Appendix A – Setting-Level Demographics Survey

Diagnostic Safety Capacity Building – TeamSTEPPS® Resource

Please complete the following information about your practice:

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

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?	❑ Please specify which TeamSTEPPS® Course you previously implemented: _____ _____	❑

Information about Patient Safety and Quality Improvement Activities of the Setting

	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?	❑	❑