APPENDIX

Community Tracking Study

Physician Survey Methodology Report
2004-05 (Round Four)

APPENDIX A

ROUND FOUR COGNITIVE INTERVIEWING PROTOCOLS AND REPORT, ADVANCE LETTERS, AND FINAL SURVEY INSTRUMENT

COGNITIVE INTERVIEWING PROTOCOLS AND REPORT

THE GALLUP ORGANIZATION

FOR

The Center for Studying Health System Change

Cognitive Interview Report

Community Tracking Study

2003-2004 Round Four Physician Survey

Submitted to:

The Center for Studying Health System Change

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1. Overview

The Community Tracking Study (CTS) is the core research effort of the Center for Studying Health System Change (HSC), a nonpartisan policy research organization located in Washington, D.C., and funded by the Robert Wood Johnson Foundation. HSC's mission is to inform health care decision makers about changes in the health care system at both the local and the national levels, as well as about how such changes will affect people. HSC conducts national surveys of those involved in or affected by changes in the health care system – households, physicians, employers – and interviews health care leaders in 12 communities.

The Physician Survey is a nationally representative telephone survey of non-federal, patient care physicians, which offers perspective on how healthcare delivery is changing. Physicians respond to a series of questions about whether they are able to provide needed services for patients, how they are compensated, and what effects various care management strategies have on their practices, as well as questions about their practice arrangements.

For the first three rounds of the physician survey, HSC provided technical direction and oversight for the physician survey, The Gallup Organization conducted the interviewing, and Mathematica Policy Research (MPR) was responsible for the sample design, sample weights, variance estimation, and tracing of physicians who could not be located.

For the first time in Round 4, Gallup was also responsible for the cognitive interviewing. This report details the results of the cognitive interviewing.

2. Field Preparation

For Round 4 of the Physician Survey, Gallup was responsible for conducting cognitive testing of potential survey modifications and additions. The objective of the cognitive testing is to determine the effectiveness of the potential survey modifications and gather feedback from the sample population on potential survey alterations focusing on comprehension of response options, the retrieval processes for behavioral questions, and the appropriateness of survey topics.

2.1 Instrument Development

Potential alterations to the Round 3 questionnaire were compiled by the HSC staff and submitted to Gallup for cognitive interviewing. Gallup then organized these items into survey script format. The items included in the cognitive interviews were divided into two groups to stay within reasonable time limitations and ease respondent burden. Group A included questions regarding access (except for charity care) and compensation. Group B included questions regarding charity care, productivity, consumer information, cost sharing, case mix, coordination and patient safety, and threat to quality. Because of complicated skips and fill-ins, Group A was programmed into Computer-Assisted Telephone Interviewing (CATI) to ease the interviewers' ability to navigate the script. The skip patterns included in Group B are not as complex as those in Group A and did not require CATI programming.

2.2 Sample

Gallup purchased a nationally representative sample of physicians from Medical Marketing Service, Inc. (MMS) that provided an appropriate distribution of primary care physicians and specialists. Three hundred cases were initially purchased[1]. Special care was taken to ensure that the sample had adequate coverage in Medicare and SCHIPS states.

The sample excluded the following:

- Full-time federal employees
- Residents or fellows
- Physicians who perform less than 20 hours of direct patient care during a typical week
- Physicians who practice outside of the continental United States
- Specialties excluded from previous rounds of the Physician Survey

The questionnaires also included screener questions to ensure that only qualified physicians completed the survey.

[1] Additional cases were ordered during the field period. See Section 3 for more information.

