



**Community Tracking Study
Physician Survey
Interviewer Training Manual**

Technical Publication No.

6

July 1998

EXECUTIVE INTERVIEWING MANUAL

**COMMUNITY TRACKING STUDY
PHYSICIAN SURVEY
INTERVIEWER TRAINING MANUAL**

**Center for Studying Health System Change
The Gallup Organization
July 1996**

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This is one of a series of technical documents that have been done as part of the Community Tracking Study being conducted by the Center for Studying Health System Change. The study will examine changes in the local health systems and the effects of those changes on the people living in the area.

The Center welcomes your comments on this document. Write to us at 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024-2512 or visit our web site at www.hschange.org.

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COMMUNITY TRACKING STUDY PHYSICIAN SURVEY INTERVIEWER TRAINING MANUAL

1. Introduction

The Center for Studying Health System Change (HSC), a subsidiary of Mathematica Policy Research, Inc. (MPR), has been funded by the Robert Wood Johnson Foundation to undertake a comprehensive study of the nation's health care system. A major activity of HSC is a longitudinal study of communities designed to track changes in the health care system and their effects on care delivery and people. The goal of the study is to inform public and private leaders about the effects of health system change to enable them to make better policy decisions.

The study will document health system change and analyze its effects in representative communities throughout the United States. Intensive case studies will be conducted in 12 communities (high intensity sites) through site visits and surveys; another 48 communities will be studied less intensively (low intensity sites) through surveys with smaller samples. The case studies will provide in-depth understanding of health system changes. The larger sample of communities will provide a national portrait of health system change, permit placing the case study communities in the broader context of the nation, and strengthen the ability to relate system change to its effects on people.

The analysis will address two broad questions:

How is the organization of the health system changing? How are organizational relationships among insurers and health plans, hospitals, physician groups and physicians, safety net providers, public health agencies and other providers changing? How are these various organizations being affected by and responding to changing market structure? What role do employers, consumers and government play in driving changes in the health care system?

How do these changes affect people? For the case study communities and the nation, how are insurance coverage; access to care; use and delivery of services; health care cost; and quality, satisfaction, and health outcomes changing over time? How do these changes differ across communities and population subgroups? Finally, are insurance coverage, access, use, costs, quality and satisfaction related to changes in the health system?

Data for the analysis will be drawn from a variety of sources, including site visits, a household survey, a physician survey, surveys of health care organizations (insurers and health plans, physician groups and organizations, and hospitals), an employer survey and hospital discharge abstracts, as well as focus groups and secondary data where appropriate. Because another focus of the study is on change, the communities will be followed over time, with data collection beginning in 1996 and follow-up periodically over at least the next four years with different intervals depending on the content and method of data collection.

Physician Survey

Gallup will be conducting the baseline physician survey, with interviewing scheduled to begin in July, 1996 and continue into early March, 1997. There will be a follow-up physician survey, to be conducted in 1998-1999.

The physician survey will be a key source for evaluating how changes in the health care system have affected physicians and how they deliver care. The information gathered in this survey will include: (1) clinical vignettes for primary care physicians to assess practice style, including selection of treatment options and referral patterns; (2) organizational characteristics, such as whether they are in solo or group practice, and whether they are part of a network operated by health plans or providers; (3) characteristics of practice, such as the use of guidelines, treatment protocols, and restricted formularies; (4) method of compensation, such as salary, capitation, or fee-for-service and degree of risk-sharing; (5) characteristics of patients seen in practice, including the percent of patients who are privately insured, Medicaid, Medicare, or uninsured; (6) satisfaction with aspects of practice, including the degree of autonomy in making treatment decision, technical quality, ability to meet patients' needs and (7) limited data on income and practice expenses. Information on demographics (age, sex, race/ethnicity), specialty board certification, country of medical training and location of the practice will also be obtained either as part of the survey or from the list providers, the American Medical Association and the American Osteopathic Association.

Computer-assisted telephone surveys of non-federal patient care physicians will be conducted in 60 sites. In each of the 12 high intensity sites, an average of 430 physicians will be interviewed, and in each of the low intensity sites, an average of 130 physicians will be interviewed. A national sample of physicians will also be selected. Approximately 1,200

interviews will be conducted with physicians in the national sample. In all, we will be conducting a total of 12,600 physician interviews over the next 8 months.

The study is based on a mixed longitudinal/cross-sectional sample design, with the initial interview in 1996 and the follow-up interview in 1998. About half of the baseline sample will be randomly selected to be re-interviewed in 1998; the other half of the follow-up sample will be a newly selected cross-section. Interviews will be conducted with 12,600 physicians during the follow-up study. Gallup will bid on this project when the request for proposals is released.

2. The Role of Gallup Interviewers

Your role on this project is both challenging and crucial. Simply stated, your role is to collect the survey data by conducting telephone interviews with physicians. Our target response rate is 65% for this study. This, in itself, is a challenging target. However, because the study results will be used by a wide variety of public and private leaders and will serve as the basis for important health care policy decisions, the data are also likely to come under intense scrutiny. To meet these challenges, we must:

- Achieve the highest response rate possible

Those of you who worked on the Physician Payment Review Commission study (PPRC) will recall that we achieved a 63% response rate. For this study, we must exceed that excellent performance to achieve our target response rate of 65%. Fortunately, we will have a longer field period for this study which will allow us to do additional follow-up work to increase our response rate. We are also building in some procedures for tracing physicians who cannot be reached at the address or phone number we have.

- Complete the full call design for every case

The call design for this study requires a minimum of ten attempts to reach the physician and an additional five attempts to complete the interview with the physician once reached. Thus, we have set the call maximum at 15 for this study. As you know, these call attempts are to be spread out across days and times of day.

NO SUBSTITUTIONS ARE PERMITTED. You must interview the sampled physician.

- Be creative in finding ways to complete cases

Please share your good ideas for gaining cooperation from physicians and their "gatekeepers."

3. Advance Preparation for This Study

Advance letters from the Robert Wood Johnson Foundation will be sent to physicians each week prior to releasing the physicians' names into the active sample. Letters will be sent about 4 business days prior to release. This means that by the time you call the physician, he/she should have received the letter.

A copy of the letter is reproduced here for your information. You will also have available copies of the letter with the name and address field blank that you can use to fax to physicians' offices upon request. The letter describes the study, asks for the physician's participation, and lists physician organizations that are endorsing the project. We are offering a \$25 honorarium for participation.

We are pleased to be able to list most of the largest and most influential physician organizations among our endorsers. These include the AMA and AOA as well as more specific organizations such as the American Academy of Pediatrics and the American Society of Internal Medicine. Many of these organizations rarely endorse research projects, but have agreed to endorse this study because of the importance of the data that will be collected.

4. The Sample of Physicians

The sample of physicians has been obtained from two sources, the American Medical Association (AMA) Masterfile and the American Osteopathic Association (AOA) Masterfile. Physicians sampled from the AMA Masterfile have the title MD (Medical Doctor). The AOA physicians have the title DO (Osteopathic Physician). (DOs consider the term Doctor of Osteopathy a derogatory term.) Both MDs and DOs receive exactly the same interview. The only difference between the two groups for your purposes is that some specialties are different. These differences have been programmed into the interview and should be transparent to you.

Sampled physicians (both MD and DO) are categorized into two groups: (1) primary care physicians, and (2) non-primary care physicians.

We will be interviewing more primary care physicians than non-primary care physicians. Physician specialties classified as primary care include the following, listed here along with the three digit specialty codes you will be using during the interviews:

019	Family Practice
023	General Practice
042	Internal Medicine (if they tell us during the interview that they practice “General” Internal Medicine and not a subspecialty)
088	Pediatrics (if “General”)
137	Internal Medicine/Pediatrics (if “General”)

There has been a recent trend for some physicians who are trained in medical subspecialties to spend most of their time providing general medical care. So, physicians whose primary specialty is one of the medical specialties will be asked whether they spend most of their time practicing in their subspecialty or providing general medical care. If they mostly provide general care, they will be treated as primary care physicians throughout the survey.

Physicians who spend most of their time practicing in a subspecialty are considered non-primary care physicians. The interviews with non-primary care physicians will be 4-5 minutes shorter than with primary care physicians.

Eligibility Criteria

We asked the AMA and AOA to exclude some physicians from the sample. In particular, we only want to interview physicians who are engaged in direct patient care for 20 or more hours per week, who are not federal employees, not medical residents, clinical fellows, or research fellows. Even though we have tried to select the right physicians into the sample, we will still have to screen respondents to be sure they meet the eligibility criteria.

Since we want to include only physicians who provide care directly to patients, certain physician specialties will be excluded from the study. Most of these will already be screened out by the AMA or AOA when we receive the sample. However, just in case someone actually has a different specialty than the one listed by AMA or AOA, the survey is programmed to terminate interviews for certain excluded specialties.

Those of you who worked on the PPRC study will remember that you had to ask the physician's specialty during the interview, then enter a three digit code on your screen. For this study, we will verify the primary specialty of each physician. If the physician agrees that his/her primary specialty is the one listed by AMA or AOA, you will not have to enter the specialty code. However, if the physician disagrees with the AMA or AOA listing, you will need to look up the specialty he/she names on the Physician Specialty List cards provided, then enter the three digit code corresponding to the specialty named by the physician. The list of physician specialties will be provided to you on cards for your use during interviewing.

It is critical that you make every effort to find a code for the specialty named by the physician. If a respondent mentions a specialty that you cannot find on the Physician Specialty List, ask him/her if the specialty could be listed under a more general name. Explain that you must find and enter a specialty code that is on your list before the interview can proceed. Here's an example from the pretest. The AMA listing showed the physician as a "Pediatrician." When asked, she said "No, my specialty is 'Hypertension.'" This is not a specialty we have listed. However, the respondent recognized that this was likely and told the interviewer her specialty could also be coded as "Nephrology." Any specialty that is coded as "Other, list" will be terminated from the interview. This is why it is so important to work with the respondent to find a codable response.

5. Study Procedures

Working the Sample

The field period for this survey will last for eight months. We have the following goals for completing our work during these eight months:

- Complete a total of 12,600 physician interviews by March 1, 1997.
- Complete 4,000 interviews by September 1, 1996.
- Complete the full call design for each released case within 12 weeks of release.

To meet these goals, we will be releasing sample replicates on a weekly basis. At the start of the study, you will each receive 50 - 75 cases to work. Each week thereafter, you will receive an additional 20 - 25 cases. The sample replicates will be numbered. Each week, you will be notified of the range of sample replicates released that week. So, for example, the first week, we

will release sample replicates 1-42. The information you receive about each new case will include the replicate number.

It is critical that cases are finalized within 12 weeks of their release. What this means to you is that you should always be working through your lowest open replicates trying to finalize cases. Of course, the preferable outcome is a completed interview, but it is imperative that you work through the call design completely with each case during the 12 week time frame. We will talk about this in detail during the training. There will be some special procedures set up to help you complete cases within the 12 week window. The next sections describe these.

Tracing Cases

Unlike many other studies you have worked on, respondents who cannot be located are not automatically disqualified from this survey. We must try to find them and screen them for eligibility before we can count them as final. So, if you get a disconnected number or if the physician no longer works in the office you call, you should call directory assistance to try to get a good number for him/her (as you usually do). If you are unable to obtain a new number for the respondent, the case will be referred to "tracing." Jason Hemenway will be handling the tracing for the project. His job will be to pull the "tracing" cases and attempt to locate them. He will do this by using our CD containing all white and yellow page listings in the U.S. He'll run the physician's name against this list for possible matches, then he will follow up to find the correct physician. Once a correct address is found, we will return the case to active status.

The tracing activities will be most successful if we can identify tracing cases as early as possible. Please be sure to call through all of your new cases as soon as possible after they are released to identify any disconnected or other bad numbers as well as doctors who no longer work in the office we are calling.

The survey has been programmed to allow you to record your attempts to locate the physician. There are screens in the program where you will enter the results of your calls to directory assistance or any information you may obtain from the physician's former office. This information will help in tracing physicians you are unable to locate through usual means.

Refusal Conversion

We are also required by our contract to keep track of refusal conversion efforts. Gina will be working with you to implement our refusal conversion procedures. She will identify interviewers who can work as "refusal converters." The refusal converters will review all hard refusal cases and decide whether to try them again. This means that the more information you can record about refusal cases the better. Your explanation of what happened during a hard refusal call will help the refusal converters decide how to follow up with the case.

Depending on the circumstances, refusal converters may also take over cases that, though not refusals, have not been finalized after repeated attempts, a week or two before the end of the 12 weeks to try to get a completed interview. You may also request that a particularly difficult case be reassigned to a refusal converter if you think this will increase the likelihood of getting a completed interview.

Monitoring

Your work will be monitored not only by Gallup staff but also by client staff. Weekly listen-ins will be set up for the client. Interviewer evaluation forms will be completed weekly for each interviewer working on the study. We will go over these forms with you during training so you know how you will be evaluated. The evaluation will include survey content issues as well as the usual interviewer style factors.

Our plan is to monitor more heavily at the beginning of the study. We will give you feedback and will be available to answer questions that you may have. This is a complex survey. The questionnaire development process has taken more than six months. Every word in every question has been scrutinized again and again. The question by question specifications later in this manual contain information about the purpose of questions, the meaning of terms and concepts, and other instructions. Further, many of the screens contain a lot of information meant to help you and the respondent understand what is meant by the questions. We are aware, however, that it will take time for you to completely master all of this. One important purpose of monitoring will be to provide feedback that will help you complete interviews as the questionnaire designers intended.

Special Issues in Gaining Physician Cooperation

When attempting to gain cooperation from physicians, the advance letter will be your best friend. Make sure you are thoroughly familiar with the contents of this letter. Key points to emphasize are:

- The study is being done by the Robert Wood Johnson Foundation.
- The purpose of the study is to learn how changes in the health care system are affecting physicians' practices and the way they deliver medical care to their patients.
- Results will be used by public and private leaders to make better health policy decisions.
- Memorize the list of endorsing associations. Pay attention to the specialty of the doctor you are calling. Is he/she a pediatrician? Mention that the study is endorsed by the American Academy of Pediatrics.
- Mention the honorarium of \$25.
- All information will be kept confidential. It will only be used in statistical analysis and reported at the group level.

Make use of the fax. Our pretest interviewers had success in getting past office staff to the doctor by insisting on faxing a copy of the advance letter. The pretest interviewers will be at training to describe how this worked for them.

Here are a couple of additional points you may find useful in gaining respondent cooperation:

High and Low Intensity Sites. The earlier discussion mentioned that of the 60 study sites, 12 will be high intensity sites and 48 will be low intensity sites. What this means is that about three times as many interviews will be completed in each high intensity site as in each low intensity site.

At some point during the study, the names of the high intensity sites will be released publicly. Data from the high intensity sites will be available at the local level. The names of the low intensity sites will not be released publicly and data will not be available locally, but only in aggregate form at the national or, possibly, regional level.

The information you receive with each case will identify the case as high or low intensity. In the high intensity sites, it may help you convince physicians to participate when you tell them they will be contributing to a report on their own local area. Make sure you only mention this to respondents in high intensity sites, however, because local data won't be available in low intensity sites.

Availability of Study Report. Our client does not have sufficient funds in their project budget to send study reports out to all participating physicians. So, they have asked us not to offer to send reports to everyone. However, during your negotiations with the physician to gain his/her cooperation for an interview, if the physician asks whether he/she can receive a copy of the study report you may say yes.

At the end of the interview, there is a screen that asks you if the physician requested a copy of the study report. If you indicate that he/she did ask for it, a copy will be sent to the physician at the same address to which we send the check. However, be aware that the study report will not be available until mid-1997 at the earliest.

Special Issues

More than one sampled physician in the same practice. Since physicians will be randomly sampled within sites, it is possible that more than one physician in the same group practice will be chosen to participate. This is especially likely in the smaller, rural sites. In a few cases, we are sampling all available physicians within particular counties.

The pretest interviewers have asked whether we will be able to group together physicians in the same practice because it would be more efficient to work the cases if they could be grouped in this way. Unfortunately, the answer is no. The sample will be released in randomly selected replicates. So, it is possible that you will contact a practice one week looking for Dr. Jones and will have to call back the next week looking for Dr. Smith. The requirements of our sampling procedure just won't allow us to group them together in the same replicate. We will talk about strategies for dealing with this situation during training.

Hardcopy Interviewing. This survey is very complex. Some skip patterns are based on physician specialty codes, words appear differently in some questions depending on the location of the respondent's practice, and there are consistency checks programmed into the CATI

instrument. For these reasons, no interviews should be conducted using a hardcopy instrument. Please discuss any possible exceptions to this rule with Gina.

6. Survey Content

Health Care Costs and Physician Reimbursement Mechanisms

The more you know about the health care system and how physicians are paid, the better able you will be to understand respondents' questions and to help them when they are stumped by our questions. The following few pages have been prepared to help you fill in your knowledge of these topics.

As an experienced physician interviewer, you will be familiar with many of the terms used in the "jargon" of health care costs and reimbursements. However, the health system is changing so rapidly that new developments are occurring all the time. In addition, the terminology used to discuss health care reflects the rapid rate of change -- even some of the most basic terms are used differently by different people or have evolved in their meanings over the last few years. It is important that you understand how we are using health care terminology in this interview.

This section begins with a discussion of some very general terms that you will need. Then it goes on to discuss two broad categories of health insurance -- public and private.

Some General Terms

Some payments to physicians come directly from the patient or his or her family. These are generally referred to as "self-pay". Generally speaking, these payments fall into three categories:

Deductibles: This term refers to the amount that must be paid "out-of-pocket" before the insurance plan will begin to pay. Deductibles are typically used with traditional or "indemnity" insurance plans (see below) or when the patient is using out-of-plan services in preferred provider organizations (PPOs) and point-of-service plans (see below).

Coinsurance & Copayments are terms that are often used interchangeably. Technically, there are differences between them as reflected in the definitions to follow. However, for all practical purposes, they are used interchangeably.

Coinsurance: This term refers to the percentage of a charge that the patient is responsible for. After the deductible has been satisfied, the insurance plan usually pays a certain percentage (say, 75% or 80%), depending on the type of service, and the patient pays the remainder, which is referred to as the coinsurance. Like deductibles, coinsurance is typically used with traditional or "indemnity" insurance plans (see below) or with the use of out-of-plan services in PPOs and point-of-service plans (see below).

Copayments: This term refers to a predetermined flat fee amount that must be paid "out-of-pocket" for each visit to a health care provider participating in the plan, regardless of the services provided on that visit. These amounts are usually small (\$5 - \$15), but may vary according to the type of physician seen. Copayments usually occur in connection with managed care insurance plans (see below).

Methods of Payment

In addition to the three "self-pay" methods just described, the following paragraphs describe other methods of physician payment.

Fee for Service (FFS) is a method used to reimburse physicians in which the amount paid to the provider will be determined according to the actual services provided. The physicians might be paid \$60 for an office visit and \$15 for a blood test, for example.

Discounted Fee for Service arrangements mean that the provider has agreed to provide services to plan members but to charge the plan less than his or her full established charge.

Capitation is a method of payment used to reimburse physicians and other health care providers in many managed care plans. Under capitated agreements, a health care providers agrees to make a specific set of services available to a covered individual for a predetermined, fixed price, regardless of how many services that person actually receives. So, for example, under XYZ Insurance plan, the physician receives \$50 per year for each patient insured under the plan who chooses him/her as their primary care physician. Patient A never comes in to see the doctor during the year, so the doctor makes \$50 without providing any services. Patient B, however, insists on seeing the doctor every two or three weeks complaining of various ailments. For this patient, \$50 doesn't even come close to covering the cost of the patient's care.

