiate treatment | □1 | □2 | □3 | □4 |
|  Refer the patient to a different health professional | □1 | □2 | □3 | □4 |

 |
|

|  |
| --- |
| The next questions are about the primary care team, which is a small team of you and other staff (e.g., nurse, medical assistant, nurse practitioner) within your primary practice location who work closely with you to provide primary care for patients. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **20i. At the primary practice location, how confident are you that you or your primary care team can…** | **Not at all confident**  | **Not too confident** | **Somewhat Confident** | **Very Confident** |
|  a. …plan care for patients outside the clinic visit when appropriate | □1 | □2 | □3 | □4 |
|  b. …identify patient subgroups with distinct needs (e.g., smoking, hypertension) to target care interventions and management | □1 | □2 | □3 | □4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **20j. To what extent do you agree or disagree with the following statements about primary care provided at your *primary practice location*?** | **Strongly****Agree** | **Somewhat****Agree** | **Somewhat****Disagree** | **Strongly****Disagree** | **Uncertain** |
| a. The primary care team is responsible for coordinating all patient care across multiple settings. | □1 | □2 | □3 | □4 | □5 |
| b. The primary care team routinely identifies patients with a hospital admission or emergency department visit. | □1 | □2 | □3 | □4 | □5 |
| c. The primary care team routinely obtains patient discharge summaries across all care settings, including transfers from one care setting to another (as in hospital to sub-acute) | □1 | □2 | □3 | □4 | □5 |
| d. The primary care team contacts patients soon after hospital discharge to coordinate follow-up care. | □1 | □2 | □3 | □4 | □5 |
| e. The primary care team routinely reconciles medications with patients after care transitions. | □1 | □2 | □3 | □4 | □5 |
| f. The primary care team provides consultants or specialists the clinical reason for the referral. | □1 | □2 | □3 | □4 | □5 |
| g. The primary care team routinely tracks the status of referrals. | □1 | □2 | □3 | □4 | □5 |
| h. The primary care team routinely follows up with specialists to obtain reports.. | □1 | □2 | □3 | □4 | □5 |
| i. The primary care team routinely asks patients about self-referrals to request reports from those clinicians. | □1 | □2 | □3 | □4 | □5 |

**20k. Has your primary practice location been recognized as a Patient Centered Medical Home (PCMH) by a state, a commercial health plan, or a national organization, such as the National Committee for Quality Assurance (NCQA), the Joint Commission, URAC, or the Accreditation Association of Health Care Practice?**□1 Yes□2 No, but we are preparing to apply within 12 months□3 No and no plans to apply to apply within 12 months□4 Uncertain |

|  |
| --- |
| The next questions are about the characteristics of the medical organization that employs you. By medical organization we mean the organization that employs physicians who work together and may share staff, patient medical records, and income, and includes solo practices and groups owned by a hospital. If the medical organization has more than one location answer across all locations. |

1. Including yourself, how many physicians are in your medical organization? Include all practice locations.

□1 100 or fewer physicians 🡪 |\_\_\_|\_\_\_|\_\_\_| physicians are in my organization

□2 More than 100 physicians

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. How would you rate this medical organization’s performance in each of the following areas over the past 12 months?
 | Excellent | Very Good | Good | Fair | Poor | Uncertain |
|  **Financial performance**  | □1 | □2 | □3 | □4 | □5 | □6 |
|  **Leadership of the organization**  | □1 | □2 | □3 | □4 | □5 | □6 |
|  **Quality of patient care** | □1 | □2 | □3 | □4 | □5 | □6 |

|  |  |
| --- | --- |
| 1. Which of the following best describes this medical organization? CHECK ONE ONLY.

□1 Independent physician practice□2 Group or staff model HMO□3 Network of physicians owned by a hospital, hospital system or medical school□4 Hospital or medical school staff□5 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. What are the three most common physician specialties represented in your medical organization?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1. Who owns the medical organization? CHECK ALL THAT APPLY.

□1 Physicians in the practice□2 Another physician group□3 Insurance company, health plan, or HMO □4 Community health center□5 Medical school or university/academic health center □6 Other public or private hospital, health system, or foundation owned by a hospital □7 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you a full- or part- owner, an employee, or an independent contractor within your medical organization?