2.3 Interviewers

Two Executive Interviewers, Laura Bishop and Allen Jarchow, conducted all cognitive interviews. Both interviewers were selected from the team that has worked on the Physician Survey for all three previous rounds. In addition to their experience interviewing physicians, the selected interviewers have extensive experience with in-depth interviewing. Gallup conducted a training session with the interviewers with assistance from HSC. Training included a thorough review of each question and each follow-up probe. Interviewers were instructed to ask every survey item exactly as worded, but to use their judgment in asking the cognitive follow-up questions. The interviewers were taught in detail why each question was being considered for modification and/or addition to the CTS questionnaire so they would better understand how to probe respondents. Gallup's Cognitive Testing Director listened to audiotapes of each interviewer's first few completed interviews and Gallup's Co-Project Director reviewed the written transcripts. Detailed feedback was then provided to the interviewers and their supervisor before any further interviews were attempted. The interviewers typed all responses and each interview was tape-recorded and transcribed.

2.4 Recruitment

A recruiting screener was used to ensure both primary care physicians and specialists were recruited. Screener question from the Physician Survey were also included to ensure that participants met the eligibility requirements[2].

Physicians were offered $100 incentives for completion of the survey.

[2] See Section 2.2 for a list of the eligibility requirements.

3. Data Collection

Interviewing began on November 17, 2003. During the first few weeks of interviewing, however, the interviewers confronted considerable obstacles and had little success in completing interviews. Obstacles encountered included:

- A national flu epidemic that made primary care physicians difficult to reach
- Vacations and/or limited working hours around the winter holiday season
- Personal health problems that impeded the two trained interviewers from spending sufficient time working to recruit participants.

In an effort to counteract these problems, Gallup and HSC took two main steps. The first was for HSC to draft a letter from the President of HSC, Paul Ginsberg, that the interviewers faxed to hesitant participants. The letter described the focus of the cognitive interviews and urged physicians to participate.[3] The second step was to purchase an additional 600-piece sample set from MMS. Because the cognitive interviewing used a convenience sample, flooding the interviewers with fresh cases was not an important issue. The new sample followed the same specifications as the original sample and was split evenly between primary care physicians and all other specialties.

While progress remained slower than anticipated due to the reasons outlined above, the final interview was conducted on January 2, 2004. The $100 honorarium checks were mailed to all 35 participants on January 8, 2004.

[3] A copy of this letter is attached to this document as Appendix C.

4. Detailed Findings

This section of the report contains the actual question items that composed both the Group A and Group B interviews followed by a summary of the respondents' answers to the follow-up questions. After each response summary, Gallup offers a recommendation for how to approach the new question(s).

4.1 Group A

4.1.1 Access to Medical Services (Other Than Charity Care)

4.1.1.1 Questions 1 and 1a

Questions 1 and 1a ask about the physicians' ability to obtain services for their patients that they believed to be medically necessary.

1. During the last 12 months, were you unable to obtain any of the following services for your patients when you thought they were medically necessary? How about **(read and rotate A-E)**?

   A. Referrals to high quality specialists
   B. High quality ancillary services, such as physical therapy, home health care, nutritional counseling, and so forth
   C. Non-emergency hospital admissions
   D. High quality diagnostic imaging services
   E. High quality outpatient mental health services

1a. **(For each code 1 in #1 A-E, ask:)** During the last 12 months, for what percentage of your patients who needed **(read and rotate A-E, as appropriate)**, were you unable to obtain the service?

   A. Referrals to high quality specialists
   B. High quality ancillary services, such as physical therapy, home health care, nutritional counseling, and so forth
   C. Non-emergency hospital admissions
   D. High quality diagnostic imaging services
   E. High quality outpatient mental health services

Most respondents were very confident in their responses. The lowest level of confidence was described as "fairly."

Nearly all physicians agreed that 12 months was a good timeframe to use in this question. They indicated that limiting it to one month might be too small to be accurate, and that 12 months provides a better reflection of the practice because conditions would not have changed that would materially impact availability within one month. One physician pointed out that solo practitioners need to close their books every year, so 12 months would be the simplest and most accurate way for them to think of a response. Another respondent said that a 1-month timeframe would be more accurate, but a 12-month timeframe is more reflective of the whole picture.