Capitation involves the provider in a risk-sharing arrangement, that is, because the amount of care needed by each enrollee could vary, the provider assumes at least some of the financial risk involved in providing health care services.

Bonuses are used by many insurance and managed care plans to create financial incentives for physicians to contain costs. A bonus is an additional payment made

to the physician or his/her practice, which is determined based on analysis of his/her performance or productivity in comparison with peers.

Withholds are used by many insurance and managed care plans to create financial incentives for physicians to contain costs. Under withhold systems, some percentage of a physician's payment is retained or withheld. The portion of the withhold that is later returned is tied to financial performance.

Sources of Payment

The previous paragraphs have described various methods of making payments to physicians. The next few paragraphs describe several sources of physician payments. Broadly speaking, these can be broken into two types: (1) public health insurance programs; and (2) private health insurance.

Public Health Insurance Programs

Medicare and Medicaid are the two main forms of public insurance.

Medicare is a Federal Health Insurance program for people 65 or older and for certain disabled people. Because Medicare is an insurance plan, it has many features in common with private health insurance. Medicare has two parts. **Part A (Hospital Insurance)** helps pay for inpatient hospital care, and for some nursing home, home health, and hospice care. **Part B (Medical Insurance)** helps pay for doctor's services, outpatient hospital services, medical equipment, and some other services not covered by Part A.

Physicians who accept Medicare patients agree to charge no more than Medicare Approved Amounts for covered services. Medicare then pays the physician a percentage of this charge. Patients are also responsible for premiums (for Part B), after the patient has met the annual deductible, for copayments, and for the cost of uncovered services (including dental care and prescriptions).

Because Medicare does not cover 100% of a beneficiary's health costs, many enrollees purchase supplemental insurance known as **Medigap** policies. These policies are not covered by any public funding, therefore any revenue a physician receives from Medigap coverage should be thought of as private or commercial insurance.

Increasingly, Medicare patients are being provided coverage under managed care plans. **Medicare Managed Care** operates much like other managed care plans described below, the physician receives payment from the managed care plan, not from the Medicare program. However, because Medicare is the ultimate payer, we consider that revenue received from these patients is still Medicare revenue. Be

aware, however, that some physicians may not know which managed care patients are being covered under Medicare and which are not, and so may not be able to separate revenue in this way.

Medicaid is funded by both the Federal government and individual states. It is publically-funded insurance for low income persons. Each state designs and administers its own Medicaid program within Federal guidelines; thus eligibility requirements and covered services vary from state to state. Within states, Medicaid programs are often referred to as Medical Assistance programs. Qualifications for Medicaid vary from state to state. Medicaid does not require any premiums or copays. As noted above, Medicaid programs vary by state. As with Medicare, some Medicaid programs provide coverage under managed care plans. States may also have their own terminology for Medicare. **MediCAL** is the Medicaid program in California, **AHCCCS** (pronounced "Access") is the Medicaid program in Arizona. In addition to the plans named, there are many other state, county, and local assistance programs.

Bear in mind that some patients may be covered under both Medicare and Medicaid. In that case, Medicare pays as it normally would and then Medicaid pays the premiums, deductibles, and coinsurance. During this survey, patients covered under both Medicare and Medicaid should be classified under Medicare.

There are also three types of insurance provided by the United States military which you may encounter:

CHAMPUS is an indemnity plan for military retirees and their families and for active duty military members (and their families) who do not have access to a military hospital or doctor. Revenue received from CHAMPUS plans should be included with revenue from other public insurance.

CHAMPVA covers veterans (not retirees) who are not eligible for Medicare, who have service-related illnesses or disabilities. Revenue received from CHAMPVA should be included with revenue from other public insurance.

TRICARE is the new managed health care system for the military. So far it has been implemented in seven states, including California and Texas. The rest of the states will be converted to this system over the next year or so. Revenue received from Tricare should be included with revenue from other public insurance.

Private Health Insurance

In general, most private health care insurance can be thought of as falling into one of two categories, indemnity insurance or managed care, although the boundary between these two is not as clear as it was a few years ago:

Indemnity Insurance is the "traditional" insurance plan. These are the types of plans that primarily existed before the rise of HMOs and other kinds of managed care. Under these plans, each enrollee is free to receive services from any covered, licensed provider (primary care or specialist) and facility. Most indemnity plans require enrollees to pay a deductible before the company begins paying some predetermined percentage of the enrollee's medical costs. Physicians are reimbursed on a fee-for-service or discounted fee-for-service basis. Some indemnity plans have begun to adopt cost containment measures similar to those used by managed care plans, such as requiring prior authorization before hospital stays.

Managed Care includes any type of group health plan using financial incentives or specific controls to encourage enrollees to use certain providers, services, or sites associated with the plan. Managed care plans also typically include formal programs of quality assurance and utilization review (see glossary). Physicians may be paid in several ways. They may be salaried (as in the case of a staff model HMO). They may agree to accept a certain fixed payment for each enrolled patient, that is, to be paid on a risk-sharing or capitated basis. Or they may agree to accept payments that are lower than their usual fee, that is, to be paid on a discounted fee-for-service basis. Some examples of managed care plans are HMOs, PPOs, IPAs and point of service plans (POS). Direct contracts with employers paid on a discounted fee-for-service or capitated or other prepaid basis are sometimes also be considered managed care.

Until a few years ago, most people were insured under traditional indemnity plans. Managed care plans, however, have grown rapidly over the past two decades, and in most parts of the country now account for the larger share of the insurance market. Today there are many variants of managed care plans; here are some of the most common:

Health Maintenance Organization (HMO) is an organized prepaid health care system under which enrollees pay a fixed monthly charge. Instead of being charged separately for each visit or service, they pay only a small amount (see copayment above) for most office visits and may pay little or nothing for other kinds of services. Enrollees are typically covered only for services received from physicians who are part of the plan.

Several types of HMOs exist:

Staff Model: Under this model, care is delivered by salaried physicians who are employed by the HMO. Physicians offices are located in facilities owned and operated by the HMO. Physicians in staff model HMOs usually see only patients who belong to the HMO.

Group Model: Under this model, the HMO contracts with one or more large, multi-disciplinary physician groups to provide health services, again in a central facility

but usually one that is owned by the physician group. The physician group practice has usually been organized specifically to provide services for the HMO. Physicians in group model HMOs usually see only patients who belong to the HMO.

Network Model and Individual Practice Associations (IPAs): Under this model, individual physicians (or group practices) sign contracts with an HMO to deliver services to HMO enrollees in the physician's own offices. The physicians also see other non-HMO patients. The HMO enrollees are given a directory of physicians from which they choose a primary care physician. The primary care physician acts as a "gatekeeper" and refers the enrollee to specialists in the HMO as needed. Physicians in Network Model and IPA HMOs usually also see patients covered by other insurance plans outside of their own HMO.

Note: Sometimes staff or group model HMOs find it is not cost-effective to have specialists on staff, particularly if they will be needed only infrequently. The HMO may negotiate a contract with a specialist to provide services to HMO enrollees who need the specialist services. The HMO might pay for these "carved-out" services on a capitated basis or on a fee-for-service basis. Hence, the patient is on a prepaid or capitated basis, but the physician might be reimbursed by the patient's health care plan on a fee-for-service basis.

Not all managed care plans are HMOs. Other types of managed care plans include:

Integrated Health Systems (IHS) link hospitals and physicians into a single organization, which combines assets, efforts, risk and revenues to deliver comprehensive health care services. These systems are generally created to give the physicians who participate increased bargaining power and marketability in the managed care system. An IHS consists of a parent holding company that owns at least two or more subsidiary organizations, one of which is, owns, or operates a medical practice, and the other is, owns or operates a hospital. Frequently IHS's also include other kinds of health care facilities or services, such as long term care facilities or mental health services. May also be called Integrated Service Networks (ISN) or Integrated Health Care Systems (IHCS).

Physician-Hospital Organization (PHO): A legal entity formed by hospitals and physicians which serves as a negotiating, contracting, and marketing organization. PHOs may own and operate ambulatory/ancillary care projects or act as an agent for managed care contracts. PHOs are similar to Integrated Health Systems, but generally do not have a parent holding company.

Preferred Provider Organizations (PPOs) are health care delivery systems through which the sponsor negotiates price discounts with providers in exchange for higher patient volumes. The sponsor may be an insurer, employer, or third party administrator. As in indemnity plans, enrollees are usually free to receive services

from any covered, licensed provider (primary care or specialist) and facility, however, enrollees who see participating providers pay only a small copayment; enrollees who see providers who are not part of the plan must pay a percentage (usually 20-30%) of the regular, non-discounted fee. Some PPOs use a gatekeeper concept, that is, they require the enrollee to choose a primary care specialist who decides if and when they should be referred to a specialist.

Point of Service (POS) plans, also called **open-ended HMOs, HMO swing-outs, or HMO/PPO hybrids**, provide a network of physicians who work for the HMO but also reimburse enrollees for services received outside the HMO. As in PPOs, enrollees pay a greater percentage of the cost for services outside the plan.

These are the main types of managed care plans. Other terminology you may encounter when talking to physician's about practice arrangements include:

Foundations are corporations, usually hospital affiliates or subsidiaries, that acquire all assets of medical group practices and negotiate/execute managed care contracts in their own name on behalf of the hospital and physicians as a unit.

Gatekeepers, sometimes called case managers, are used as cost containment measures in many managed care plans. Under a gatekeeper system, plan enrollees must obtain permission from their assigned primary care physician, or "gatekeeper", in order to see specialists or have special tests or procedures.

Management Services Organizations (MSO) are legal entities which provide practice management, administrative, and other types of support services to physicians, group practices, or hospitals. They are frequently used by providers in negotiating risk-sharing or capitation arrangements.

Independent Practice Associations (IPA) (that is not an HMO) are similar to PPOs in that they are comprised of a network of multi-specialist physicians who bind together to negotiate with managed care organizations and to compete for enrollees. This type of arrangement is especially common in California but is also beginning to appear elsewhere in the country.

The Interview – Question by Question Specifications

This section lists the text for each of the questions in the survey along with explanatory information that may be helpful to you when conducting the interview. The explanatory information is in bold type

- S1. DOCTOR TYPE: (Code from fone file)
 - 1 DO
 - 2 MD
- S1a. REPLICATE RELEASE DATE: (Code from fone file)
- S1b. REPLICATE NUMBER: (Code from fone file)
- S2. DOCTOR NAME: (Code from fone file)
- S3. PRIMARY SPECIALTY (Code from fone file)
- S4. SITE NUMBER (Code from fone file)
- S5. SITE TYPE (Code from fone file)
 - 1 High intensity (Site #01-12
 - 2 Low intensity (Site #13-#60)
 - 3 National sample (Site #00)
- S6. ZIP CODE: (Code from fone file)

SECTION A. INTRODUCTION AND SCREENING

Hello, Dr. (name from fone file) my name is _____ from The Gallup Organization. A short time ago, you should have received a letter from the Robert Wood Johnson Foundation indicating that Gallup is conducting a national survey of physicians for the Foundation. The survey is part of a study of changes in the health care system in communities across the nation. It concerns how such changes are affecting physicians, their practices and the health care they provide to their patients.

The interview will take about 20-25 minutes and we are providing an honorarium of \$25 as a small token of our appreciation to each physician who completes an interview. All the information you provide will be kept strictly confidential. It will be used in statistical analysis and reported only as group totals. I can conduct the interview now or at any time that's convenient for you.

- 1 Available – (Skip to #A1)
- 2 Not available – (Set time to call back)
- 3 No longer works/lives here – (Skip to S8)
- 4 Never heard of respondent – (Continue)
- 5 Non-respondent hard refusal - (Skip to S13)
- 6 Physician soft refusal – (Skip to S13)
- 7 Physician hard refusal – (Skip to S13)
- 8 Answering service/
Can't ever reach physician at this number (Skip to S11)
- 9 Other – (Skip to S13)

Notice that there are three refusal codes. You should use code "5" if you get a hard refusal from someone besides the sampled physician. Use "6" if the physician him/herself gives a soft refusal and use "7" for a hard refusal from the sampled physician. These codes will help our refusal conversion team know how to follow up.

S7. (If code "4" in "INTRO", ask:) I would like to verify that I have reached (phone number from fone file).

- 1 Yes (Thank and Terminate; Skip to S11)
- 2 No (READ:) I am sorry to have bothered you. - (Reset to "INTRO")
- 3 (DK) (Thank and Terminate; Skip to S11)
- 4 (Refused) (Thank and Terminate; Skip to S11)

This is the first step in checking a "bad" number.

S8. (If code "3" in "INTRO", ask:) Dr. (response in S2) is a very important part of a medical study for the Robert Wood Johnson Foundation. Do you have the address or telephone number where I can reach (him/her)?

- 1 Yes (Skip to S10)
- 2 No/Unknown (Continue)
- 3 (DK) (Continue)
- 4 (Refused) (Continue)

Hopefully, the person you speak with will know the whereabouts of the sampled physician. Even if he/she does not know the physicians complete new address, you may be able to get a partial address. Even the name of the city and/or state will be helpful. This is the first in a series of questions that allows you to record any information you receive.

S9. (If code "2-4" in S8, ask:) Do you happen to know if the doctor is still in this area, or is (he/she) in another city?

- 1 Same area (Thank and Terminate; Skip to S11)
- 2 Different city (Continue)
- 3 (DK) (Thank and Terminate; Skip to S11)
- 4 (Refused) (Thank and Terminate; Skip to S11) ()

Maybe the person doesn't have an exact address or telephone number, but even knowing whether the doctor is still in the same city or not will be a big help in tracing him/her.

S10. (If code "2" in S9 OR If code "1" in S8:) ENTER PHONE NUMBER AND ADDRESS OR AS MUCH OF IT AS POSSIBLE.

WORK PHONE NUMBER	(517 - 526)
HOME PHONE NUMBER	(527 - 539)
STREET ADDRESS	(540 - 579)
CITY	(612 - 641)
STATE	(642) (643)
ZIP CODE:	(712 - 720)

(All in S10, Thank and Terminate;
Call new number and reset to "INTRO";
If "blank" in "WORK PHONE NUMBER" and
"HOME PHONE NUMBER" in S10, Continue)

Even a city name is helpful. If the person you are talking with only knows the name of the practice group or HMO name, please enter even these fragmentary pieces of information. This information is used only for tracing not for mailing purposes.

S11. (If code "1", "3" or "4" in S7 OR If code "8" in "INTRO" OR If code "1", "3" or "4" in S9 OR If "blank" in "WORK PHONE NUMBER" and "HOME PHONE NUMBER" in S10:) (Call directory assistance for most recent city or area code. Ask for directory assistance using full name from fone file.)

(Original phone number from fone file)

(Original city from fone file) or ("CITY" from S10)

(New city; New street address)

(Name from fone file)

- 1 New number - (Enter on next screen)
- 2 No number/match - (Thank and Terminate; Save Case ID) (1058)

Only code as "1" if there is a single exact match. If there is more than one match, and you can't identify the exact one, code "2" and enter multiple phone numbers on the verbatim screen.

S12 NEW PHONE NUMBER: (FORCE 10 DIGITS) (1059-1068)

(All in S12, call new number and reset to "INTRO")

S13. VERBATIM SCREEN: Describe what happened on this call in as much detail as possible.

You will end up at this screen if you code any of the three refusal codes ("5," "6," or "7") or Other (code "8") at the INTRO screen. You will also end up here if you have tried to obtain a new telephone number through directory assistance without success.

Give as much detail as possible on this verbatim screen. It will help with the tracing or refusal conversion efforts to follow.

CLOCK: (2812-2815)

Several of the questions in Section A are used to determine the respondent's eligibility for the survey. Those who are not eligible are thanked for their help, and the interview ends. Those who are NOT eligible include:

Full-time employees of federal agencies (such as the U.S. Public Health Service, Veterans Administration, and the military services) [A1]

Medical residents, clinical fellows, research fellows [A2]

- **Those who provide direct patient care for less than 20 hours a week [A3]**
- **Physicians whose primary specialty is excluded from the survey. [A7, A8]**

A1. *Are you currently a full-time employee of a federal agency such as the U.S. Public Health Service, Veterans Administration or a military service? (Probe:) Do you receive your paychecks from a federal agency?*

- 1 Yes (Continue)
- 2 No (Skip to #A2)

- 8 (DK) (Thank and Terminate)
 9 (Refused) (Thank and Terminate) (513)

(If YES:) In this survey, we will not be interviewing physicians who are Federal employees. So it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - (Thank and Terminate)

Notice the probe "Do you receive your paychecks from a federal agency?" This question may help respondents who are not sure whether they are employed by a federal agency. For example, if a respondent works for a group practice that is under contract to a federal agency, the physician will not receive his/her paycheck directly from the federal agency but will receive it from the practice where he/she works. In this case, the physician would NOT be considered a federal employee.

Only federal employees are ineligible for this survey. Physicians who work for state, county or city governments ARE eligible.

A2. *Are you currently a resident or fellow?*

- 1 Yes (Continue)
 2 No (Skip to #A3)
 8 (DK) (Thank and Terminate)
 9 (Refused) (Thank and Terminate) (514)

(If YES:) In this survey, we will not be interviewing physicians who are residents or fellows. So it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - (Thank and Terminate)

Residents and fellows (also called postdoctoral fellowships) are considered to be "in training" and are therefore not eligible for the survey.

A3. *During a TYPICAL week, do you provide direct patient care for at least 20 hours a week? (If necessary, read:) Direct patient care includes seeing patients and performing surgery.*

- 1 Yes (Skip to #A4)
 2 No (Continue)
 8 (DK) (Thank and Terminate)
 9 (Refused) (Thank and Terminate) (515)

(If NO:) In this survey, we will not be interviewing physicians who typically provide patient care for less than 20 hours a week. So it appears that we do not need any further

information from you at this time, but we thank you for your cooperation. - (Thank and Terminate)

Direct patient care is an important study concept. You should understand how it is defined in detail. Of course, direct patient care includes seeing patients in the doctor's office. It also:

INCLUDES surgery, time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. It also includes hours on-call when the physician is actually working, for example, talking to patients on the telephone or seeing patients in an emergency room.

EXCLUDES time spent in training, teaching or research, any hours on-call when not actually working (e.g., at home or out to dinner), and travel between home and work at the beginning and end of the work day.

A4. *Do you currently provide patient care in one practice, or more than one practice? (If necessary, read:) We consider multiple sites or offices associated with the same organization to be only one practice. (INTERVIEWER NOTE #1: Examples are: a private MD with a downtown and suburban office is one practice; a regional organization with member doctors practicing in numerous satellite clinics or offices is one practice; and multiple sites with DIFFERENT organizations are different practices.) (INTERVIEWER NOTE #2: Do not count non-patient-care activity, such as teaching or administrative jobs, as practices.)*

- | | | | |
|---|---------------|---------------|-------|
| 1 | One | (Skip to #A5) | |
| 2 | More than one | (Continue) | |
| 8 | (DK) | (Skip to #A5) | |
| 9 | (Refused) | (Skip to #A5) | (516) |

This question establishes whether the physician has one or more practices so that later questions may be asked only about his/her main practice. We are concerned only with patient-care practices. If the respondent mentions having an administrative position that doesn't involve patient care, we don't count that as a practice. However, if the respondent sees patients as part of his or her administrative duties, then it is a second practice.