 □1 Full or part owner  □2 Employee □3 Contractor |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Who is most involved with decisions for each of the following activities?
 | **Physicians at my location** | **Administrators at my location** | **Administrators off-site** **within my organization** | **Administrators outside of my medical organization** | Not applicable |
| a. Contracting with insurance plans | □1 | □2 | □3 | □4 | □5 |
| b. Purchasing medical equipment used at your primary practice location | □1 | □2 | □3 | □4 | □5 |
| c. Hiring new physicians at your primary practice location | □1 | □2 | □3 | □4 | □5 |
| d. Hiring support staff at your primary practice location | □1 | □2 | □3 | □4 | □5 |

1. To better understand medical organizations, we are conducting a complementary data collection effort. We are interested in learning about other aspects of your medical organization, such as network affiliations, payment structures, and relationships with other health care organizations. Please provide contact information for your organization’s primary practice administrator or person you think is best qualified to answer these questions. The contact information you provide will be strictly protected under Federal data privacy rules.

|  |  |
| --- | --- |
| Name |  |
| Title |  |
| Organization Name |  |
| Mailing address |  |
| Country | USA | City |  |
| State |  | Zip Code |  |
| Telephone | ( )  |
| E-mail |  @  |

|  |
| --- |
| **The next questions are about you.** All information collected will be aggregated with responses from other physicians. Consistent with Federal laws, identities of respondents will never be able to be determined |

|  |  |
| --- | --- |
| 1. In general, how satisfied or dissatisfied are you with your career in medicine?

□1 Very dissatisfied□2 Somewhat dissatisfied□3 Neither satisfied nor dissatisfied□4 Somewhat satisfied□5 Very satisfied1. What is your race? (CHECK ALL THAT APPLY)

□1 White□2 Black□**3** Asian□4 American Indian, Alaska Native, or Pacific Islander□5 Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. What is your ethnicity?

□1 Hispanic or Latino□2 Not Hispanic or Latino  | 1. In what clinical area(s) are you board certified?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Regardless of board certification, what is your main specialty or subspecialty (that is the area considered to be your primary clinical focus)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. In what year did you begin working in this specialty area? (please do not include years in residencies or fellowships)

\_\_\_\_\_\_\_\_ YEAR1. In your personal life, are you the primary caregiver for anyone in your family including children or adults (e.g., spouse, partner, parent, or relative)?

□1Yes□2 No |

1. Please estimate your personal total pre-tax income from the practice of medicine in 2013. This information will be strictly protected under Federal data privacy rules and only used in aggregate from across groups of many physicians. Please feel free to round to the nearest $20,000.

$ \_\_ \_\_ \_\_, \_\_ \_\_ \_\_, \_\_ \_\_ \_\_

|  |
| --- |
| 1. Estimate what percentage of your total compensation is based on the following ways that physicians are paid. *Your percentage of total compensation should sum to 100%.*
 |
| Guaranteed or “base” salary ( not directly tied to your productivity or clinical performance)  | \_\_\_\_\_\_\_% |
| Your own individual productivity (e.g., cash collection, billings, relative value units, visits) | \_\_\_\_\_\_\_% |
| Your own management of health care resources for your patients as compared to other physicians | \_\_\_\_\_\_\_% |
| Performance on measures of your patients’ satisfaction with the care you provide( e.g., results of patient satisfaction surveys) | \_\_\_\_\_\_\_% |
| Performance on measures of the quality of care you provide to your patients (e.g., measures of adherence to guidelines, complication rates, quality review by peers) | \_\_\_\_\_\_\_% |
| Some share of your medical organization’s net revenue | \_\_\_\_\_\_\_% |
| Other ( Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_% |

Total 100%

1. Would you have preferred to complete this questionnaire through a Website or would you have preferred to complete this questionnaire by paper?

1□ Strong paper preference

2□ Slight paper preference

3□ Slight website preference

4□ Strong website preference

1. Who completed this survey?

1□ The physician to whom it was addressed

2□ Office staff

3□ Other

1. Were you asked to skip ahead because you do not do clinical work more than 3 hours a week?

1□ Yes (go to 40a)

2□ No (Thank you- for your participation – please provide comments about the survey in the Comment box)

**40a. What do you spend most of your work time doing? (Select all that apply**)

1□ Administrative tasks

2□ Teaching activities

3□ Research activities

4□ Professional activities

5□ I am retired

6□ I practice medicine no more than 3 hours a week.

7□ Other (*Please specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comment Box: **Were there any questions that you had problems answering or question you were unable to express your response fully?**

|  |  |
| --- | --- |
| **Thank you for your participation. Please return your survey in the envelope provided. If you have misplaced this envelope, please send survey to: 2605 Meridian Parkway, Suite 200, Durham, NC 27713**  | Boxes for Admin Use |