One physician recommended changing the question wording to ask whether the respondents were "able" to obtain the services instead of "unable" to obtain the services. He believed that the positive wording would make "you concentrate more on how to answer, makes you answer the question correctly rather than thinking about the issue."

Another recommendation was to offer some examples for what services are included in the categories.

One respondent pointed out the difference between hospital admissions in rural versus urban areas. Reasons for lack of access in rural areas might be that the facilities are not available, whereas in urban areas, there are typically a large number of facilities but not enough bed space.

Many physicians wanted to explain their answers. In those cases, the interviewers told them that the next questions expanded on that point.

Recommendation: Because all respondents expressed some degree of confidence in their responses, Gallup suggests that Question 1 be added to the Round 4 Physician Survey as it is. Similarly, Gallup also believes that Question 1a should be added to the Round 4 Physician Survey as it is. While a few physician respondents indicated that it would be easier to recall specifics over a 1-month timeframe, nearly all agreed that a 12-month timeframe was more sensible and more reflective overall.

4.1.1.2 Questions 2 and 2b

Respondents who reported that they were unable to obtain referrals to high-quality specialists, non-emergency hospital admissions, or high-quality outpatient mental health services, continued with Questions 2 and 2b. All others skipped to Question 3.

Questions 2a and 2b ask the same question about reasons why a physician might be unable to obtain various services testing two alternatives of the response scale. 2a uses a numeric scale from one to ten with only the endpoint labeled. Question 2b uses a fully labeled, four-point verbal "importance" scale.

2a. I am now going to read some reasons why you might be unable to obtain various services. Using any number from

one-to-ten, where 1 is not important and 10 is very important, rate each of the following reasons for your being unable to obtain **(read a-c)**. How about **(read A-C)**?

2b. Now I am going to read some reasons why you might be unable to obtain various services. For each one, tell me whether it a very important, moderately important, not very important, or not at all important reason for your being unable to obtain **(read a-c)**. How about **(read A-C)**?

a. **(If code 001-100 in #1a-A, ask:)** Referrals to high quality specialists
b. **(If code 001-100 in #1a-C, ask:)** Non-emergency hospital admissions
c. **(If code 001-100 in #1a-E, ask:)** High quality outpatient mental health services, when you think it is medically necessary

A. There aren't enough qualified service providers or facilities in my area
B. Health plan networks and administrative barriers limit patient access
C. Patients lack health insurance or have inadequate insurance coverage

Quite a few respondents preferred the verbal scale, saying that they do not need the level of gradation offered by the numeric scale. However, a majority favored the 10-point scale for the opposite reason. They appreciated having the ability to be more specific.

Two recommendations offered by respondents were to add a verbal midpoint to the numerical scale (such as 5 equals neutral), and to provide an "Other" category that could be selected when the reasons provided are not explicitly applicable.

Recommendation: While substituting the verbal scale would allow more consistency with other question items, Gallup suggests continuing the numeric scale. Respondents did not seem to have difficulty switching between the verbal and numeric scales. Gallup also recommends considering offering an open-ended "Other" option.

4.1.1.3 Question 3

Question 3 asks about whether the respondent's practice is accepting new patients with certain health plans. The focus of this question is to determine whether respondents are familiar with SCHIP and how it differs from Medicaid.

3. 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 **(read A-E, as appropriate)**?

A. New patients who are insured through Medicare, including Medicare managed care patients
B. **(If code 06 in Sc, ask:)** New patients who are insured through MediCAL, including MediCAL managed care patients
C. **(If code 04 in Sc, ask:)** New patients who are insured through AHCCCS (Say: Access)
D. **(If code 01-03, 05, or 07-56 in Sc, ask:)** New patients who are insured through Medicaid, including Medicaid managed care patients
E. **(If code 1 in Sa, ask:)** New patients who are insured by a **(response in Si)**

Overall, respondents were not familiar with SCHIP and therefore were unable to differentiate between SCHIP and Medicaid practices.

Recommendation: Gallup recommends either not including the SCHIP category in Question 3 or providing a description or explanation of the SCHIP programs.