Notice that multiple sites or offices connected with one organization are considered to be only one practice. For instance, a physician could have a city office, a suburban office and another in a hospital that are all part of the same practice. This physician has just ONE practice. Another physician could work at more than one site for more than one organization; these sites would count as different practices. This physician has MORE THAN ONE practice.

A4a. *(If code "2" in #A4, ask:) In how many different practices do you provide patient care? (Open ended and code actual number)*

DK (DK)

RF (Refused) (517) (518)

- A5. *We'd like you to think about the practice location at which you spend the greatest amount of time in direct patient care. Is this practice located in (county and state from fone file)?*(INTERVIEWER NOTE: Surgeons should give the location of their office, not the hospital where they perform surgery.)

1 Yes (Skip to #A6)

2 No (Continue)

8 (DK) (Continue)

9 (Refused) (Continue)

Notice the interviewer note: Surgeons should give the location of their office, not the hospital where they perform surgery.

The county and state listed in the fone file will appear in this question so you can verify that the physician is practicing where we expect him/her to be. Sometimes, however, the address we have for the physician may be his/her home address or possibly it may be an office address, but not be the practice location where he/she spends the most patient care time.

A5a. (If code "2" or "8-9" in #A5, ask:) In what county and state is the practice located?.
(Open ended) (VERIFY SPELLING)

DK (DK)

RF (Refused)

COUNTY:

(1434-1458)

STATE:

(1459)(1460)

It is **CRITICAL** that you verify the spelling of the county name! Even simple names can be spelled differently than you expect. For example, there are several "Green" counties and several "Greene" counties in the U.S.

Do not enter the word "COUNTY" or the abbreviation "CO." For example, if the doctor says his practice is in Orange County, California, please enter "ORANGE" and "CA". We will be using a computer program to match the county name you enter with a FIPS code. Entering "COUNTY" or the abbreviation "CO." may cause a mismatch.

A6. In what year did you begin medical practice after completing your undergraduate and graduate medical training? (INTERVIEWER NOTE: A residency or fellowship would be considered graduate medical training.) (Open ended and code last two digits of year)

98 (DK)

99 (Refused)

(523) (524)

We consider the doctor to have begun medical practice after the completion of graduate medical training. So, for example, some physicians began medical practice in the military or overseas. As long as this is after completion of their medical training, it should be counted.

A7. *We have your primary specialty listed as (response in "SPECIALTY"). Is this correct? (If necessary, read:) We define primary specialty as that in which the most hours are spent weekly.*

1 Yes (Autocode "SPECIALTY" in #A8)

2 No (Continue)

8 (DK) (Thank and Terminate)

9 (Refused) (Thank and Terminate) (525)

You will first try to verify that we have the correct primary specialty listed for this physician. If so, you will not need to enter a specialty code. If not, you will continue with #A8.

A8. *(If code "2" in #A7, ask:) What is your primary specialty? (If necessary, read:) We define primary specialty as that in which the most hours are spent weekly. (Open ended and code from hard copy) (INTERVIEWER NOTE: Probe for codable response)*

We define primary specialty as that in which the most hours are spent weekly.

If the physician's primary specialty is different from the specialty listed in the AMA Masterfile, you will have to find that specialty on the Physician Specialty List card and enter the three digit code for that specialty. It is especially important to distinguish between primary care physicians and specialists.

The following specialties are considered primary care:

019 Family Practice

020 General Practice

042 Internal Medicine

088 Pediatrics

137 Internal Medicine/Pediatrics

Notice the instruction for code "997 - Other (list)" - USE VERY SPARINGLY. It is critical that you make every effort to find a code for the specialty named by the physician. If a respondent mentions a specialty that you cannot find on the Physician Specialty List, ask him/her if the specialty could be listed under a more general name. Explain that you must find and enter a specialty code that is on your list before the interview can proceed. Any specialty that is coded as "997-Other,

list" will be terminated from the interview. This is why it is so important to work with the respondent to find a codable response. You may read possible codes to the respondent if you cannot find an exact match.

Here's an example from the pretest. The AMA listing showed the physician as a "Pediatrician." When asked, she said "No, my specialty is 'Hypertension.'" This is not a specialty on our list. However, the respondent recognized that this was likely and told the interviewer her specialty could also be coded as "Nephrology."

- A8. (If code "003", "005-007", "013-014", "018", "025", "028", "057", "099", "103-115", "117-123", "129-131", "135", "138-143" or "148-149" in #A8, read:) In this survey, we are only interviewing physicians in certain specialties, and your specialty is not among those being interviewed. So, it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - (Thank and Terminate)

This termination screen appears for the specialties that are excluded from this survey.

*(If code "042", "088" or "137" in #A8, Continue;
If code "001-002", "004", "009", "012", "015-016",
"020-022", "024", "035-041", "043-048", "055-056", "085",
"116", "128", "136" or "147" in #A8, Skip to #A9a;
If code "017", "049-054", "063", "086-087", "089-094",
"095-098", "133" or "144-145" in #A8, Skip to #A9b;
Otherwise, Skip to #A15)*

Questions A9 - A10: In this series of questions, we are trying to determine if the physician is a primary care physician (PCP) or a non-primary care physician (Non-PCP). An important reason for obtaining this information is that at certain points in the interview, different questions will appear depending on whether the respondent is a primary care physician or a non-primary care physician.

- A9. (If code "042", "088" or "137" in #A8, ask:) Do you spend more hours weekly in general (response in #A8), or a subspecialty in (response in #A8)? (INTERVIEWER NOTE: If respondent says "50/50 split", code as "1")

- 1 General (Skip to #A15)
- 2 Subspecialty (including adolescent medicine or geriatrics) (Skip to #A10)
- 8 (DK) (Skip to #A15)

9 (Refused)

(Skip to #A15)

(529)

If physicians say they practice both the general specialty and a subspecialty, explain we're interested in the one in which they spend the most hours weekly. If their time is evenly split, they will be treated as primary care physicians.

A9a. (If code "001-002", "004", "009", "012", "015-016", "020-022", "024", "035-041", "043-048", "055-056", "085", "116", "128", "136" or "147" in #A8, ask:) Do you spend most of your time practicing in (response in #A8), or in general internal medicine?
(INTERVIEWER NOTE: If respondent says "50/50 split", code as "1")

1 Subspecialty

2 General internal medicine (or general family practice)

3 General pediatrics

8 (DK)

9 (Refused)

(1280)

(All in #A9a, Skip to #A15)

This question will be asked of physicians whose primary specialty is listed as one of the medical subspecialties. If it turns out that the physician actually spends most of his/her time practicing general internal medicine, he/she will be treated as a PCP in the remainder of the interview.

A9b. (If code "017", "049-054", "063", "086-087", "089-098", "133" or "144-145" in #A8, ask:) Do you spend most of your time practicing in (response in #A8), or in general pediatrics? (INTERVIEWER NOTE: If respondent says "50/50 split", code as "1")

- 1 Subspecialty
- 2 General internal medicine (or general family practice)
- 3 General pediatrics
- 8 (DK)
- 9 (Refused) (877)

(All in #A9b, Skip to #A15)

This question will be asked of physicians whose primary specialty is listed as one of the pediatric medical subspecialties. If it turns out that the physician actually spends most of his/her time practicing general pediatrics, he/she will be treated as a PCP in the remainder of the interview.

A10. (If code "2" in #A9, ask:) And what is that subspecialty? (If "More than one", read:) We're interested in the one in which you spend the most hours weekly.

If a subspecialty is given, you will find the 3 digit code from the Physician Specialty List card. Be sure to make every effort to find a codable specialty because any coded as "997-Other(list)" will be terminated from the interview.

Questions A11-A18 ask about board certification and board eligibility. The skip pattern through this series of questions varies depending on the physician's specialty. Since we anticipate that you will use this manual as a reference during the field period, the definitions of board certification and board eligibility have been repeated as appropriate under each of the following questions.

A11. *Are you board-certified in (response in #A10)?*

- 1 Yes (Skip to #A19)
- 2 No (Continue)
- 8 (DK) (Continue)
- 9 (Refused) (Continue) (878)

Becoming board-certified in a specialty usually involves completing an extended residency, demonstrating experience, completing special studies and passing an examination. The recognition comes from one of 23 organizations belonging to the American Board of Medical Specialties. The 23 boards also grant certification in more than 40 subspecialties after physicians have shown further study, experience and examination.

A12. (If code "2" or "8-9" in #A11, ask:) Are you board-eligible in (response in #A10)?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused) (533)

Board eligibility means the physician has completed the necessary education and training requirements for board certification, but has not yet taken or passed the qualifying specialty board examination, and has not exhausted the allowable time period or eligibility requirements for doing so.

A13. Are you board-certified in (response in #A8)?

- 1 Yes (Skip to #A19)
- 2 No (Continue)
- 8 (DK) (Continue)
- 9 (Refused) (Continue) (534)

(If code "1" in #A12, Skip to #A19; Otherwise, Continue)

Becoming board-certified in a specialty usually involves completing an extended residency, demonstrating experience, completing special studies and passing an examination. The recognition comes from one of 23 organizations belonging to the American Board of Medical Specialties. The 23 boards also grant certification in more than 40 subspecialties after physicians have shown further study, experience and examination.

A14. (If code "2" or "8-9" in #A13, ask:) Are you board-eligible in (response in #A8)?

- 1 Yes

- 2 No
- 8 (DK)
- 9 (Refused) (535)

(All in #A14, Skip to #A19)

Board eligibility means the physician has completed the necessary education and training requirements for board certification, but has not yet taken or passed the qualifying specialty board examination, and has not exhausted the allowable time period or eligibility requirements for doing so.

A15. Are you board-certified in (response in #A8)? (INTERVIEWER NOTE of code "137" in #A8: If physician is says "Board certified in Internal Medicine" or "Board certified in Pediatrics", code as "1")

- 1 Yes (Skip to #A19)
- 2 No (Continue)
- 8 (DK) (Continue)
- 9 (Refused) (Continue) (536)

Becoming board-certified in a specialty usually involves completing an extended residency, demonstrating experience, completing special studies and passing an examination. The recognition comes from one of 23 organizations belonging to the American Board of Medical Specialties. The 23 boards also grant certification in more than 40 subspecialties after physicians have shown further study, experience and examination.

A16. (If code "2" or "8-9" in #A15 AND code "137" in #A8, ask:) Are you board-eligible in (response in #A8)? (INTERVIEWER NOTE: If physician is says "Board eligible in Internal Medicine" or "Board eligible in Pediatrics", code as "1")

(Otherwise, ask:) Are you board-eligible in (response in #A8)?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused) (537)

Board eligibility means the physician has completed the necessary education and training requirements for board certification, but has not yet taken or passed the qualifying specialty board examination, and has not exhausted the allowable time period or eligibility requirements for doing so.

(If code "019", "023", "042", "088" or "137" in #A8,
Skip to #A19; Otherwise, Continue)

A17. *Are you board certified in any specialty?*

- 1 Yes (Skip to #A19)
- 2 No (Continue)
- 8 (DK) (Continue)
- 9 (Refused) (Continue) (538)

(If code "1" in #A16, Skip to #A19; Otherwise, Continue)

Becoming board-certified in a specialty usually involves completing an extended residency, demonstrating experience, completing special studies and passing an examination. The recognition comes from one of 23 organizations belonging to the American Board of Medical Specialties. The 23 boards also grant certification in more than 40 subspecialties after physicians have shown further study, experience and examination.

A18. (If code "2" or "8-9" in #A17, ask:) Are you board eligible in any specialty?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused) (539)

Board eligibility means the physician has completed the necessary education and training requirements for board certification, but has not yet taken or passed the qualifying speciality board examination, and has not exhausted the allowable time period or eligibility requirements for doing so.

A19 *Many of the remaining questions are about your practice and your relationships with patients. Before we begin those kinds of questions, let me ask you: Thinking very generally about your satisfaction with your overall career in medicine, would you say that you are currently very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied, OR neither satisfied nor dissatisfied.*

- 5 Very satisfied
- 4 Somewhat satisfied
- 3 Somewhat dissatisfied
- 2 Very dissatisfied
- 1 OR, Neither satisfied nor dissatisfied
- 8 (DK)
- 9 (Refused) (540)

This is an opinion question and should be answered according to the physician's interpretation of the phrase "satisfaction with your overall career in medicine."

CLOCK: (2816-2819)

SECTION B. UTILIZATION OF TIME

B1. (If code "2" in #A4 AND code "03-97" in #A4a OR If code "8-9" in #A4, ask:)
Considering all of your practices, approximately how many weeks did you practice medicine during 1995? Exclude time missed due to vacation, illness and other absences. (If necessary, read:) Exclude family leave, military service, and professional conferences. If your office is closed for several weeks of the year, those weeks should NOT be counted as weeks worked. (Open ended and code actual number)

This version of question B1 is read to respondents with more than two practices or those who answer "Don't know" or "Refused" to the question about how many practices they have.

(If code "2" in #A4 AND code "02" in #A4a, ask:) *Considering both of your practices, approximately how many weeks did you practice medicine during 1995? Exclude time missed due to vacation, illness and other absences. (If necessary, read:) Exclude family leave, military service, and professional conferences. If your office is closed for several weeks of the year, those weeks should NOT be counted as weeks worked. (Open ended and code actual number)*

This version of question B1 is read to respondents with two practices.

(If code "1" in #A4, ask:) *Approximately how many weeks did you practice medicine during 1995? Exclude time missed due to vacation, illness and other absences. (If necessary, read:) Exclude family leave, military service, and professional conferences. If your office is closed for several weeks of the year, those weeks should NOT be counted as weeks worked. (Open ended and code actual number)*

This version of question B1 is read to respondents with only one practice.

53

97 BLOCK

DK (DK)

RF (Refused) (541) (542)

In question B1, exclude time missed due to vacation, illness, family leave, military service, and professional conferences. If the physician's office is closed for several weeks of the year, those weeks should NOT be counted as weeks worked.

Family leave includes maternity and paternity leave, as well as time off to care for a sick child, parent, or other family member.

Professional conferences for which the physician took vacation time to attend would be excluded from time worked. However, professional conferences and continuing medical education courses that the physician attended during work time or without taking vacation time should be included as time worked.

- B2. (If code "2" in #A4 AND code "03-97" in #A4a OR If code "8-9" in #A4, ask:) *Considering all of your practices, during your last complete week of work, approximately how many hours did you spend in all medically related activities? Please include all time spent in administrative tasks, professional activities and direct patient care. Exclude time on call when not actually working. (Open ended and code actual number)*

This version of B2 is for physicians with more than two practices.

(If code "2" in #A4 AND code "02" in #A4a, ask:) *Considering both of your practices, during your last complete week of work, approximately how many hours did you spend in all medically related activities? Please include all time spent in administrative tasks, professional activities and direct patient care. Exclude time on call when not actually working. (Open ended and code actual number)*

This version of B2 is for physicians with two practices.

(If code "1" in #A4, ask:) *During your last complete week of work, approximately how many hours did you spend in all medically related activities? Please include all time spent in administrative tasks, professional activities and direct patient care. Exclude time on call when not actually working. (Open ended and code actual number)*

This version of B2 is for physicians with one practice.

169-

997 BLOCK

DK (DK)

RF (Refused) (543) (544) (545)

The last complete week of work is the most recent week during which the physician worked his or her normal schedule (i.e., without taking time off for vacation, sick leave, family leave, military service, etc.). If a physician normally works only a part-time schedule, then the last week s/he worked this complete part-time schedule is the last complete week of work.

This question is asking for an estimate of the TOTAL hours the physician worked in the last complete week in ALL medically related activities. The only "work" time that should be excluded are on-call hours when the physician is not actually working.

On-call hours can be split into two parts:

1. On-call hours when the physician IS NOT actually working

These hours are what most people think of by on-call hours. The physician is required to be accessible by beeper, but can be pursuing other non-work activities (e.g., at home or out to dinner). These hours should be EXCLUDED from the answer to this question.

2. On-call hours when the physician IS actually working

This category includes hours during which the physician is required to be physically present in a facility (e.g., a hospital or nursing home) in case a medical need arises or when working while on call (e.g., on the phone with patients or seeing patients in an emergency room). These hours should be INCLUDED as part of the estimate of total hours worked.

If the respondent is having difficulty with this question, it is probably best to focus on the exclusion of on-call hours when not actually working and just ask the physician to subtract these hours from all other hours worked.

If specific examples of activities that would be included are needed, you can read from the following list:

- seeing patients or performing surgery
- telephone consultation with patients, their families, or other physicians
- interpreting lab tests and x-rays and providing other services to patients
- reviewing or completing patients' medical records
- traveling between patient care sites during the work day (e.g., between hospitals, offices, nursing homes, etc.)
- administrative and managerial activities connected with the practice and/or other medical facilities
- patient billing and handling of insurance claims
- professional activities not related to patient care
- supervising residents or medical students, teaching, lecturing, conducting research, and/or professional writing

B3. (If code "001-168" in #B2, ask:) *Of these (response in #B2) hours, how many did you spend in direct patient care activities? (If necessary, read:) INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. (If appropriate, read:) INCLUDE ALL PRACTICES, not just the main practice. (Open ended and code actual number)*

(If code "DK" or "RF" in #B2, ask:) *About how many hours did you spend in direct patient care activities? (If necessary, read:) INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. (If appropriate, read:) INCLUDE ALL PRACTICES, not just the main practice. (Open ended and code actual number)*

169-

997 BLOCK

DK (DK)

RF (Refused)

(546) (547) (548)

This question is asking for a subset of the hours reported in B2. The emphasis is on time spent in activities related to the care of patients. These activities would INCLUDE:

- seeing patients or performing surgery
- telephone consultation with patients, their families, or other physicians
- interpreting lab tests and x-rays and providing other services to patients
- reviewing or completing patients' medical records
- traveling between patient care sites during the work day (e.g., between hospitals, offices, nursing homes, etc.)
- on call hours when actually working

Time spent in the following activities should be EXCLUDED when answering this question:

- administrative and managerial activities connected with the practice and/or other medical facilities
- patient billing and handling of insurance claims
- professional activities not related to patient care
- supervising residents or medical students, teaching, lecturing, conducting research, and/or professional writing
- traveling between home and work at the beginning and end of the work day
- on-call hours when NOT actually working

(If response in #B3 = response in #B2, Continue;

If response in #B3 > response in #B2,

Skip to B4; Otherwise, Skip to #B6)

B3a. So, you spent all of your time working in direct patient care, is that right?

- | | | | |
|---|-----------|---------------|-------|
| 1 | Yes | (Skip to #B6) | |
| 2 | No | (Continue) | |
| 8 | (DK) | (Skip to #B6) | |
| 9 | (Refused) | (Skip to #B6) | (575) |

This is the first in a series of questions that will allow you to check the respondent's answers to B2 and B3, then make corrections if necessary. Read through questions

B3a, B3b, B3c, B3d, B4 and B5 to make sure you understand how this check series works.

B3b. (If code "2" in #B3a, ask:) I have recorded that you spent (response in #B2) hours in all medically related activities and (response in #B3) hours in direct patient care. Which of these is incorrect?

