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?	☐	☐

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 60 minutes per response, the estimated time required to complete the survey. 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: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857.