4.1.1.4 Question 4

Respondents who indicated that their practices are accepting only some or no new patients insured through Medicare continued to Question 4. Other respondents skipped to Question 5.

Question 4 asked the physicians to rate the importance of various potential reasons why physician practices may be limiting or not accepting new Medicare patients.

4. I am going to read some reasons why physician practices may be limiting or not accepting new Medicare patients. For each one, tell me whether it a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in #3-A, read:)** not accepting/**(If code 2 in #3-A, read:)** limiting] new Medicare patients. How about **(read and rotate A-E)**?

   A. Billing requirements
   B. Concern about a Medicare audit
   C. Inadequate reimbursement
   D. Full panel
   E. Medicare patients have high clinical burden

Several respondents cited reimbursement as another reason that they would limit their new Medicare patients, though Question 4B had already asked about reimbursement. Others indicated that it would entail hiring more administrators, which they do not have the capacity to do, and one said that his discipline simply does not include those types of patients. Alternately, several physicians said that there were not any factors other than those listed in Question 4 that affected their decisions.

None of the respondents had difficulty with the scale used in this question. Recommendations for improving the question included changing to a yes/no scale, and introducing the four categories at the beginning and then asking them to consider each one individually.

Opinions were mixed about whether the term "billing requirements" refers to administrative burden. Some felt that administrative burden is a distinct reason that should be included on the list, while some described billing requirements as "purely administrative."

Respondents agreed that the term "Medicare audit" does not require explanation. It is a term that anyone who has ever accepted a Medicare patient would be familiar with.

However, most respondents did not understand what "full panel" meant. A few successfully guessed the meaning, but were not confident.

Recommendations:

- While none of the respondents had difficulty answering Question 4A about billing requirements, several indicated in the follow-up question that it did not necessarily fully encapsulate administrative burden. Gallup suggests modifying the wording to "billing requirements including all associated paperwork and filing."
- Respondents were comfortable with the term "Medicare audit." They were not, however, familiar with "full panel." Gallup recommends adding a definition or simply using the definition and not including the term.
- Gallup recommends considering changing this item to a yes/no format.

4.1.1.5 Question 5

Physicians who indicated that they were only accepting some or no new patients who are insured through MediCAL or Medicaid were asked Question 5. Others continued to Question 6.

Question 5 asks about reasons why practices may be limiting or not accepting new MediCAL or Medicaid patients.

5. Next, I am going to read some reasons why physician

> practices may be limiting or not accepting new [**(If code 06 in Sc, read:)** MediCal/**(Otherwise, read:)** Medicaid] patients. Again, tell me whether each one is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in #3-D, read:)** not accepting/**(If code 2 in #3-D, read:)** limiting] new Medicaid patients. How about **(read and rotate A-E)**?
>
> A. Billing requirements
> B. Delayed reimbursement
> C. Inadequate reimbursement
> D. Full panel
> E. Medicaid patients have high clinical burden

A few physicians referred to the associated administrative burden as another reason that their practice accepts only some or no new MediCAL or Medicaid patients. One respondent said that his practice does not include those types of patients, as in Question 4. Those respondents seem to perceive the term "billing requirements" as meaning part of larger bureaucratic issues caused by MediCAL or Medicaid patients.

One physician said that Medicaid patients are less of a clinical burden, but more of a legal burden or risk and suggested adding another question about the possibility of legal ramifications for mistakes. Another indicated that Medicaid patients tend to not be responsible in terms of keeping appointments.

Respondents did not have any difficulty with the scale on Question 5.

As mentioned previously, most respondents are not familiar with the term "full panel" and believe that it requires explanation.

Overall, respondents had positive opinions about Question 5 and believed that it would provide "appropriate and helpful" data that could allow the Medicare and Medicaid programs to consider modifications to increase practitioner ease.

Recommendation: Gallup's recommendation for Question 5 is the same as that provided for Question 4.