- 1 All medically related activities hours (Continue)
- 2 Direct patient care hours (Skip to #B3d)
- 3 (Neither are correct) (Continue)
- 4 (Both are correct) (Skip to #B6)
- 8 (DK) (Skip to #B6)
- 9 (Refused) (Skip to #B6) (576)

B3c. (If code "1" or "3" in #B3b, ask:) Thinking of your last complete week of work, approximately how many hours did you spend in all medically related activities? Please include all time spent in administrative tasks, professional activities and direct patient care. Exclude time on call when not actually working. (Open ended and code actual number)

- 169
- 997 BLOCK
- DK (DK)
- RF (Refused) (577) (578) (579)

B3d. (If code "2" or "3" in #B3b, ask:) Thinking of your last complete week of work, about how many hours did you spend in direct patient care activities? (If necessary, read:) INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. (If appropriate, read:) INCLUDE ALL PRACTICES, not just the main practice. (Open ended and code actual number)

- 169
- 997 BLOCK
- DK (DK)
- RF (Refused) (674) (675) (676)

(All in #B3d, Skip to #B6)

- B4. *I may have made a recording mistake. My computer is showing that I've recorded more hours spent in direct patient care than in ALL medical activities. So, during your last complete week of work, approximately how many hours did you spend in ALL medically related activities? Please include all time spent in administrative tasks, professional activities and direct patient care, as well as any hours spent on call when actually working? (Open ended and code actual number)*

169

997 BLOCK

DK (DK)

RF (Refused) (549) (550) (551)

The same definitions and instructions apply to B4 as to B2.

- B5. *And of those total [(response in #B4)] hours, about how many did you spend in direct patient care activities? (If necessary, read:) INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. (If appropriate, read:) INCLUDE ALL PRACTICES, not just the main practice. (Open ended and code actual number)*

169-997 BLOCK

DK (DK)

RF (Refused) (552) (553) (554)

The same definitions and instructions apply to B5 as to B3.

- B6. *(If code "8-9" in #A4 OR If code "03-97" in #A4a, ask:) Again thinking of all your practices, during the LAST MONTH, how many hours, if any, did you spend providing CHARITY care? By this we mean, that because of the financial need of the patient you charged either no fee or a reduced fee. Please do not include time spent providing services for which you expected, but did not receive, payment. (Probe:) Your best estimate would be fine. (Open ended and code actual number)*

This version of the question is asked of physicians with more than two practices.

(If code "02" in #A4a, ask:) Again thinking of both of your practices, during the LAST MONTH, how many hours, if any, did you spend providing CHARITY care? By this we mean, that because of the financial need of the patient you charged either no fee or a reduced fee. Please do not include time spent providing services for which you expected, but did not receive, payment. (Probe:) Your best estimate would be fine. (Open ended and code actual number)

This version of the question is asked of physicians with two practices.

(If code "1" in #A4, ask:) During the LAST MONTH, how many hours, if any, did you spend providing CHARITY care? By this we mean, that because of the financial need of the patient you charged either no fee or a reduced fee. Please do not include time spent providing services for which you expected, but did not receive, payment. (Probe:) Your best estimate would be fine. (Open ended and code actual number)

This version of the question is asked of physicians with one practice.

(If necessary, read:) EXCLUDE bad debt and time spent providing services under a discounted fee for service contract or seeing Medicare.

Question B6 is asking only about "charity" care. During the pretest, some physicians said "Well, you never know for sure if you are going to get paid." The following definitions clarify what we want in this question.

***No fee:* Physicians sometimes provide services for which they are never paid. If they expected to be paid at the time the services were rendered, the money that should have been earned but that was never collected is classified as bad debt. Hours spent providing services that become bad debt **SHOULD NOT BE INCLUDED** in the answer to this question. It is not charity care because the physician expected to be paid.**

In other cases, the physician never expected to be paid but, rather, provided the service for free because the patient could not afford to pay. These services are classified as charity care and hours spent providing this care SHOULD BE INCLUDED in the answer to this question.

***Reduced fee:* Medicare and Medicaid generally pay lower rates to physicians than do private insurers. The same is true for many contracts with private insurers where the physician has agreed to accept a discounted fee instead of the regular full fee. Physicians may hear the words "reduced fee" in the question, and try to include hours spent seeing these types of patients. These hours SHOULD NOT BE INCLUDED in the answer to this question. The focus in the question is on fees that have been reduced due to the financial need of the patient, not simply on reduced or discounted fees.**

Some states also have programs that pay physicians a very low fee for providing care to persons who cannot pay (low-income, uninsured persons). These programs are distinct from the state's Medicaid program, and their fees are typically much lower than even the Medicaid fees. There are also a few similar programs run by private-sector organizations. In these cases, the fee is more like a token payment; it is not expected to come close to covering the true cost to the physician of treating the patient. For the purposes of this survey, any time spent providing services to patients covered by these types of programs will be considered charity care, and SHOULD BE INCLUDED in the answer to this question.

(If code "06" in "STATE", read:) MediCAL patients.

(If code "04" in "STATE", read:) AHCCCS (pronounced "access") patients.

(If code "01-03", "05" or "07-56" in "STATE", read:) Medicaid patients.

In California, the Medicaid program is called MediCAL. In Arizona, the Medicaid program is called AHCCCS. Survent will substitute these words, as appropriate, for respondents from these states. However, you should be aware that these programs are the same as Medicaid.

(If necessary, read:) By the LAST MONTH, we mean the last 4 weeks.

DK (DK)

RF (Refused) (1064) (1065) (1066)

(If code "1" in #A4, Skip to SECTION C;
Otherwise, Continue)

(If code "2" or "8-9" in #A4, read:) *In many of the questions throughout this survey, we will be asking you to tell us about your main practice. By that we mean the one where you spend the most patient care hours in a typical week.*

B7. (If code "2" or "8-9" in #A4, ask:) Of the time you spend in direct patient care, about what percentage do you typically spend in your main practice? (Probe:) Your best estimate would be fine. (Open ended and code actual percent)

PERCENT

000 None

001 1 percent or less

101 Resp not given in percent/Resp given in hours

DK (DK)

RF (Refused) (557) (558) (559)

HOURS

000 None

100 100+

101 Response not given in hours

DK (DK)

RF (Refused) (560) (561) (562)

This question will be asked only of physicians who said in Question A4 that they provide patient care in more than one practice. They will be read a definition of the "main practice" just prior to Question B7. The purpose of B7 is simply to determine whether the physician spends the bulk of his or her patient care time in one practice (even though s/he works in more than one practice), or has this time split more evenly over two or more practices. Since many of the remaining questions in the survey will be asking about the main practice, the answer to B7 will enable analysts

to know how important the main practice is relative to all of the physician's other practices.

CLOCK:
2827)

(2824-

SECTION C. TYPE AND SIZE OF PRACTICECA. PRACTICE: (Code only)

- 1 (If code "1" in #A4:) Practice
- 2 (If code "2" or "8-9" in #A4:) Main Practice

(READ:) *Now I would like to ask you a series of questions about the (response in #CA) in which you work.*

C1. *Are you a full owner, a part owner, or not an owner of your practice?*

(INTERVIEWER NOTE: A shareholder of the practice in which they work should be coded as "2 - Part owner")

- 1 Full owner (Continue)
- 2 Part owner (Continue)
- 3 Not an owner (Skip to #C3)
- 8 (DK) (Skip to #C3)
- 9 (Refused) (Skip to #C3) (564)

For most physicians this is a straightforward question. However, during the pretest a few physicians said they were not sure how to answer the question because they are shareholders of their practices. We consider a shareholder to be a part owner of the practice.

C2. *(If code "1" or "2" in #C1, ask:) Which of the following best describes your practice? Is it a self-employed solo practice, a two-physician-OWNED practice, a group practice, a group model HMO, a staff model HMO, a free-standing clinic or something else?*

(INTERVIEWER NOTE: A free-standing clinic includes ambulatory care, surgical and emergency care centers)

- 01 OR, Something else (list)
- 02-05 HOLD
- 06 A practice owned by one physician (solo practice)
- 07 A two physician practice
- 08 A group practice of three or more physicians
(see AMA definition on card)
- 09 A group model HMO (Skip to #C7)
- 10 A staff model HMO (Skip to #C7)

11-15 HOLD

16 A free-standing clinic

98 (DK) (Skip to #C4)

99 (Refused) (Skip to C#4) (565) (566)

(If code "1" in #C1 AND code "06" in #C2, Skip to #C7;
Otherwise, Skip to #C4)

You should read the responses to this question, but as soon as the physician Interrupts you with the answer, you should stop reading the categories. The organization of many physician practices is changing rapidly, so you need to be familiar with the possible types and how to classify the responses.

For instance, a physician may think his/her practice is a group practice because s/he is one of several physicians employed by one other doctor. However, the practice is not a group practice because the employed physicians are not owners of the practice. It is a one physician owned practice which employs additional physicians.

HMO - A health maintenance organization is an organized system of health care that assures the delivery of an agreed-upon set of health maintenance and health treatment services to a voluntarily enrolled group of persons. A member generally must receive care from HMO physicians; otherwise the expense is not covered unless the person was referred by the HMO or there was a medical emergency. The cost of a visit is typically covered in full or the member has to pay a small amount.

Staff model HMO - A type of HMO in which the physicians are salaried employees of the HMO and practice in the HMO's facilities.

Group model HMO - The HMO contracts with a separately incorporated medical group to provide service to the HMO's members.

A free-standing clinic includes ambulatory care, surgical and emergency care clinics.

C3. (If code "3" or "8-9" in #C1, ask:) Which of the following best describes your current employer or employment arrangement? Are you employed by (read 06-16, then 01)? (INTERVIEWER NOTE: Stop once response is given) (If necessary, read:) An EMPLOYER is the entity that pays you and should not be confused with where you work. For instance, your employer could be a group practice even if you work in a hospital.

- | | | |
|-------|---|----------------------------|
| 01 | OR, Something else (do NOT list here; more options listed in #C3b) | (Skip to #C3b) |
| 02-05 | HOLD | |
| 06 | A practice owned by one physician (solo practice) | (Skip to #C5) |
| 07 | A two physician practice | (Skip to #C4) |
| 08 | A group practice of three or more physicians (see AMA definition on card) | (Skip to #C4) |
| 09 | A group model HMO | (Skip to #C7) |
| 10 | A staff model HMO | (Skip to #C7) |
| 12 | A medical school or university - (Skip to #C10) | |
| 13 | A non-government hospital or group of hospitals | (Skip to #C10) |
| 14 | City, county or state government- (Continue) | |
| 16 | A free-standing clinic - (Skip to #C4) | |
| 98 | (DK) | (Skip to #C3b) |
| 99 | (Refused) | (Skip to #C3b) (567) (568) |

Again, you should read the responses to this question about the type of practice of the physician's employer, but as soon as the physician interrupts you with the answer, you should stop reading the categories. The section in your manual on managed care and health care expenditures should help you become familiar with the possible practice arrangements and some definitions are listed below.

Do not let yourself get involved in long discussions with physicians whose practice arrangements do not fit our definitions exactly. We have listed only the most common practice arrangements on this screen. However, if you code "01" - Something else, the next screen to appear will list additional options. You should become familiar with those options as well as the ones on this screen.

The key to correct coding of responses to this question is to listen very carefully to what the respondent tells you. Do not immediately jump to coding "hospital" if the respondent is describing a "physician-hospital organization." The latter category is on the next screen.

***One physician owned practice (solo practice)* - This is a practice owned by one physician.**

Often, physicians who are the sole owners of their practices will say they are in "solo

practice." However, a one physician owned practice may employ more than one doctor as in the example above.

Two physician practice - The AMA defined a two physician practice as two physicians formally organized as a legal entity in which business and clinical facilities, records and personnel are shared, and income from medical services provided by the group are divided according to some prearranged plan.

Group practice of three or more physicians - The AMA defines group practice as three or more physicians formally organized as a legal entity in which business and clinical facilities, records and personnel are shared, and income from medical services provided by the group are treated as receipts of the group and distributed according to some prearranged plan.

HMO - A health maintenance organization is an organized system of health care that assures the delivery of an agreed-upon set of health maintenance and health treatment services to a voluntarily enrolled group of persons. A member generally must receive care from HMO physicians; otherwise the expense is not covered unless the person was referred by the HMO or there was a medical emergency. The cost of a visit is typically covered in full or the member has to pay a small amount.

Staff model HMO - A type of HMO in which the physicians are salaried employees of the HMO and practice in the HMO's facilities.

Group model HMO - The HMO contracts with a separately incorporated medical group to provide service to the HMO's members.

A free-standing clinic includes ambulatory care, surgical and emergency care clinics.

C3a. (If code "14" in #C3, ask:) *Is this a hospital, clinic or some other setting?*

- | | | |
|-----------------------|----------------|-------|
| 1 Hospital | (Skip to #C10) | |
| 2 Clinic | (Skip to #C10) | |
| 3 Other (do NOT list) | (Skip to #C10) | |
| 8 (DK) | (Skip to #C10) | |
| 9 (Refused) | (Skip to #C10) | (678) |

If the respondent is employed by city, state, or county government, this follow-up question will appear. Be aware of this question when listening to responses in C3. For example, if the respondent says he is employed by a California State Hospital,

you would code "14" - City, county, or state government in C3 and "1" - Hospital in this question (C3a).

C3b. (If code "01" or "98-99" in #C3, ask:) Are you employed by (read 11-21, as appropriate, then 01)?

- 01 Something else (list)
- 02-05 HOLD
- 11 Other HMO, insurance company or health plan (Skip to #C10)
- 15 An integrated health or delivery system (Skip to #C10)
- 17 A physician practice management company or other for-profit investment company (Skip to #C10)
- 18 Community health center (Continue)
- 19 Management Services Organization (MSO) (Skip to #C10)
- 20 Physician-Hospital Organization (PHO) (Skip to #C10)
- 21 Locum tenens- (Skip to #C10) (Skip to #C10)
- 98 (DK) (Skip to #C4)
- 99 (Refused) (Skip to #C4) () ()

Here are several more options to describe the respondent's employer if those listed in C3 do not fit. There is no follow-up to this question. So, here, if you cannot fit the respondent's answer into one of the listed categories, you should code "01" and type the response verbatim for later coding.

Do not try to force the respondent's answer into these categories if you are not sure. Obviously, if the doctor uses the exact words listed on the screen to describe her employer, coding will not be difficult. However, during the pretest, a few physicians gave detailed descriptions that could not easily be coded. In these cases, it is best to type the description verbatim.

***Other HMO, insurance company or health plan* - In C3, the options included Group and Staff Model HMOs. Other types of HMOs exist, such as Network Model and Individual Practice Associations (IPAs). Under this model, individual physicians (or group practices) sign contracts with an HMO to deliver services to HMO enrollees in the physician's own offices. The physicians also see other non-HMO patients. The HMO enrollees are given a directory of physicians from which they choose a primary care physician. The primary care physician acts as a "gatekeeper" and**

refers the enrollee to specialists in the HMO as needed. Physicians in Network Model and IPA HMOs usually also see patients covered by other insurance plans outside of their own HMO.

Integrated health or delivery system - An arrangement that links hospitals and physicians into a single organization, which combines assets, efforts, risk and revenues to deliver comprehensive health care services. An integrated health system consists of a parent holding company that owns at least two or more subsidiary organizations, one of which is, owns, or operates a medical practice, and the other of which is, owns or operates a hospital.

Physician practice management company or other for-profit investment company - an independent business that provides a means of management, administration and/or related support services to one or more medical practices as specified by contract.

Management Services Organizations (MSO) - Legal entities which provide practice management, administrative, and other types of support services to physicians, group practices, or hospitals. They are frequently used by providers in negotiating risk-sharing or capitation arrangements.

Physician-Hospital Organization (PHO) - A legal entity formed by hospitals and physicians which serves as a negotiating, contracting, and marketing organization. PHOs may own and operate ambulatory/ancillary care projects or act as an agent for managed care contracts. PHOs are similar to Integrated Health Systems, but generally do not have a parent holding company.

Locum tenens - a term that refers to a physician who is temporarily substituting for another physician in a practice setting.

C4. Do one or more of the other physicians who practice in the organization have an ownership interest in your practice?

1 Yes

2 No

8 (DK)

9 (Refused)

(569)

C5. Do any of the following have an ownership interest in the practice in which you work? This ownership interest may include ownership of only the assets or accounts receivable. Does (read A-D) have an ownership interest in the practice? (If necessary, read:) Do not include leased equipment.

- | | | |
|----|--|-------|
| 1 | Yes | |
| 2 | No | |
| 8 | (DK) | |
| 9 | (Refused) | |
| | | |
| A. | Another physician group | (612) |
| B. | A hospital or group of hospitals | (613) |
| C. | An insurance company, health plan or HMO | (614) |
| D. | Any other organization (listed on next screen) | (615) |

(If code "1" in #C5-D, Continue;
 If code "2" to ALL in #C5 A-D, Skip to #C6a;
 Otherwise, Skip to #C7)

Again, listen carefully to exactly what the respondent tells you. If you read "Another physician group" and the respondent says "Well, not exactly, it's a physician-hospital organization," you should code "No" to both A and B and "Yes" to D. You will then get a follow-up screen that allows you to code the response exactly. Be sure to become familiar with the additional options listed on the next screen.

C6. (If code "1" in #C5-D, ask:) What kinds of organizations are these? (Open ended and code) (ENTER ALL RESPONSES)

- | | | | |
|----|--|---|-------|
| 01 | Other (list) | 1 | (616) |
| 02 | (DK) | 2 | |
| 03 | (Refused) | 3 | |
| 04 | No others | 4 | |
| 05 | HOLD | | |
| 06 | Integrated health or delivery system | 6 | |
| | | | |
| 07 | Physician practice management or other for-profit investment company | 7 | |
| 08 | Management Services Organization (MSO) | 8 | |

09	Physician-Hospital Organization (PHO)	9	
10	University/Medical school	0	
11	Medical Foundation or Non-profit Foundation	1	(617)
12	Other Non-profit or community-based organization	2	
		HOLD	(618-627)

If the respondent says "Yes" to "Any other organization" in C5d, you will ask C6, which is an open-ended question. Some precoded answers have been provided in C6 so that you can code the responses quickly, but, again, do not get involved in a discussion of definitions. The physician's verbatim answer can be recorded in the "Other (Specify)" space and coded later. Prompt the physician for all possible answers by saying, "Anything else?" This is a multiple response question, so you may enter as many responses as the physician mentions.

Some other possible ownership arrangements include:

Integrated health or delivery system - An arrangement that links hospitals and physicians into a single organization, which combines assets, efforts, risk and revenues to deliver comprehensive health care services. An integrated health system consists of a parent holding company that owns at least two or more subsidiary organizations, one of which is, owns, or operates a medical practice, and the other of which is, owns or operates a hospital.

Physician practice management company or other for-profit investment company - an independent business that provides a means of management, administration and/or related support services to one or more medical practices as specified by contract.

Management Services Organizations (MSO) - Legal entities which provide practice management, administrative, and other types of support services to physicians, group practices, or hospitals. They are frequently used by providers in negotiating risk-sharing or capitation arrangements.

Physician-Hospital Organization (PHO) - A legal entity formed by hospitals and physicians which serves as a negotiating, contracting, and marketing organization. PHOs may

own and operate ambulatory/ancillary care projects or act as an agent for managed care contracts. PHOs are similar to Integrated Health Systems, but generally do not have a parent holding company.

Foundations - Corporations, usually hospital affiliates or subsidiaries, that acquire all assets of medical group practices and negotiate/execute managed care contracts in their own name on behalf of the hospital and physicians as a unit.

