Appendix A – Practice Descriptive Characteristics

Diagnostic Safety Capacity Building – Patient and Family Resource

Form Approved
OMB No. xxxx-xxxx
Exp. Date xx/xx/20

Please complete the following information about your practice:

General Information About Your Practice

Practice Name		
Location (City, State)		
Select one:	**Urban** **Inner City** **Rural** **Suburban** **Other (Specify)**	
Contact Person		
Medical Director		
Number of	**Physicians** **Nurse Practitioners** **Nurses** **Medical Assistants** **Pharmacists** **Social Workers** **Case Managers** **Other Practice Staff** **Other (specify)**	_____ _____ _____ _____ _____ _____ _____ _____ _____
Total Number of Patients Served by Practice		
Payer Mix (Indicate % of Patients)	Self-Pay Medicare Medicaid Private Insurance Uninsured Other	_____% _____% _____% _____% _____% _____%
Race (indicate % of patients)	**White** **Black or African American** **American Indian or Alaska Native** **Asian** **Native Hawaiian or Other Pacific Islander**	_____% _____% _____% _____% _____%
Ethnicity (indicate % of patients)	**Hispanic or Latino** **Not Hispanic or Latino**	_____% _____%

Information about Patient Safety and Quality Improvement Activities of the Practice

	Yes	No

Does your practice routinely conduct a patient safety culture survey?	☐ Please specify which survey you use: _____ • Date of the last survey _____	☐
Is your practice part of a larger healthcare system?	☐ Please indicate which health system you are affiliated with: _____	☐
Is your practice currently working on any other practice improvement strategies?	☐	☐
Does your practice have or use the services of a practice facilitator?	☐	☐