4.1.2 Compensation

4.1.2.1 Questions 6 and 7

Question 6 begins the second portion of the interview that deals with compensation and practice revenues.

Question 6 asks physicians what proportion of their patient care revenue is paid on a capitated or other prepaid basis. This question has been used on previous rounds of the Physician Survey and is used as a screener for Question 7.

6. 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)**

A few respondents were not familiar enough with the term "capitated" and required the interviewer to read the definition. Others who were familiar with the term felt that the definition was useful to include for younger physicians or those who don't deal with the business side of the practice.

Respondents who indicated that any amount of their patient care revenue was capitated or prepaid continued to Question 7. Others skipped to Question 8.

Question 7 asks how much of the practice's capitated revenue is global or primary care.

7. Global capitation typically covers hospital, specialist, and primary care services, whereas primary care capitation only covers primary care services. What percentage of the practice's capitated revenues is **(read A-B)** capitation?

   A. Global

   B. Primary Care

The definitions of global and primary care capitation were clear and physicians were familiar with them, but there was some confusion about whether the percentages should total 100%, whether they were referring to the practice's overall revenue or capitated revenue. Once it was determined that the question was asking for a percentage of the capitated portion of the revenue alone, they did not have much trouble answering. One did mention that administrators could answer the question more easily.

The issue of whether prescription drugs are included in global capitation elicited mixed responses. According to one respondent, they are included for employees. Another indicated that they are only included in primary care capitation. Other respondents did not know the answer to this question.

One respondent suggested having a screener question before Question 7 that asks whether the respondent is in any plans that have global or individual capitation. If so, then the subsequent questions could be modified to directly apply to the respondent.

Recommendation: For Question 7, Gallup suggests adding either an Interviewer Note explaining that the percentages should sum to 100% or a preface to the question clarifying that point for the respondent. For instance: "The next question will ask you to divide the practice's capitated revenues into global or primary care capitation."

4.1.2.2 Questions 8, 8a, and 9

Solo practitioners skipped the next few questions to Question 13. Others continued with Question 8.

Question 8, 8a, and 9 asked physicians about how they get paid. Questions 8 and 8a have been used on previous rounds of the Physician Survey and are used here as screeners for Question 9.

8. Are you a salaried physician?

8a. Are you 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)**

9. Are you eligible to receive end-of-year adjustments, returns on withholds, or any type of supplemental payments, either from this practice or from health plans? **(If necessary, read:)** Withhold is a percentage of the capitation or fee-for-service payment that is retained by the health plan. Withhold funds may be distributed to physicians as bonuses at the end of the contract year if they have not been expended on health care services.

Only a very few physicians were not completely familiar with the term "return on withhold" and required the interviewer to read the definition. Most respondents believed that the question was clear and that it would be applicable to the majority of physicians in multi-owner practices.

Recommendation: Gallup believes that Question 9 could yield interesting data and suggests considering its inclusion in the Round 4 Physician Survey pretest.

4.1.2.3 Question 10

Question 10 asks physicians whether certain factors are accounted for in their compensation. Questions 10A-D have been used on previous rounds of the Physician Survey and are being used here for context to test Question 10E.

10. 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 when determining your pay. When your pay is determined, does the practice consider **(read and rotate A-E)**?

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
B. Results of satisfaction surveys completed by your own patients
C. Specific measures of quality of care, such as rates of preventive care services for your patients
D. Results of practice profiling 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.)**
E. The overall financial performance of your practice, but not your own productivity

Most respondents did not have difficulty differentiating between their own productivity and the practice's performance. A few indicated having "slight" difficulty because it is not an issue that they keep up with.

One respondent suggested that Question 10E ("The overall financial performance of your practice but not your own productivity") sounds like an either/or question. For many, if not most physicians, however, pay is based on a combination of the two. "If we do a good job and treat our patients in an appropriate way, we'll get referrals and have more patients satisfied and not have them shop elsewhere." Breaking 10A and 10E into mutually exclusive choices is too limiting for physicians in this situation. It was suggested that another option be included that would combine individual productivity and the practice's financial performance.