C6a. (If code "3" in #C1 AND code "2" in #C4 AND code "2" to ALL in #C5 A-D, ask:) *Who owns the practice in which you work? (Open ended)*

01 Other (list)

02 (DK)

03 (Refused)

04 HOLD

05 HOLD

(772) (773)

If the respondent indicates that he/she is not an owner and answers "No" to all other questions about practice ownership, this question will be asked. You will record the respondent's answer verbatim.

C7. *How many physicians, including yourself, are in your practice? Please include all locations of the practice. (Probe:) Your best estimate would be fine. (Open ended and code actual number) (INTERVIEWER NOTE: If asked, this includes both full- and part-time physicians)*

997 997+

DK (DK)

RF (Refused)

(628) (629) (630)

We realize that physicians in large practices can't be precise about these answers.

Emphasize that an estimate would be fine. Notice that we are asking about both full- and part-time employees.

C8. *How many physician assistants, nurse practitioners, nurse midwives, and clinical nurse specialists are employed by your practice including all locations? Include both full-time and part-time employees in your answer. (Probe:) Your best estimate would be fine. (Open ended and code actual number) (INTERVIEWER NOTE: Do NOT include office staff or nursing or other personnel who do not fit these categories; examples: LPNs or RNs who are not nurse practitioners or clinical nurse specialists should not be included)*

997	997+			
DK	(DK)			
RF	(Refused)	(631)	(632)	(633)

(If code "08" in #C2 or #C3 AND
code "025-997" in #C7, Continue;
Otherwise, Skip to #C10)

During the pretest, physicians frequently answered this question by counting their office nurses. Unless the staff members fit the categories mentioned in the question, they are NOT to be counted.

We realize that physicians in large practices can't be precise about these answers. Emphasize that an estimate would be fine. Notice that we are asking about both full- and part-time employees.

C9. Is your practice either a group model HMO or organized exclusively to provide services to a group model HMO?

1	Yes	
2	No	
8	(DK)	
9	(Refused)	(634)

If the physician is part of a group practice and more than 25 physicians are in the practice, we ask if the practice is a group model HMO or if it is organized to provide services to a group model HMO. In the latter case, the group may be a separate entity from the HMO, but the only patients that group members treat are members of the HMO. Either of the two is coded as a "Yes".

C10. In the last two years, were you part of a practice that was purchased by another practice or organization? (If necessary, read:) We are only interested in purchases over the last two years that occurred while you were part of the practice.

- | | | |
|-------------|-----------------------|-------|
| 1 Yes | (Continue) | |
| 2 No | (Skip to "SECTION D") | |
| 8 (DK) | (Skip to "SECTION D") | |
| 9 (Refused) | (Skip to "SECTION D") | (635) |

In this question, we are interested in purchases that occurred during the last two years, while the physician was a part of the practice. Read the explanatory note if necessary.

C11. (If code "1" in #C10, ask:) At the time of the purchase, were you a full owner, a part owner, or not an owner of the practice that was purchased? (INTERVIEWER NOTE: If multiple purchases, ask about the most recent)

- | | | |
|---|--------------|-------|
| 1 | Full owner | |
| 2 | Part owner | |
| 3 | Not an owner | |
| 8 | (DK) | |
| 9 | (Refused) | (636) |

If more than one purchase took place in the two-year time period, ask the respondent to answer C11 only for the most recent purchase.

CLOCK: (2832-2835)

SECTION D. MEDICAL CARE MANAGEMENT

MANAGEMENT STRATEGIES

(READ:) *Now I would like to ask you a series of questions about various medical care management techniques or strategies that are sometimes used to manage the care physicians provide to their patients. For each, I'll ask you how large an effect they have on your practice of medicine. The choices are: a very large effect, large, moderate, small, very small, or no effect at all. (If code "2" or "8-9" in #A4, read:) As you answer, please think only about your main practice.*

Questions D1a - D1f. In the last 10 years or so, it has become more common for health insurance organizations and others to require physicians to use strategies to manage the care that physicians are providing to their patients. In addition, physician practices themselves have introduced certain care management strategies.

These strategies are intended to accomplish multiple goals. Some of them are primarily designed to help physicians deal with the ever-increasing store of knowledge available about recent developments pertaining to the diagnosis and treatment of various conditions. Some of them are primarily designed to control costs.

Physicians can be expected to have mixed reactions to the use of these strategies. Some of them will see certain strategies as interference in their freedom to practice the way they would like to. Others may see the same strategies in a much more positive light.

This series of questions asks how large an effect six different care management strategies have on their practice of medicine at present. We are not asking if the physician views the effect positively or negatively. The strategies we ask about are:

- the use of computers to obtain or record clinical data (that is, keeping their patients' medical records on computer) ;
- the use of computers to obtain information about treatment alternatives (having clinical guidelines on computer so they can look up recommended treatments for specific ailments);

- the use of reminders when specific preventive services are due;
- the use of formal, clinical guidelines;
- practice profiles comparing the physician's pattern of using medical resources to treat patients with that of other physicians; and
- the use of feedback from patient satisfaction surveys

Remember -- although a respondent may make "side" remarks to you about his/her opinions of these care management strategies, we are only interested in whether they are having an effect on his or her practice of medicine. If respondents want to tell you their opinions of the use of particular strategies, you need to find a way to bring them back to the subject by saying something like:

"Many people feel that way, but in this question, we are just interested in how large an effect this is having on your practice of medicine at present."

D1. At present, how large an effect (do/does) (read and rotate A-F)? Would you say that it has a (read 5-0)? (If physician says "Do not use/receive", read:) Does this mean (it/they)(has/have) no effect?

- | | |
|---|----------------------|
| 5 | Very large |
| 4 | Large |
| 3 | Moderate |
| 2 | Small |
| 1 | Very small |
| 0 | OR, no effect at all |
| 8 | (DK) |
| 9 | (Refused) |

Notice that if the physician says he/she does not use computers or guidelines or does not receive reminders, profiles, or feedback from patient satisfaction surveys, you should probe to make sure that means these strategies have no effect on his/her practice of medicine. The pressure to use these strategies may be having an effect on the physician even if he/she does not currently use them.

A. Your use of computers to obtain or record clinical data, such as medical records and lab results, have on your practice of medicine (INTERVIEWER NOTE: This could include

the physician's own computer system or that provided by a health insurance plan or HMO, hospital or other institution.) (637)

This could include the physician's own computer system or that provided by a health insurance plan or HMO, hospital or other institution.

B. *Your use of computers to obtain information about treatment alternatives or recommended guidelines have on your practice of medicine* (INTERVIEWER NOTE: This could include the physician's own computer system or that provided by a health insurance plan or HMO, hospital or other institution.) (639)

C. (If code "019-020", "023", "043", "062", "064-065", "085" or "133" in #A10/#A8, OR If code "1" in #A9, OR If code "2" or "3" in #A9a, OR If code "2" or "3" in #A9b, ask:) Reminders that you receive from either a medical group, insurance company or HMO alerting you about specific preventive services that may be due for your individual patients have on your practice of medicine (INTERVIEWER NOTE: includes reminders from either the medical practice, insurance companies, clinics or HMOs. Does NOT include general educational material about preventive services or other reminders that are not about specific services for specific patients.) (641)

We are interested only in reminders sent to physicians, not those sent to patients.

D. *Your use of FORMAL, WRITTEN practice guidelines such as those generated by physician organizations, insurance companies or HMOs, or government agencies have on your practice of medicine* (INTERVIEWER NOTE: Exclude guidelines that are unique to the physician.) (If physician says that s/he uses his/her own guidelines, read: In this question, we are only interested in the use of formal, written guidelines such as those generated by physician organizations, insurance companies or HMOs, or other such groups.) (643)

- E. *The results of practice profiles comparing your pattern of using medical resources to treat patients with that of other physicians have on your practice of medicine*
(INTERVIEWER NOTE: We are not interested in informal feedback, but only specific, quantified information about the physician's practice patterns.) (If necessary, read:) *A practice profile is a report that is usually computer generated which compares you to other physicians on things like referrals to specialists, hospitalizations, or other measures of cost-effectiveness.* (645)
- F. *Feedback from patient satisfaction surveys have on your practice of medicine* (647)

(There is no D2 - D6)

(If code "019-020", "023", "043", "085" or
"133" in #A10/#A8, OR If code "1" in #A9, OR
If code "2" or "3" in #A9a, OR
If code "2" or "3" in #A9b, Continue;
Otherwise, Skip to "READ" before #D11)

Questions D7 through D10: These questions will appear only in interviews with primary care physicians.

Questions D7 through D8: These questions are concerned with whether the complexity or severity of cases for which primary care physicians (PCPs) provide care without referrals to specialists has changed in the last 2 years and PCPs' opinions about the level of complexity or severity of patients' conditions for which they are currently expected to provide care without referral to specialists. In these questions, we are using the terms "complexity" and "severity" more or less interchangeably. You should not try to define either term for the respondents. Just ask them to use their own definitions.

(READ:) *Now I would like to ask you a couple of questions about the range and complexity of conditions you treat without referral to specialists.*

D7. *During the last 2 years, has the complexity or severity of patients' conditions for which you provide care without referral to specialists (read 5-1)? (INTERVIEWER NOTE: If respondent says he/she has not been practicing medicine for 2 years, ask about time since he/she started.)*

- 5 Increased a lot
- 4 Increased a little
- 3 Stayed about the same
- 2 Decreased a little
- 1 OR, Decreased a lot
- 8 (DK)
- 9 (Refused) (649)

If respondent says he/she has not been practicing medicine for 2 years, ask about time since he/she started.

D8. *In general, would you say that the complexity or severity of patients' conditions for which you are currently expected to provide care without referral is (read 5-1)?*

- 5 Much greater than it should be
- 4 Somewhat greater than it should be
- 3 About right
- 2 Somewhat less than it should be
- 1 OR, Much less than it should be
- 8 (DK)
- 9 (Refused) (650)

D9. *During the last two years, how much has the number of patients that you refer to specialists (read 5-1)?*

- 5 Increased a lot
- 4 Increased a little
- 3 Stayed about the same
- 2 Decreased a little
- 1 Decreased a lot
- 8 (DK)
- 9 (Refused) (651)

D10. *Some insurance plans or medical groups REQUIRE their enrollees to obtain permission from a primary care physician before seeing a specialist. For roughly what percent of your patients do you serve in this role? (Open ended and code actual percent)*

(If necessary, read:) The term "gatekeeper" is often used to refer to this role.

(If necessary, read:) Include only those patients for whom it is required, not for patients who choose to do so voluntarily.

000	None	(Skip to SECTION E)			
001	1 percent or less	(Skip to SECTION E)			
002					
100		(Skip to SECTION E)			
DK	(DK)	(Continue)			
RF	(Refused)	(Continue)	(652)	(653)	(654)

This question asks for what percent of patients the physician serves in the role of a PCP from whom permission must be obtained before seeing a specialist. There is an explanation you can read if you need to which explains that the term "gatekeeper" is often used to refer to his role. You should read this explanation quickly if you think the doctor is having trouble understanding the question.

The question should be fairly self-explanatory. If the respondent has a difficult time estimating the answer, the CATI program will take you to a follow-up question where we try to get the answer in ranges.

D10a (If code "DK" or "RF" in #D10, ask:) *Would you say you serve in this role for (read 1-2)?*

1	Less than 25 percent of your patients, OR	(Skip to #D10c)			
2	25 percent or more of your patients	(Continue)			
8	(DK)	(Skip to SECTION E)			
9	(Refused)	(Skip to SECTION E)			(655)

D10b (If code "2" in #D10a, ask:) Would you say for (read 1-2)?

- 1 Less than 50 percent of your patients, OR
- 2 50 percent or more of your patients
- 8 (DK)
- 9 (Refused) (656)

(All in #D10b, Skip to SECTION E)

D10c (If code "1" in #D10a, ask:) Would you say for (read 1-2)?

- 1 Less than 10 percent of your patients, OR
- 2 10 percent or more of your patients
- 8 (DK)
- 9 (Refused) (657)

(All in #D10c, Skip to SECTION E)

(READ:) Now I would like to ask you a couple of questions about the range and complexity of conditions you treat.

Questions D11 through D13: These questions will appear only in interviews with specialists.

Questions D11 and D12: These questions are the "mirror image" of D7 and D8 for PCPs.

They are concerned with whether the complexity or severity of cases referred to the specialists by PCPs has changed in the last 2 years and the specialists' opinions about the level of complexity or severity of patients' conditions at the time of referral. As in D7 and D8, we are using the terms "complexity" and "severity" more or less interchangeably. You should not try to define either term for the respondents. Just ask them to use their own definitions.

D11. During the last two years, has the complexity or severity of patients' conditions at the time of referral to you by primary care physicians (read 5-1)?

- 5 Increased a lot
- 4 Increased a little
- 3 Stayed about the same
- 2 Decreased a little
- 1 OR, Decreased a lot
- 8 (DK)
- 9 (Refused) (658)

D12. In general, would you say that the complexity or severity of patients' conditions at the time of referral to you by primary care physicians is (read 5-1)?

- 5 Much greater than it should be
- 4 Somewhat greater than it should be
- 3 About right
- 2 Somewhat less than it should be
- 1 OR, Much less than it should be
- 8 (DK)
- 9 (Refused) (659)

D13. During the last two years, has the number of patients referred to you by primary care physicians (read 5-1)?

- 5 Increased a lot
- 4 Increased a little
- 3 Stayed about the same
- 2 Decreased a little
- 1 OR, Decreased a lot
- 8 (DK)
- 9 (Refused) (660)

CLOCK: (2840-2843)

SECTION E. VIGNETTES

This section contains a series of vignettes, or descriptions of cases. Physicians will be asked for percentages of their patients for whom they would recommend the test, treatment, or evaluation. Here are some things you should know about these vignettes:

- The purpose of these questions is to look at practice patterns across whole communities of physicians. This study will be repeated in one or two years, so researchers will be evaluating how practice patterns have changed during that time.
- The purpose is NOT to assess the quality of care or appropriateness of treatment being provided by any individual physician.
- Some physicians might ask you for additional information about the patients described in the vignettes (e.g., what kind of insurance they have, etc.). You should say that you do not have any additional information and that we would like the physician to try to make an estimate based on the information given.
- Some physicians might say something like "Well, I would do it this way for some of my patients and a different way for other patients." We can't take two answers, only one, so if this happens, ask the physician to make his/her best estimate across all of the patients in the practice.
- Emphasize to the physician that ANY answer is OK. These vignettes were chosen because we expect that different physicians will answer in different ways. There is no right or wrong answer--this is not a test!

(If code "019", "023" or "137" in #A8, OR
 If code "2" or "3" in #A9a OR
 If code "2" or "3" in #A9b, Continue;
 Otherwise, Skip to "Note" after #EA)

EA. Does your (response in #CA) include providing care to (read 1-3)?

- | | | |
|---|--------------------------|---------------------------|
| 1 | Adults only | |
| 2 | Children only, OR | |
| 3 | Both adults and children | |
| 8 | (DK) | (Skip to SECTION F) |
| 9 | (Refused) | (Skip to SECTION F) (661) |

(If code "042" in #A8 AND code "1" in #A9, OR
 If code "1" in #EA, code as "1" in "FORM";
 If code "088" in #A8 AND code "1" in #A9, OR
 If code "2" in #EA, code as "2" in "FORM";
 If code "3" in #EA, code as "3" in "FORM";

Otherwise, Skip to SECTION F)

FORM:

- 1 FORM 1 (E1, E3, E4, E5, E9 and E10)
- 2 FORM 2 (E11, E16, E17, E18, E20 and E21)
- 3 FORM 3 (Randomly select
Either E5 or E9 AND Either E1 or E10 AND
Either E3 or E4 AND Either E17 or E20 AND
Either E11 or E16 AND Either E18 or E21) (662)

There are vignettes that describe adult patients and vignettes that describe pediatric patients. This question will permit correct assignment to adult, pediatric or mixed vignettes for some specialties.

(READ:) *I am going to read a description of a patient and I'll ask about a possible test, treatment, or recommendation. We want you to think about patients with similar problems you've seen in your own practice during the past twelve months. The key question I'll ask is for what percentage of the patients with that problem would you recommend the test, treatment, or evaluation? Reasons for not recommending the treatment may include feeling that no treatment, or that an alternative treatment, is a better option. Any percentage, from zero to 100 percent, is a valid response.*

(If code "2" or "8-9" in #A4, read:) *As you answer, please think only about your main practice.*

(If code "2" in "FORM", Skip to #E11;
Otherwise, Continue)

E1. (If code "1" or "3" in "FORM", ask:) What about treating an elevated cholesterol with oral agents for a 50 year old man who has no other cardiac risk factors except elevated cholesterol? After six months on a low cholesterol diet, his total cholesterol is 240 and his LDL is 150. His HDL cholesterol is 50, giving a ratio of total cholesterol to HDL cholesterol of 4.8. For what percentage of such patients would you recommend oral agents at this point? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

000	None	(Skip to #E3)			
001	1 percent or less	(Skip to #E3)			
002					
100		(Skip to #E3)			
DK	(DK)	(Continue)			
RF	(Refused)	(Skip to #E3)	(663)	(664)	(665)

Oral agents: any medication that is given by mouth (orally).

LDL cholesterol: low density lipoprotein cholesterol is the "bad" type of cholesterol.

HDL cholesterol: high density lipoprotein cholesterol is the "good" type of cholesterol.

E1a (If code "DK" in #E1, ask:) Would you recommend oral agents (read 6-1)

6	Always			
5	Almost always			
4	Frequently			
3	Sometimes			
2	Rarely, OR			
1	Never			
8	(DK)			
9	(Refused)			(666)

(There is no #E2)

E3. (If code "1" or "3" in "FORM", ask:) *What about a urology referral for further evaluation of symptoms of benign prostatic hyperplasia in a 60 year old man. He is moderately symptomatic, has no evidence of renal compromise or cancer. The patient is somewhat bothered by these symptoms. For what percentage of such patients would you recommend a urology referral? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.*

000	None	(Skip to #E4)			
001	1 percent or less	(Skip to #E4)			
002-100		(Skip to #E4)			
DK	(DK)	(Continue)			
RF	(Refused)	(Skip to #E4)	(712)	(713)	(714)

benign prostatic hyperplasia: enlargement of the prostate in older men that is NOT due to cancer of the prostate, hence it is "benign," sometimes called BPH.

Renal compromise: some problem with the kidneys (renal means kidney-related).

E3a. (If code "DK" in #E3, ask:) *Would you recommend a urology referral (read 6-1)?*

6	Always			
5	Almost always			
4	Frequently			
3	Sometimes			
2	Rarely, OR			
1	Never			
8	(DK)			
9	(Refused)			(715)

E4 (If code "1" or "3" in "FORM", ask:) *What about a cardiology referral after a stress test for a 50 year old man with a one month history of exertional chest pain. On no medications, after 6 minutes of exercise, he developed 2 millimeters of ST depression in leads II, III, and F. For what percentage of such patients would you recommend a cardiology referral at this point? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.*

000	None	(Skip to #E5)			
001	1 percent or less	(Skip to #E5)			
002-100		(Skip to #E5)			
DK	(DK) – (Continue)				
RF	(Refused) – (Skip to #E5)		(716)	(717)	(718)

2 millimeters of ST depression in leads II, III, and F: these are the classic findings of myocardial ischemia (a heart attack) on an EKG. The EKG tracing line is literally depressed downward by 2 millimeters or more on the paper.

