

Appendix A – Setting-Level Demographics Survey

Diagnostic Safety Capacity Building – TeamSTEPPS® Resource

Form Approved OMB No. xxxx-xxxx Exp. Date xx/xx/20
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Please complete the following information about your practice:

General Information About Your Practice

Practice Name		
Mailing Address (City, State, Zip code)		
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	_____ %
	Multiple racial categories	_____ %
Ethnicity (indicate % of patients)	Hispanic or Latino	_____ %
	Not Hispanic or Latino	_____ %

Information about Previous Implementation of TeamSTEPPS® Strategies in the Setting

	Yes	No
Has your organization implemented/ attempted to implement a TeamSTEPPS® training course in the past?	<input type="checkbox"/> Please specify which TeamSTEPPS® Course you previously implemented: _____ _____	<input type="checkbox"/>

Information about Patient Safety and Quality Improvement Activities of the Setting

	Yes	No
Does your practice routinely conduct a patient safety culture survey?	<input type="checkbox"/> Please specify which survey you use: _____ Date of the last survey: _____	<input type="checkbox"/>
Is your practice part of a larger healthcare system?	<input type="checkbox"/> Please indicate which health system you are affiliated with: _____	<input type="checkbox"/>
Is your practice currently working on any other practice improvement strategies?	<input type="checkbox"/>	<input type="checkbox"/>
Does your practice have or use the services of a practice facilitator?	<input type="checkbox"/>	<input type="checkbox"/>

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.