E4a (If code "DK" in #E4, ask:) Would you recommend a cardiology referral (read 6-1)?

- | | | |
|---|---------------|-------|
| 6 | Always | |
| 5 | Almost always | |
| 4 | Frequently | |
| 3 | Sometimes | |
| 2 | Rarely, OR | |
| 1 | Never | |
| 8 | (DK) | |
| 9 | (Refused) | (719) |

E5. (If code "1" or "3" in "FORM", ask:) What about an MRI for a 35-year-old man who developed low back pain after shoveling snow three weeks ago. He presents to the office for an evaluation. On examination there is a new left foot drop. For what percentage of such patients would you recommend an MRI? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

- | | | |
|-----|---------------------------|-------------------|
| 000 | None | (Skip to #E9) |
| 001 | 1 percent or less | (Skip to #E9) |
| 002 | | |
| 100 | (Skip to #E9) | |
| DK | (DK)- (Continue) | |
| RF | (Refused) – (Skip to #E9) | (720) (721) (722) |

MRI: magnetic resonance imaging. A relatively new and very expensive procedure that produces fancy x-rays of the body.

Left foot drop: an abnormal finding where the patient cannot hold up the foot due to a neurological problem related to the back and spinal cord.

E5a. (If code "DK" in #E5, ask:) Would recommend an MRI (read 6-1)?

- | | |
|---|---------------|
| 6 | Always |
| 5 | Almost always |
| 4 | Frequently |

3	Sometimes	
2	Rarely, OR	
1	Never	
8	(DK)	
9	(Refused)	(723)

(There is no #E6 - #E8)

E9. (If code "1" or "3" in "FORM", ask:) *What about PSA screening in an asymptomatic 60 year old white man who has no family history of prostate cancer and a normal digital rectal exam. For what percentage of such patients would you recommend a PSA (Prostate Specific Antigen) test? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.?*

PSA screening: prostate specific antigen is a new blood test that detects early prostate cancer in men.

000	None	(Skip to #E10)		
001	1 percent or less	(Skip to #E10)		
002				
100	(Skip to #E10)			
DK	(DK) – (Continue)			
RF	(Refused) – (Skip to #E10)	(736)	(737)	(738)

E9a (If code "DK" in #E9, ask:) *Would recommend a PSA test(read 6-1)??*

6	Always	
5	Almost always	
4	Frequently	
3	Sometimes	
2	Rarely, OR	
1	Never	
8	(DK)	
9	(Refused)	(739)

E10. (If code "1" or "3" in "FORM", ask:) *What about recommending an office visit for a 40 year old monogamous, married woman who calls to report a two day history of vaginal itching and thick white discharge. She has no abdominal pain or fever. For what percentage of such patients would you recommend an office visit to evaluate the vaginal discharge? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.*

000	None	(Skip to "Note" before #E11)		
001	1 percent or less	(Skip to "Note" before #E11)		
002				
100	(Skip to "Note" before #E11)			
DK	(DK) – (Continue)			
RF	(Refused) – (Skip to "Note" before #E11)	(740)	(741)	(742)

E10a. (If code "DK" in #E10, ask:) Would you recommend an office visit (read 6-1)?

6	Always			
5	Almost always			
4	Frequently			
3	Sometimes			
2	Rarely, OR			
1	Never			
8	(DK)			
9	(Refused)			(743)

(If code "1" in "FORM", Skip to SECTION F;

Otherwise, Continue)

E11. (If code "2" or "3" in "FORM", ask:) What about use of DDAVP for an otherwise healthy 10 year old boy who presents with long-term primary enuresis (en-your-ee-sis), repeatedly negative urinalysis and cultures, and who has failed fluid restriction and environmental interventions. For what percentage of such patients would you recommend DDAVP? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

000	None	(Skip to #E16)		
001	1 percent or less	(Skip to #E16)		
002-100		(Skip to #E16)		
DK	(DK) – Continue)			
RF	(Refused) – (Skip to #E16)	(744)	(745)	(746)

DDAVP: a drug that is used to control bed-wetting (enuresis).

Long-term primary enuresis: bed-wetting that has always been present, i.e., the child has never gone long periods without wetting the bed; as compared to someone who after months or years of nighttime bladder control, suddenly begins wetting again.

Environmental interventions (for enuresis): interventions for bed-wetting that include restriction of fluids before bed time, using a "star" chart to monitor progress, using alarms; anything short of using drugs like DDAVP.

E11a. (If code "DK" in #E11, ask:) Would you recommend DDAVP (read 6-1)?

- | | | |
|---|---------------|-------|
| 6 | Always | |
| 5 | Almost always | |
| 4 | Frequently | |
| 3 | Sometimes | |
| 2 | Rarely, OR | |
| 1 | Never | |
| 8 | (DK) | |
| 9 | (Refused) | (747) |

(There is no #E12 - #E15)

E16 (If code "2" or "3" in "FORM", ask:) What about an office visit for an otherwise healthy 10 year old boy whose parent calls to report a two day history of fever to 101 degrees, sore throat, nasal stuffiness, and no other signs or symptoms. For what percentage of such patients would you recommend an office visit in the next day or so? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

- | | | | |
|---------|----------------------------|----------------|-------------|
| 000 | None | (Skip to #E17) | |
| 001 | 1 percent or less | (Skip to #E17) | |
| 002-100 | | (Skip to #E17) | |
| DK | (DK) – (Continue) | | |
| RF | (Refused) – (Skip to #E17) | (764) | (765) (766) |

E16a (If code "DK" in #E16, ask:) Would you recommend an office visit in the next day or so (read 6-1)?

- | | | |
|---|---------------|-------|
| 6 | Always | |
| 5 | Almost always | |
| 4 | Frequently | |
| 3 | Sometimes | |
| 2 | Rarely, OR | |
| 1 | Never | |
| 8 | (DK) | |
| 9 | (Refused) | (767) |

E17. (If code "2" or "3" in "FORM", ask:) What about a chest x-ray for a previously healthy 10 year old girl with a three day history of fever to 101.5, productive cough, tachypnea (tah-kip-knee-uh) and rales at the right base. She is taking fluids, is uncomfortable, but not in acute distress. For what percentage of such patients would you recommend a chest x-ray? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

- | | | |
|---------|---------------------------|-------------------|
| 000 | None | (Skip to #E18) |
| 001 | 1 percent or less | (Skip to #E18) |
| 002-100 | | (Skip to #E18) |
| DK | (DK) – (Continue) | |
| RF | (Refused) – (Skip to #18) | (768) (769) (770) |

Tachypnea: breathing faster than normal.

Rales at the right base: rales are the sound that you hear in the lungs (in this case at the bottom on the right side) with a stethoscope that indicate pneumonia or some other problem.

E17a. (If code "DK" in #E17, ask:) Would you recommend a chest x-ray (read 6-1)?

6	Always	
5	Almost always	
4	Frequently	
3	Sometimes	
2	Rarely, OR	
1	Never	
8	(DK)	
9	(Refused)	(771)

E18 (If code "2" or "3" in "FORM", ask:) What about referral to an ENT specialist for PE tubes for an otherwise healthy 24 month old girl who presents with a history of six episodes of suppurative (SUPper-uh-tive) otitis media over the last year, treated with antibiotics with complete clearing. After her fifth episode she was placed on prophylactic antibiotics, but had a recurrence that again responded completely to antimicrobials. She is otherwise in good health and has normal hearing. For what percentage of such patients would you recommend referral to an ENT specialist for placement of PE tubes? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

000	None	(Skip to #E20)		
001	1 percent or less	(Skip to #E20)		
002-100		(Skip to #E20)		
DK	(DK0 – (Conintue)			
RF	(Refused) – (Skip to E#20)	(812)	(813)	(814)

PE tubes: pressure equalizing tubes that are inserted into the ear drums to treat chronic ear infections (otitis media).

Suppurative otitis media: is the fancy term for an acute ear infection.

Antimicrobials: antibiotics, a medicine used for treating bacterial infections.

E18a (If code "DK" in #E18, ask:) Would you recommend referral to an ENT specialist for placement of PE tubes (read 6-1)

- | | | |
|---|---------------|-------|
| 6 | Always | |
| 5 | Almost always | |
| 4 | Frequently | |
| 3 | Sometimes | |
| 2 | Rarely, OR | |
| 1 | Never | |
| 8 | (DK) | |
| 9 | (Refused) | (815) |

(There is no #E19)

E20. (If code "2" or "3" in "FORM", ask:) What about a sepsis workup including at least a CBC, sterile urine, and blood cultures, for a well-appearing and otherwise normal, full-term six week old child with a fever of 101. In what percentage of such patients would you recommend a sepsis workup including at least a CBC, sterile urine, and blood cultures? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

- | | | |
|------|----------------------------|-------------------|
| 000 | None | (Skip to #E21) |
| 001 | 1 percent or less | (Skip to #E21) |
| 002- | | |
| 100 | | (Skip to #E21) |
| DK | (DK) – (Continue) | |
| RF | (Refused) – (Skip to #E21) | (820) (821) (822) |

Sepsis workup: the battery of tests used to detect a serious blood infection, or "sepsis."

CBC (complete blood count): a blood test done to check for infection or anemia.

E20a. (If code "DK" in #E20, ask:) Would you recommend a sepsis workup (read 6-1)?

- | | |
|---|---------------|
| 6 | Always |
| 5 | Almost always |
| 4 | Frequently |
| 3 | Sometimes |
| 2 | Rarely, OR |
| 1 | Never |
| 8 | (DK) |

9 (Refused)

(823)

E21. (If code "2" or "3" in "FORM", ask:) What about referral to an allergist for a four year old with eczema and seasonal asthma whose asthma has been managed with intermittent oral steroids and bronchodilators. The frequency of asthma attacks is increasing despite prophylactic use of inhaled steroids. For what percentage of such patients would you recommend referral to an allergist for evaluation? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) Consider all your patients with similar clinical descriptions.

000 None (Skip to SECTION F)

001 1 percent or less (Skip to SECTION F)

002-100 (Skip to SECTION F)

DK (DK) – (Continue)

RF (Refused) – (Skip to SECTION F) (824) (825) (826)

Oral bronchodilators: a medication given by mouth that treats asthma (that dilates the bronchi).

E21a (If code "DK" in #E21, ask:) Would you recommend referral to an allergist for evaluation (read 6-1)?

6 Always

5 Almost always

4 Frequently

3 Sometimes

2 Rarely, OR

1 Never

8 (DK)

9 (Refused) (827)

CLOCK: (2848-2851)

SECTION F. PHYSICIAN-PATIENT INTERACTIONS

Next I am going to read you several statements. For each, I'd like you to tell me if you agree strongly, agree somewhat, disagree somewhat, disagree strongly, or if you neither agree nor disagree.

As you answer, please think only about your main practice.

Questions F1 through F7: The section begins with seven opinion questions in which you will read statements to respondents and ask them to use a 5-point scale for responding.

The scale is:

Agree strongly

Agree somewhat

Disagree somewhat

Disagree strongly

OR, do you neither agree nor disagree

We would like you to read the first four answer categories slowly and then, after a brief pause, read the last one (OR -- do you neither agree nor disagree) as a kind of "afterthought". We are hoping that respondents do not use the last category too often. (Of course, if a respondent chooses the last category, you should accept that response without comment.)

Probably after the first 2 or 3 questions, respondents will have "caught on" to the answer categories in the scale and will offer you a response without waiting for you to read them all. As long as you are sure the respondent is actually using one of the categories shown, that is acceptable and you do not have to read all the remaining categories. However, if this happens on the first or second question, say: "Let me just be sure I have explained all the answer categories to you" and read them all.

Do not try to define terms used in these questions or explain what is meant by any of the questions except as indicated in the interviewer notes which appear on the screen. These are opinion questions and the respondents should use their best judgment in deciding what they mean and how to answer.

F1. Next I am going to read you several statements. For each, I'd like you to tell me if you agree strongly, agree somewhat, disagree somewhat, disagree strongly, or if you neither agree nor disagree. (If code "2" or "8-9" in #A4, read:) As you answer, please think only about your main practice. (Read and rotate A-H) Do you (read 5-1)? (If necessary, read:) We'd like you to think across all patients that you see in your practice?

- 5 Agree strongly
- 4 Agree somewhat
- 3 Disagree somewhat
- 2 Disagree strongly
- 1 OR, do you neither agree nor disagree
- 7 (Doctor does not have office visits) [A only]
- 7 (Doctor does not have continuing relationship with patients) [H only]
- 8 (DK)
- 9 (Refused)

A. I have adequate time to spend with my patients during their office visits?
(INTERVIEWER NOTE: Do not further differentiate the level of visit, that is, whether brief, intermediate, etc.) (If necessary, read:) We would like you to answer in general or on AVERAGE over all types of visits. (828)

Do not further differentiate the level of visit, that is, whether brief, intermediate, etc.

B. (If code "7" in #F1-A, ask:) I have adequate time to spend with my patients during a typical patient visit (INTERVIEWER NOTE: This does not include surgery) (871)

C. I have the freedom to make clinical decisions that meet my patients' needs (829)

D. It is possible to provide high quality care to all of my patients (830)

E. I can make clinical decisions in the best interests of my patients without the possibility of reducing my income (831)

F. (If code "019-020", "023", "043", "085" or "133" in #A10/#A8, OR If code "1" in #A9, OR If code "2" or "3" in #A9a, OR If code "2" or "3" in #A9b, ask:) The level of communication I have with specialists about the patients I refer to them is sufficient to ensure the delivery of high quality care (832)

- G. (If NOT in F1-F, ask:) *The level of communication I have with primary care physicians about the patients they refer to me is sufficient to ensure the delivery of high quality* (833)
- H. *It is possible to maintain the kind of continuing relationships with patients over time that promote the delivery of high quality* (834)

(There is no F2 - F7)

- F8 *Now I'm going to ask you about obtaining certain services for patients in your when you think they are medically necessary. How often are you able to obtain (read and rotate A, B and E, then read and rotate C and D, then read and rotate F and G, as appropriate) when you think (they are/it is) medically necessary? Would you say (read 6-1)? (If physician says it depends on which patients, read:) We'd like you to think across all the patients that you see in your (response in #CA) and tell us how often you are able to obtain these services when you think they are medically necessary.*

(If physician says "it depends on which patients,":) We'd like you to think across all the patients that you see and tell us how often you are able to obtain these services when you think they are medically necessary.

- 6 Always
- 5 Almost always
- 4 Frequently
- 3 Sometimes
- 2 Rarely
- 1 OR, Never
- 7 (Does not apply)
- 8 (DK)
- 9 (Refused)

- A. (If code "019", "020", "023", "043", "085" or "133" in #A10/#A8 OR code "1" in #A9 OR code "2" or "3" in #A9a OR code "2" or "3" in #A9b, ask:) *Referrals to specialists of high quality*

(Otherwise, ask:) *Referrals to other specialists of high quality* (835)

- B. *High quality ancillary services, such as physical therapy, home health care, nutritional counseling, and so forth* (836)

- C. *Non-emergency hospital admissions* (837)
- D. *Adequate number of inpatient days for your hospitalized patients* (838)
- E. *High quality Diagnostic Imaging Services* (839)
- F. (If code "010", "019", "020", "023", "043", "062", "064-065", "082-085", "127", "132" or "133" in #A10/#A8 OR code "1" in #A9 OR code "2" or "3" in #A9a OR code "2" or "3" in #A9b, ask:) High quality INPATIENT mental health care (840)
- G. (If code "010", "019", "020", "023", "043", "062", "064-065", "082-085", "127", "132" or "133" in #A10/#A8 OR code "1" in #A9 or code "2" or "3" in #A9a OR code "2" or "3" in #A9b, ask:) High quality OUTPATIENT mental health services (841)

This question asks the physician to use a 6-point scale to indicate how often s/he is able to obtain certain services for his or her patients when they think they are medically necessary.

The scale that we ask respondents to use to answer the questions varies from "always" to "never". Some physicians may find it a little difficult to answer these questions because their experiences in obtaining various services varies according to the insurance plan the patient is enrolled in. On the screen, you will see a probe that we'd like you to use when this happens: "We'd like you to think across all the patients that you see and tell us how often you are able to obtain these services when you think they are medically necessary."

- F9. *Now I'd like to ask you about new patients the practice in which you work might be accepting. Is the practice accepting all, most, some or no new patients who are insured through (read A-C)? (INTERVIEWER NOTE: Medicaid and Medicare beneficiaries who are enrolled in managed care plans should be included in A or B, respectively.)*

- | | |
|---|----------------------|
| 4 | All |
| 3 | Most |
| 2 | Some |
| 1 | No new patients/None |
| 8 | (DK) |
| 9 | (Refused) |

- A. *Medicare, including Medicare managed care patients* (843)
- B. (If code "06" in "STATE", ask:) *MediCAL, including MediCAL managed care patients*
(If code "04" in "STATE", ask:) *AHCCCS (pronounced "access")*
(If code "01-03", "05" or "07-56" in "STATE", ask:) *Medicaid, including Medicaid managed care patients* (842)
- C. *Private or commercial insurance plans including managed care plans and HMOs with whom the practice has contracts. (If necessary, read:) This includes both fee for service patients and patients enrolled in managed care plans with whom the practice has a contract. It excludes Medicaid or Medicare managed care* (844).

This is a series of questions about whether the respondent's practice is accepting all, some or no new patients who are insured through 3 types of insurance -- Medicare, Medicaid and private or commercial insurance plans. Some Medicare and Medicaid beneficiaries are now enrolled in managed care plans. As indicated in the note on the screen, we want these to be included in with traditional Medicaid and Medicare beneficiaries in the answer to this question.

CLOCK: (2856-2859)

SECTION G. PRACTICE REVENUE

This is probably the most complicated section -- for both you and the respondent. With these questions we are trying to obtain information on physicians' practice revenue. We are interested here in the revenue received by the whole practice, not just the physician's own patients. We realize that physicians may not have the information we want at their fingertips. For many questions, we ask them to provide only a rough estimate. However, some physicians still may not be able to answer the questions without consulting a business or office manager.

You should do your best to probe for answers to these questions. However, if it becomes clear to you that the respondent really has no idea and could only take a wild guess, you should accept a "Don't know" answer.

G1. Now I'm going to ask you some questions about the patient care revenue received by the (response in #CA) in which you work. Approximately what percentage of the PRACTICE REVENUE FROM PATIENT CARE would you say comes from (read A-B)? (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) We're asking about the patient care revenue of the practice in which you work, not just the revenue from the patients YOU see.

000	None
001	1 percent or less
DK	(DK)
RF	(Refused)

- A. *Payments from all Medicare, including Medicare managed care (845) (846) (847)*
- B. *(If code "06" in "STATE", ask:) Payments from MediCAL or any other public insurance, including Medicaid managed care.*

(If code "04" in "STATE", ask:) Payments from AHCCCS (pronounced "access") or any other public insurance

(If code "01-03", "05" or "07-56" in "STATE", ask:) *Payments from Medicaid or any other public insurance, including Medicaid managed care* (848) (849) (850)

(There is no C or D)

(If response in #G1-A + response in #G1-B > 100, Continue;
Otherwise, Skip to #G3)

Patients covered under both Medicare and Medicaid should be counted in the Medicare category for this question.

***Medicare* is a Federal Health Insurance program for people 65 or older and for certain disabled people. Because Medicare is an insurance plan, it has many features in common with private health insurance. Medicare has two parts. Part A (Hospital Insurance) helps pay for inpatient hospital care, and for some nursing home, home health, and hospice care. Part B (Medical Insurance) helps pay for doctor's services, outpatient hospital services, medical equipment, and some other services not covered by Part A.**

***Medicaid* is funded by both the Federal government and individual states. It is a public insurance program for low income persons. Each state designs and administers its own Medicaid program within Federal guidelines; thus eligibility requirements and covered services vary from state to state. In many states, Medicaid programs are referred to as Medical Assistance programs. Qualifications for Medicaid vary from state to state. Medicaid does not require any premiums or copays, however, the recipient must contribute any monthly income to their medical expenses before Medicaid will pay.**

***MediCAL* is the Medicaid program in California, AHCCCS (called "Access") is the Medicaid program in Arizona. In addition to the plans named, there are many other state, county, and local assistance programs.**

G1a. *I have recorded that the combined practice revenue from Medicare and Medicaid is greater than 100 percent, can you help me resolve this? Approximately what percentage of the practice's revenue from patient care comes from (read A-B)? (INTERVIEWER NOTE: Revenue from patients covered by both Medicare and Medicaid should be counted in MEDICARE ONLY) (Open ended and code actual percent) (Probe:) Your best estimate will be fine. (If necessary, read:) We're asking about the patient care revenue of the practice in which you work, not just the revenue from the patients YOU see*

- 000 None
- 001 1 percent or less
- DK (DK)
- RF (Refused)

A. *Payments from all Medicare, including Medicare managed care*
(845) (846) (847)

B. *(If code "06" in "STATE", ask:) Payments from MediCAL or any other public insurance, including Medicaid managed care*

(If code "04" in "STATE", ask:) Payments from AHCCCS (pronounced "access") or any other public insurance

(If code "01-03", "05" or "07-56" in "STATE", ask:) Payments from Medicaid or any other public insurance, including Medicaid managed care (848) (849) (850)

This is a consistency check question and will appear if the combined percentages in G1a and G1b exceed 100%. Do you best to resolve the inconsistency. However, don't risk angering the respondent by arguing with him/her if the total exceeds 100% after your attempted reconciliation. Just move on to the next question after recording what you are told.

(There is no #G2)

G3 Now again thinking about the patient care revenue from ALL sources received by the practice in which you work, what percentage is paid on a capitated or other prepaid basis? (If necessary, read:) Under capitation, a fixed amount is paid per patient per month regardless of services provided. (Probe:) Your best estimate would be fine. (Open ended and code actual percent) (INTERVIEWER NOTE: Includes payments made on a capitated or other prepaid basis from Medicare or Medicaid)

000	None			
001	1 percent or less			
002				
100				
DK	(DK)			
RF	(Refused)	(938)	(939)	(940)

Capitation is a method of payment used to reimburse physicians and other health care providers in many managed care plans. Under capitated agreements, a health care providers agrees to make a specific set of services available to a covered individual for a predetermined, fixed price, regardless of how many services that person actually receives. So, for example, under XYZ Insurance plan, the physician receives \$50 per year for each patient insured under the plan. Patient A never comes in to see the doctor during the year, so the doctor makes \$50 without providing any services. Patient B, however, insists on seeing the doctor every two or three weeks complaining of various ailments. For this patient, \$50 doesn't even come close to covering the cost of the patient's care.

Capitation involves the provider in a risk-sharing arrangement, that is, because the amount of care needed by each enrollee could vary, the provider assumes at least some of the financial risk involved in providing health care services.

(There is no #G3a - #G5)

G6 Thinking again about the practice in which you work, we have a few questions about contracts with managed care plans such as HMOs, PPOs, IPAs and Point-Of-Service plans. First, roughly how many managed care contracts does the practice have? (Probe:) (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (INTERVIEWER NOTE: Include Medicare managed care, Medicaid managed care, and other government managed care contracts but not traditional Medicare or Medicaid.) (Open ended and code actual number)

00	None - (Skip to #G7)		
01			
19	(Skip to #G8)		
20			
97	(Skip to #G6b)		
DK	(DK)	(Continue)	
RF	(Refused)	(Continue)	(958) (959)

Notice the explanations of managed care:

Managed care plans include, but are not limited to, those with HMOs, PPOs, IPAs, and point-of-service plans. Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms also are considered managed care. Payers can include Medicare managed care, Medicaid managed care, and other government managed care contracts, but not traditional Medicare or Medicaid.

G6a. (If code "DK" or "RF" in #G6, ask:) Would you say less than 3 contracts, 3 to 10, or more than 10 contracts?

0	(None) – (Skip to #G7)	
1	Less than 3 (1 or 2)	(Skip to #G8)
2	3 to 10 – (Skip to #G8)	
3	More than 10 (11+)	(Skip to #G8)
8	(DK)	
9	(Refused)	(960)

If the physician does not know the number of contracts, you will ask him/her to estimate using categories provided in G6a.

G6b. (If code "20-97" in #G6, ask:) *Just to be sure, is this the number of contracts or patients?*

- 1 Contracts - (Skip to #G8)
- 2 Patients - (Continue)
- 3 (DK) (Skip to #G8)
- 4 (Refused) (Skip to #G8)

If the respondent tells you the practice has 20 or more contracts, you will ask this follow-up question to make sure he/she is thinking of contracts, not individual patients.

G6c. (If code "2" in #G6b, ask:) *In this question, we are asking about contracts. So, roughly how many managed care CONTRACTS does this practice have? (Open ended and code actual number)*

- 00 None (Continue)
- 01 (Skip to #G8)
- 97
- DK (DK) (Skip to #G8)
- RF (Refused) (Skip to #G8) ()

If it turns out that the physician was confused and thought about patients instead of contracts, this question allows you to clear up the confusion.

G7. (If code "00" in #G6, ask:) *What percentage, if any, of the patient care revenue received by the practice in which you work comes from all managed care combined? Please include ALL revenue from managed care including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care programs include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)*

- 000 None
- 001 1 percent or less
- DK (DK)
- RF (Refused)

(All in #G7, Skip to SECTION H)

This question is asked of respondents who have said their practice has NO managed care contracts. Even though the practice does not have managed care contracts, it is still possible that the practice may receive revenue from managed care.

- G8. (If code "02-97" in #G6 or code "2" or "3" in #G6a or code "02-97" in #G6c, ask:) What percentage of the patient care revenue received by the practice in which you work comes from these (response in #G6) managed care contracts combined? (If code "001-100", "DK" or "RF" in #G3, read:) Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)

This form of G8 is asked of respondents whose practices have two or more managed care contracts.

(If code "01" in #G6 or #G6c, ask:) What percentage of the patient care revenue received by the practice in which you work comes from this managed care contract? (If code "001-100", "DK" or "RF" in #G3, read:) Please include ALL revenue from this contract including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)

This form of G8 is asked of respondents whose practices have only one managed care contract.

(If code "DK" or "RF" in #G6 or code "1-3", "8", or "9" in #G6a or code "DK" or "RF" in #G6c, ask:) What percentage of the patient care revenue received by the practice in which you work comes from all of the practice's managed care contracts combined? (If code "001-100", "DK" or "RF" in #G3, read:) Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)

This form of G8 is asked of respondents who could not give a definite answer regarding the number of managed care contracts their practices have.

000	None – (Skip to SECTION H)			
001	1 percent or less (Continue)			
002-100	(Continue)			
DK	(DK)	(Skip to #G9)		
RF	(Refused)	(Skip to #G9)	(962)	(963) (964)

G8 is followed by a series of consistency checks. The following questions allow you to clarify possibly inconsistent responses to prior questions.

G8a. (If response in #G8 is less than response in #G3, ask:) I have recorded that your revenue from all managed care contracts is less than the amount you received on a capitated or prepaid basis. We would like you to include all capitated payments in estimating managed care revenue. Would you like to change your answer of (read 1-2)?

1	(Response in #G8) percent from all managed care contracts OR – (Continue)
2	(Response in #G3) percent received on a capitated or prepaid basis – (Skip to #G8c)
3	(Both) – (Continue)
4	(Neither) (Skip to Note before #G9)

8	(DK)	(Skip to Note before #G9)
9	(Refused)	(Skip to Note before #G9)

(If code "8", "9" or "blank" in #G6a AND code "DK", "RF", or "blank" in #G6c, skip to Note before #G9; Otherwise continue.)

G8b. (If code "1" or "3" in #G8a, ask:)

(If code "02-97" in #G6 or code "1-3" in #G6a or code "02-97" in #G6c, ask:) *So, what percentage of the practice's revenue from patient care would you say comes from all of these managed care contracts combined?* (Open ended and code actual percent)

(If code "01" in #G6 or #G6c, ask:) *So, what percentage of the practice's revenue from patient care would you say comes from this managed care contract?* (Open ended and code actual percent)

000	None			
001	1 percent or less			
DK	(DK)			
RF	(Refused)	(966)	(967)	(968)

G8c. (If code "2" or "3" in #G8a, ask:) *So what percentage of patient care revenue received by the practice in which you work is paid on a capitated or other prepaid basis? (If necessary, read:) Under capitation, a fixed amount is paid per patient per month regardless of services provided. (Probe:) Your best estimate would be fine.* (Open ended and code actual percent)

000	None			
001	1 percent or less			
002				
100				
DK	(DK)			
RF	(Refused)	(872)	(873)	(874)

G8d. (If response in #G8 = response in #G3, ask:) *So, all of the practice's managed care revenue is paid on a capitated, or prepaid basis, is this correct?*

1	Yes - (Skip to "Note" before #G9)
2	No – (Continue)
8	(DK) (Skip to "Note" before #G9)
9	(Refused) (Skip to "Note" before #G9)

G8e. (If code "2" in #G8d, ask:) *I have recorded that (response in #G8) percent of the practice revenue is from managed care and that (response in #G3) percent of the practice revenue is paid on a capitated or prepaid basis. Which of these is incorrect?*

- 1 Revenue from managed care (Continue)
- 2 Revenue paid on capitated or prepaid basis (Skip to #G8g)
- 3 Both are correct - (Skip to Note before #G9)
- 4 Neither are correct - (Continue)
- 8 (DK) (Skip to Note before #G9)
- 9 (Refused) (Skip to Note before #G9) ()

G8f. (If code "1" or "4" in #G8e, ask:)

(If code "02-97" in #G6 or #G6c, ask:) *What percentage of the patient care revenue received by the practice in which you work comes from these (response in #G6) managed care contracts combined? (If code "001-100", "DK" or "RF" in #G3, read:) Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)*

(If code "01" in #G6, ask:) *What percentage of the patient care revenue received by the practice in which you work comes from this managed care contract? Please include ALL revenue from this contract including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)*

(If code "DK" or "RF" in #G6 or if code "1-3", "8-9" in #G6a or "DK" or "RF" in #G6c, ask:) *What percentage of the patient care revenue received by the practice in which you work comes from all of the practice's managed care contracts combined? Please include*

ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. (If necessary, read:) Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)

000	None	(Skip to SECTION H)	
001	1 percent or less	(Continue)	
002			
100		(Continue)	
DK	(DK)	(Continue)	
RF	(Refused)	(Continue)	() () ()

G8g. *(If code "2" or "4" in #G8e, ask:) Now thinking about the patient care revenue from ALL sources received by the practice in which you work, what percentage is paid on a capitated or other prepaid basis? (If necessary, read:) Under capitation, a fixed amount is paid per patient per month regardless of services provided. (Probe:) Your best estimate would be fine. (Open ended and code actual percent) (INTERVIEWER NOTE: Includes payments made on a capitated or other prepaid basis from Medicare or Medicaid)*

000	None
001	1 percent or less
002	
100	
DK	(DK)
RF	(Refused)

(If code "01" in #G6 or #G6c, Skip to "Note" before #G11;
Otherwise, Continue)

G9. *(If code "001-100" in #G8, ask:) Now thinking of the ONE managed care contract that provides the largest amount of revenue for the practice in which you work, what percentage of the practice revenue would you say comes from this contract? (Probe:) Your best estimate will be fine. (Open ended and code actual percent)*

(If code "DK" or "RF" in #G8, ask:) *Would you be able to estimate, what percentage of the practice's revenue comes from the ONE contract that provides the largest amount of revenue in the practice in which you work? (Probe:) Your best estimate will be fine.*
(Open ended and code actual percent)

000	None			
001	1 percent or less			
DK	(DK)			
RF	(Refused)	(969)	(970)	(971)

For those respondents who have told you their practices have more than one managed care contract, G9 asks the percentage of revenue from the largest of these contracts.

G9 is followed by additional consistency check questions when inconsistent responses have been given.

(If response in #G9 > response in #G8b/#G8, Continue;
If response in #G9 = response in #G8b/#G8 AND
NOT code "01" in #G6, Skip to #G9c;
Otherwise, Skip to "Note" before #G11)

G9a *I have recorded that the percentage of revenue that comes from the largest managed care contract is greater than the total revenue from all managed care contracts. Can you help me resolve this? What percentage of the practice's revenue from patient care would you say comes from the (response in #G6c/#G6a/#G6) managed care contracts combined? (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care plans include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)*

000	None			
001	1 percent or less			
DK	(DK)			
RF	(Refused)	(1012)	(1013)	(1014)

G9b. Now thinking of the ONE managed care contract that provides the largest amount of revenue for the practice in which you work, what percentage of the practice revenue would you say comes from this contract? (Probe:) Your best estimate will be fine. (Open ended and code actual percent)

000	None			
001	1 percent or less			
DK	(DK)			
RF	(Refused)	(1015)	(1016)	(1017)

(All in #G9b, Skip to "Note" before #G11)

G9c I may have recorded something incorrectly. Earlier I recorded that the practice in which you work has more than one managed care contract. But, I have also recorded that the percentage of revenue that comes from the largest managed care contract is the same as the total revenue from all managed care contracts. Can you help me resolve this? How many managed care contracts does the practice in which you work have with health insurers or payers? (If necessary, read:) Managed care plans include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (INTERVIEWER NOTE: Can include Medicare managed care, Medicaid managed care, and other government managed care contracts but not traditional Medicare or Medicaid.) (Open ended and code actual number)

00	(Skip to SECTION H)		
01	One	(Skip to "Note" before #G11)	
02-97		(Continue)	
DK	(DK)	(Continue)	
RF	(Refused)	(Continue)	(1018) (1019)

G9d. What percentage of the practice's revenue from patient care would you say comes from these (response in #G9c) managed care contracts combined? (Probe:) Your best estimate will be fine. (If necessary, read:) Managed care plans include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended and code actual percent)

000 None
 001 1 percent or less
 DK (DK)
 RF (Refused) (1020) (1021) (1022)

G9e. *Now thinking of the ONE managed care contract that provides the largest amount of revenue for the practice in which you work, what percentage of the practice revenue would you say comes from this contract? (Probe:) Your best estimate will be fine. (Open ended and code actual percent)*

000 None
 001 1 percent or less
 DK (DK)
 RF (Refused) (1023) (1024) (1025)

(There is no #G10)

(If response in #G3 = response in #G8 AND
 code "1" in #G8d, Skip to SECTION H;
 If code "000" in #G3, Skip to "SECTION H";
 Otherwise, Continue)

G11. *Would you say that all, most, some, or none of the patient care revenue received from this managed care contract is paid on a capitated or prepaid basis?*

4 All
 3 Most
 2 Some
 3 None
 8 (DK)
 9 (Refused) (1028)

(There is no #G12)

CLOCK: (2864-
2867)

SECTION H. PHYSICIAN COMPENSATION METHODS & INCOME LEVEL

(READ:) *Now, I'm going to ask you a few questions about how the practice compensates you personally..*

(If code "2" or "8-9" in #A4, read:) Again, please answer only about the main practice in which you work.

H1. Are you a salaried physician?

- | | | | |
|---|-----------|---------------|--------|
| 1 | Yes | (Skip to #H3) | |
| 2 | No | (Continue) | |
| 8 | (DK) | (Continue) | |
| 9 | (Refused) | (Continue) | (1030) |

A salaried physician is one whose remuneration from the practice is in the form of a fixed payment per time period (e.g., every two weeks) and the amount of the paycheck is not subject to periodic upward or downward adjustments depending on either how the physician or the practice has performed.

H2. (If code "2" or "8-9" in #H1, ask:) Are you paid in direct relation to the amount of time you work, such as by the shift or by the hour?

- | | | | |
|---|-----------|---------------|--------|
| 1 | Yes | (Skip to #H4) | |
| 2 | No | (Skip to #H7) | |
| 8 | (DK) | (Skip to #H7) | |
| 9 | (Refused) | (Skip to #H7) | (1031) |

Some physicians contract out their services in return for a payment for each hour or shift worked. An example would be a physician whose main practice is to work shifts in a hospital emergency room on a contract basis.

Questions H1 and H2 are designed to identify physicians whose compensation is in the form of either a base salary (H1) or hourly rates (H2). Physicians who do not answer "yes" to one of these questions are skipped to a separate series of questions

for physicians whose compensation is determined by other means (beginning with Question H7).

H3. (If code "1" in #H1, ask:) Is your base salary a fixed amount that will not change until your salary is renegotiated or is it adjusted up or down during the present contract period depending on your performance or that of the practice? (If necessary, read:) Adjusted up or down means for example, some practices pay their physicians an amount per month that is based on their expected revenue, but this amount is adjusted periodically to reflect actual revenue produced. (INTERVIEWER NOTE: Base salary is the fixed amount of earnings, independent of bonuses or incentive payments.)

- | | | | |
|---|---------------------|---------------|--------|
| 1 | Fixed amount | (Continue) | |
| 2 | Adjusted up or down | (Skip to #H7) | |
| 8 | (DK) | (Continue) | |
| 9 | (Refused) | (Continue) | (1032) |

This question is asked of all physicians who said (in Question H1) that they are salaried, and is intended to make sure they really are salaried. Many doctors are paid according to the amount of revenue they (or their practice) generate in the year. However, since the total amount of revenue generated will not be known until the end of the year, doctors paid in this manner usually receive a regular paycheck for a fixed amount. The amount of the check is based on an estimate of how they are expected to perform, and the money is actually an advance on their expected earnings. Because they receive a regular paycheck for a fixed amount, many doctors will erroneously tell us in Question H1 that they are salaried, even though there will be some end-of-the-year reconciliation (up or down) based on their performance.

Physicians who answer Question H3 by saying that their base salary is adjusted up or down during the present contract period will not be considered to be salaried physicians. They will be skipped to the separate series of questions for physicians whose compensation is determined by other means (beginning with Question H7).

H4. (If code "1" in #H2 OR code "1" or "8-9" in #H3, ask:) Are you also currently eligible to earn income through any type of bonus or incentive plan? (INTERVIEWER NOTE: Bonus can include any type of payment above the fixed, guaranteed salary.)?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused) (1033)

This question is asked only of those physicians who are paid by the hour or shift, or who are truly salaried.

H5. *I am going to read you a short list of factors that are sometimes taken into account by medical practices when they determine the compensation paid to physicians in the practice. For each factor, please tell me whether or not it is EXPLICITLY considered.*

(If code "1" in #H1 AND code "2" or "8-9" in #H4, ask:) when your salary is determined. Does the (response in #CA) consider (read A-D)?

(If code "1" in #H1 AND code "1" in #H4, ask:) when either your base salary or bonus is determined. Does the (response in #CA) consider (read A-D)?

(If code "1" in #H2 AND code "2" or "8-9" in #H4, ask:) when your pay rate is determined. Does the (response in #CA) consider (read A-D)?

(If code "1" in #H2 AND code "1" in #H4, ask:) when either your pay rate or bonus is determined. Does the (response in #CA) consider (read A-D)?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused)

A. *Factors that reflect your own productivity (If necessary, read:) Examples include the amount of revenue you generate for the practice, the number of relative value units you produce, the number of patient visits you provide, or the size of your enrollee panel (1034)*

Physicians are often paid in some direct relation to their own "productivity". The emphasis in this question is that the payment is based on the physician's productivity, not the productivity (or profitability) of the practice overall.

A physician's productivity can be measured in many ways. Several examples are given in the question for you to read if necessary.

The most common measure is the amount of money (or revenue) the physician earns for the practice: physicians who contribute more to the earnings of the practice will be paid more.

Sometimes practices consider the number of services produced by the physician rather than the dollars brought into the practice. Services will typically be a mix of visits and procedures that range in complexity (e.g., an office visit for the flu, an office visit for a complete physical exam, a colonoscopy, a heart by-pass, etc.). In order to aggregate this mix of services to one total, practices sometimes assign "weights" or "relative value units" to individual services so all types of services are expressed in a common unit, with more complex services given a higher weight. Thus, each simple office visit might count as one unit, each physical as five units, and each colonoscopy as 50 units, etc.

If all services are more or less comparable, a practice may simplify the accounting and just count the number of patient encounters (implicitly assigning each one the same weight regardless of their relative complexities).

Finally, some practices pay physicians according to the number of patients they have enrolled with them (i.e., the size of the enrollee panel). This measure would be used mainly for primary care physicians serving as gatekeepers.

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS

Again, the emphasis is on surveys of the individual physician's patients.

C Specific measures of quality of care, such as rates of providing preventive care services for your patients

For many types of preventive care services, there is a clear standard of care: for example, all young children should receive certain immunizations at specified ages. Failure to provide these services constitutes poor quality of care. Practices will sometimes monitor whether individual physicians meet these accepted standards of care, and base a portion of the physician's pay on the results of this type of quality profiling.

D. Results of practice profiling comparing your pattern of using medical resources to treat patients with that of other physicians

Practices may also monitor physician's use of other services to see how they compare with other physicians on the same measure. Unlike the preventive services discussed above, in these cases there is no clear standard as to the appropriate level of use. For example, if one family practitioner in a large practice is referring 40 percent of his patients for specialty care, while the average for all other family practitioners in the practice is only about 10 percent, we don't know whether the one physician is referring too often or the others are not referring frequently enough. Still, some practices profile physicians on these types of measures to identify individuals who are significantly above or below the mean, and part of the physician's remuneration can be based on these profiles. For example, a physician may forfeit a bonus if he or she refers patients to specialists "too often".

If the respondent shows some confusion between Question H-5C and H-5D, try to clarify that H-5C is asking about specific measures of quality of care, whereas H-5D is asking about other types of profiling, more generally.

(If code "2" or "8-9" in #H5-D, Skip to #H9;

Otherwise, Continue)

H6. (If code "1" in #H5-D, ask:) *Are these profiles risk-adjusted to consider the health status of your patients or the severity of their illnesses?* (INTERVIEWER NOTE: Other than by age and gender)

1 Yes

2 No

8 (DK)

9 (Refused)

(1038)

(All in #H6, Skip to #H9)

This question is asked only of physicians who said part of their pay is based on general profiling. Because there is no accepted standard of care for these measures, the best profiles try to understand why individual physicians might be either significantly above or below the mean, and to adjust for these factors. In the example given earlier, it may be that the family practitioner with the 40 percent specialist referral rate is seeing all of the practice's advanced AIDS patients; a higher-than-average rate of referrals would be appropriate in these cases.

It is a relatively simple matter to adjust profiles for the age and gender mix of the patients seen by an individual physician, and many practices do this. If these are the only factors used to adjust the profiles, we want a "no" answer to this question.

Some practices will also attempt to adjust for the health status of a physician's patients or the severity of their illnesses. This will keep physicians who have sicker patients from being penalized for using more resources in the treatment of their patients. The doctor who has all of the advanced AIDS patients and a high rate of specialty referrals may not forfeit his bonus, for example, if this type of adjustment is made.

If the physician says something like, "I guess they are adjusting for health status because I know they make an age adjustment and it is a fact that older patients are sicker...", you should take this as a "no" answer. We want a "yes" answer recorded for this question only if there is an explicit adjustment made for health status or severity of illness.

H7. (If code "2" or "8-9" in #H2 or code "2" in #H3, ask:) *I am now going to read you a short list of factors that are sometimes taken into account by medical practices when they*

determine the compensation paid to physicians in the practice. For each factor, please tell me whether or not it is EXPLICITLY considered when your compensation is determined. Does the (response in #CA) in which you work consider (read A-D)?

- 1 Yes
- 2 No
- 8 (DK)
- 9 (Refused)

- A. *Factors that reflect YOUR OWN productivity (If necessary, read:) Examples include the amount of revenue you generate for the practice, the number of relative value units you produce, the number of patient visits you provide, or the size of your enrollee panel (1039)*

Physicians are often paid in some direct relation to their own "productivity". The emphasis in this question is that the payment is based on the physician's productivity, not the productivity (or profitability) of the practice overall.

If the physician says something like "Sure, my income is higher when the practice does better", you need to probe to make sure that the individual physician earns more only if s/he contributed to the higher productivity of the group. For example, if three physicians in a group split the profit of the practice equally, then each physician in the group gets 33 percent of the practice's earnings regardless of his or her contribution to the total. If the group does better (and there is more money to split among the members) because one member was very productive, the other physicians benefit even though they were not as productive. H7-A should be given a "yes" response only if the physician's earnings depend on his or her own productivity.

A physician's productivity can be measured in many ways. Several examples are given in the question for you to read if necessary.

The most common measure is the amount of money (or revenue) the physician earns for the practice: physicians who contribute more to the earnings of the practice will be paid more.

Sometimes practices consider the number of services produced by the physician rather than the dollars brought into the practice. Services will typically be a mix of visits and procedures that range in complexity (e.g., an office visit for the flu, an office visit for a complete physical exam, a colonoscopy, a heart by-pass, etc.). In order to aggregate this mix of services to one total, practices sometimes assign "weights" or "relative value units" to individual services so all types of services are expressed in a common unit, with more complex services given a higher weight. Thus, each simple office visit might count as one unit, each physical as 5 units, and each colonoscopy as 50 units, etc.

If all services are more or less comparable, a practice may simplify the accounting and just count the number of patient encounters (implicitly assigning each one the same weight regardless of their relative complexities).

Finally, some practices pay physicians according to the number of patients they have enrolled with them (i.e., the size of their enrollee panel). This measure would be used mainly for primary care physicians serving as gatekeepers.

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS

(1040)

Again, the emphasis is on surveys of the individual physician's patients.

C. Specific measures of quality of care, such as rates of preventive care services for your patients

(1041)

For many types of preventive care services, there is a clear standard of care: for example, all young children should receive certain immunizations at specified ages. Failure to provide these services constitutes poor quality of care. Practices will sometimes monitor whether individual physicians meet these accepted standards of care, and base a portion of the physician's pay on the results of this type of quality profiling.

- E. *Results of practice profiles comparing your pattern of using medical resources to treat patients with that of other physicians (INTERVIEWER NOTE: A practice profile is a report that is usually computer generated which compares you to other physicians on things like referrals to specialists, hospitalizations and other measures of cost effectiveness.)* (1042)

Practices may also monitor physician's use of other services to see how they compare with other physicians on the same measure. Unlike the preventive services discussed above, in these cases there is no clear standard as to the appropriate level of use. For example, if one family practitioner in a large practice is referring 40 percent of his patients for specialty care, while the average for all other family practitioners in the practice is only about 10 percent, we don't know whether the one physician is referring too often or the others are not referring frequently enough. Still, some practices profile physicians on these types of measures to identify individuals who are significantly above or below the mean, and part of the physician's remuneration can be based on these profiles. For example, a physician may forfeit a bonus or have his share of the group's revenues reduced if he refers patients to specialists "too often".

If the respondent shows some confusion between Question H-7C and H-7D, try to clarify that H-7C is asking about specific measures of quality of care, whereas H-7D is asking about other types of profiling, more generally.

(If code "2" or "8-9" in #H7-D, Skip to #H9;

Otherwise, Continue)

H8 (If code "1" in #H7-D, ask:) *Are these profiles risk-adjusted to consider the health status of your patients or the severity of their illnesses?* (INTERVIEWER NOTE: Other than by age and gender)?

1 Yes

2 No

8 (DK)

9 (Refused)

(1067)

This question is asked only of physicians who said part of their pay is based on general profiling. Because there is no accepted standard of care for these measures, the best profiles try to understand why individual physicians might be either significantly above or below the mean, and to adjust for these factors. In the example given earlier, it may be that the family practitioner with the 40 percent specialist referral rate is seeing all of the practice's advanced AIDS patients; a higher-than-average rate of referrals would be appropriate in these cases.

It is a relatively simple matter to adjust profiles for the age and gender mix of the patients seen by an individual physician, and many practices do this. If these are the only factors used to adjust the profiles, we want a "no" answer to this question.

Some practices will also attempt to adjust for the health status of a physician's patients or the severity of their illnesses. This will keep physicians who have sicker patients from being penalized for using more resources in the treatment of their patients. The doctor who has all of the advanced AIDS patients and a high rate of specialty referrals may not forfeit part of his share of the practice's revenue, for example, if this type of adjustment is made.

If the physician says something like, "I guess they are adjusting for health status because I know they make an age adjustment and it is a fact that older patients are sicker...", you should take this as a "no" answer. We want a "yes" answer recorded for this question only if there is an explicit adjustment made for health status or severity of illness.

H9. *Of your total income from your (response in #CA) during calendar year 1995, approximately what percent would you estimate was earned in the form of bonuses,*

returned withholds, or other incentive payments based on your performance? (Open ended and code actual percent)

000	None – (Continue)			
001	1 percent or less	- (Skip to #H10)		
002-100		(Skip to #H10)		
DK	(DK)	(Skip to #H10)		
RF	(Refused)	(Skip to #H10)	(1043)	(1044) (1045)

All physicians will be asked this question, including physicians who are paid a fixed salary or by the hour or shift but who are not eligible to earn a bonus. Even though these physicians do not earn a bonus, it is conceivable that part of their income could be derived from returned withholds from contracts or other incentive payments based on their performance.

When entering into a contract with a physician or practice, some third-party insurers will structure the payment agreement so that some of the money due to the physician or practice is placed into a set-aside (or withhold) pool. These withhold pools can be used with either capitation or fee-for-service contracts. For example, the insurer may set aside \$1 of the monthly capitation payment made for each enrolled patient or 10% of the fee paid for each service delivered. These withheld funds are returned to the physician or practice at the end of a set time period only if predetermined performance goals were met for the time period. Because receipt of these funds is linked to performance, many physicians may think of them as a bonus or incentive payment.

We are asking about calendar year 1995 because it is the last complete year.

H9a. (If code "000" in #H9, ask:) *Were you eligible to earn any bonuses or other performance-based payments in 1995?* (INTERVIEWER NOTE: This question is asking about eligibility to earn bonuses in 1995. Earlier question (#H4) asked about whether the physician is eligible to earn a bonus at the time of the interview.)

- | | | |
|---|-----------|--------|
| 1 | Yes | |
| 2 | No | |
| 8 | (DK) | |
| 9 | (Refused) | (1046) |

This follow-up question is asked of physicians who said in Question H9 that they earned no 1995 income in the form of bonuses or other incentive payments. As explained in the interviewer note, this follow-up is needed because we want to be able to differentiate between physicians who did not earn a bonus in 1995 even though they were eligible to earn one in that year, and physicians who did not earn a bonus in 1995 because they were not eligible for such payments in 1995. The earlier question on this topic (H4) asked about whether they were eligible to earn a bonus at the time of the interview. In H9a, we need to determine whether they were eligible to earn a bonus in 1995.

H10. *During 1995, what was your own net income from the practice of medicine to the nearest \$1,000, after expenses but before taxes? Please include contributions to retirement plans made for you by the practice and any bonuses as well as fees, salaries and retainers. Exclude investment income. (If code "2" in #A4, read:) Also, please include earnings from ALL practices, not just your main practice. (If necessary, read:) We define investment income as income from investments in medically related enterprises independent of a physician's medical practice(s), such as medical labs or imaging centers. (If "Refused", read:) This information is important to a complete understanding of community health care patterns and will be used only in aggregate form to ensure confidentiality of the information. (Open ended and code actual number) (If response is > \$1 million, verify)*

- | | | | | | | | |
|----------|-----------|----------------|--------|--------|--------|--------|--------|
| 0000001- | | | | | | | |
| 9999999 | | (Skip to #H11) | | | | | |
| DK | (DK) | (Continue) | | | | | |
| RF | (Refused) | (Continue) | | | | | |
| | (1047) | (1048) | (1049) | (1050) | (1051) | (1052) | (1053) |

We define investment income as income from investments in medically related enterprises independent of a physician's medical practice(s), such as medical labs or imaging centers. Deferred compensation includes cash and non-cash contributions to pensions, profit-sharing arrangements and other deferred compensation.

H10a (If code "DK" in #H10, ask:) Would you say that it was (read 01-09)?

(If code "RF" in #H10, ask:) Would you be willing to indicate if it was (read 01-09)?

- | | | | |
|----|----------------------------------|---------------------|---------------|
| 01 | Less than \$100,000 | | |
| 02 | \$100,000 to less than \$150,000 | | |
| 03 | \$150,000 to less than \$250,000 | | |
| 04 | \$250,000 or more | | |
| 98 | (DK) | (Skip to SECTION I) | |
| 99 | (Refused) | (Skip to SECTION I) | (1054) (1055) |

(There is no #H11 - #H12)

CLOCK: (2873-2876)

SECTION I. ENDING

I1. Your check for \$25 will be mailed to you within the next few days. Should we send the check to (address from fone file)?

- | | | | |
|---|-----------|----------------|--------|
| 1 | Yes | (Skip to #I3) | |
| 2 | No | (Continue) | |
| 8 | (DK) | (Skip to #I3) | |
| 9 | (Refused) | (Skip to #I13) | (1063) |

I2. (If code "2" in #I1, ask:) To what address should we send the check? (Open ended)

STREET ADDRESS: (1212-1241)

CITY: (1242-1266)

STATE: (1267-1268)

ZIP: (1269-1273)

I3. Is this the address of the practice we have been talking about during this interview? (read 1-2)?

- | | | |
|---|--------------------------|-----------------------------|
| 1 | (Address from fone file) | (Skip to "Note" before #I5) |
| 2 | (Address in #I2) | (Skip to "Note" before #I5) |
| 3 | No/Neither | (Continue) |
| 8 | (DK) | (Skip to "Note" before #I5) |
| 9 | (Refused) | (Skip to "Note" before #I5) |

I4 Will you please give me the address of the practice we have been talking about during this interview? (Open ended)

STREET ADDRESS: (1312-1341)

CITY: (1342-1366)

STATE: (1367-1368)

ZIP: (1369-1373)

(If code "08-10" in #C2 or #C3, Continue;
Otherwise, Skip to #I6)

- I5. *What is the name of the practice we have been talking about during this interview? (If necessary, read:) Over the next few years, we will also be doing surveys of group practices and other physician organizations. This information will help us identify all group practices in your community. (Open ended)*

00001 Other (list)
00002 HOLD
00003 HOLD
00004 No/Yes mind giving
00005 HOLD
99998 (DK)
99999 (Refused) (1412) (1413) (1414) (1415) (1416)

This question refers to a study that will be done in which group practices will be selected from a list of such practices maintained by the AMA. If we know the names of the group practices to which respondents in the study belong, this information can be matched to other data collected later about this same practice.

(There is no #I6 - #I9)

CLOCK: (2869-2872)

SECTION J. SWEEP-UP

I'd like to wrap up the interview by asking you a couple of very general questions.

(There is no #J1 - #J3)

J4 This concludes the survey unless you have any brief comment you would like to add.
(Open ended)

0001 Other (list)

0002

0004 No/Nothing

9998 (DK)

9999 (Refused)

(1075) (1076) (1077) (1078)

In general, we would like to discourage physicians from making open-ended comments because the survey is long. However, if the respondent wishes to add any comments, you should type them verbatim here. Often a physician will start talking very rapidly, telling you about his/her feelings or relating a particular story. You should make sure the respondent knows that you have to type every word he/she says and that you have limited space to enter comments. Ask him/her to slow down so you can be sure to capture every word. This should help to keep the comments brief.

The comments will be read by survey analysts.

J5. INTERVIEWER CODE ONLY: (INTERVIEWER NOTE: Do NOT offer to send study report to respondent unless physician requests it. Report will not be available until mid-1997 at the earliest.) Did respondent ask for study report?

1 Yes

2 No (1420)

(VALIDATE PHONE NUMBER AND THANK RESPONDENT)

INTERVIEWER I.D.#: (241) (242) (243) (244)

CLOCK: (2844-2847)

Glossary of Terms

Ancillary Services -- (AN-sil-larry) these include physical therapy, home health care, nutritional counseling, laboratory tests, x-rays, and services to hospital patients other than room and board and nursing service.

Free Standing Clinic -- includes ambulatory care, surgical and emergency care centers which are not part of a hospital.

Diagnostic Imaging Services -- any of a number of noninvasive diagnostic techniques used in the field of radiology, including traditional x-ray techniques as well as more advanced techniques such as magnetic resonance imaging (MRI); CAT (computerized axial tomography) scans; PET (positive emission tomography) scans; ultrasound, and so forth.

Group Practice -- defined as a physician practice that involves three or more physicians formally organized as a legal entity in which business and clinical facilities, records and personnel are shared, and income from medical services provided by the group are treated as receipts of the group and distributed according to some prearranged plan.

Guidelines, or clinical practice guidelines-- provide treatment recommendations for specific conditions. For this survey, we are only interested in the use of formal written guidelines such as those generated by physician organizations, insurance companies or HMOs, government agencies, or other such groups. We are not interested in guidelines which are used only by the respondent.

Inpatient-- services are those that are delivered during an overnight stay in a hospital or other inpatient facility, such as a long term care facility.

Locum Tenens -- a term that refers to a physician who is temporarily substituting for another physician in a practice setting.

On-Call -- hours that the physician is required to be present in a facility (for example, a hospital or nursing home) in case a medical need arises. Exclude hours when the physician must be accessible by beeper but can be doing other non-work activities.

Outpatient-- or ambulatory services are those that are delivered while the patient is not hospitalized. Typical outpatient services are visits to doctors' offices and urgent care centers, clinic visits, "same-day surgery", and so forth. Generally speaking, emergency room services are also considered to be outpatient or "ambulatory" care. Usually outpatients do not stay overnight in a hospital (although in recent years some hospitals have developed the concept of overnight outpatient stays).

Practice Profiles --are a tool used by many insurance providers and practices to compare use of certain medications, laboratory tests, x-rays, other diagnostic tests, hospitalizations, referrals to specialists, or other measures of cost-effectiveness and/or quality. They may or may not be adjusted to consider factors such as the health status of the physician's patients or the severity of the illnesses.

Utilization Review --is a measure meant to reduce unnecessary use of services, especially inpatient services. Utilization review usually involves a second party, who may or may not be a physician, reviewing a physician's clinical decisions. This review may take place after the fact, or before the approval of health care services such as surgery.