Recommendation: Gallup suggests considering adding another category that would combine individual productivity and the practice's financial performance.

4.1.2.4 Question 11a and 11b

Physicians who indicated that any of the factors in Question 10 were accounted for in their compensation continued with the next set of questions. Others skipped to Question 15.

Question 11 asks respondents to rate the importance of certain factors in determining their compensation. This question was posed using two different scales: a 10-point numerical scale with endpoint anchors and a 4-point verbal "importance" scale.

11a. Next, I would like you to rate the importance of [**(If code 1 to two or more in #10 A-E, read:)** these factors/**(If code 1 to ONLY ONE in #10 A-E, read:)** this factor] in determining your compensation. Using any number from one-to-ten, where 1 is not important and 10 is very important, how important is **(read A-E, as appropriate)** in determining your compensation?

11b. For each of the factors you mentioned, tell me whether it is a very important, moderately important, not very important, or not at all important in determining your compensation? How about **(read and rotate A-E, as appropriate)**?

A. **(If code 1 in #10-A, ask:)** Your own productivity
B. **(If code 1 in #10-B, ask:)** Satisfaction surveys
C. **(If code 1 in #10-C, ask:)** Quality of care measures
D. **(If code 1 in #10-D, ask:)** Results of practice profiling
E. **(If code 1 in #10-E, ask:)** Overall practice performance

Most respondents felt that it was not difficult to rate the relative importance of the listed factors. As with previous questions, many physicians preferred the numeric scale. They found it to be less confusing, particularly with an issue that can be as complicated as compensation. One respondent indicated that he regularly uses a 1-to-10 scale with his patients. A few, however, did feel that the verbal scale provided sufficient variation and thought it was easier to deal with, and more comfortable.

Recommendation: Gallup suggests including Question 11A on the Round 4 pretest.

4.1.2.5 Question 12

Physicians who said that their own productivity was used to determine their compensation were asked to rate the importance of various factors used to measure their productivity in Question 12.

12. **(If code 1 in #10-A, ask:)** Now, I am going to ask you to rate the importance of various factors used in determining your productivity. For each one, tell me whether it is very important, moderately important, not very important, or not at all important? How about **(read and rotate A-E)**?

    A. Number of patients seen
    B. Panel size
    C. Gross billings
    D. Revenues
    E. RBRVS [Resource Based Relative Value Scale]

Respondents did seem to be aware of which factors were used to determine their productivity.

Physicians who are part owners, and therefore possibly more aware of the financial status of the practice, indicated that they monitor their own productivity on a monthly basis. A few respondents indicated that their practices distribute reports that provide information such as the number of visits, procedures, injections, ancillary charges, and total number of patients seen compared to other physicians in the practice.

Most respondents did not feel that there would be any substantive difference between scaling and ranking the factors in Question 12, but that scaling is probably easier.

A very few physicians were not fully familiar with the terms "RBRVS" or "panel size" and believed that having definitions available, though not read unless necessary, would be helpful.

RBRVS was the only types of relative value scale that respondents were aware of using.

Recommendation: Gallup suggests including definitions of RBRVS and panel size as Interviewer Reads on Question 12 on the Round 4 pretest.

4.1.2.6 Question 13, 14a, and 14b

Solo practitioners who are full owners of their practices were asked Question 13 regarding whether health plans consider certain factors in determining their payments. Others skipped to Question 15.

13. Do any health plans consider the following factors in determining the payments you receive? **(Read and rotate A-C**

    A. Results of satisfaction surveys completed by your own patients

B. Specific measures of quality of care, such as rates of preventive care services for your patients
C. Results of practice profiling comparing your pattern of using medical resources to treat patients with that of other physicians

Physicians who indicated that any of the factors listed in Question 13 were considered by health plans in determining their payments continued with Question 14. Others skipped to Question 15.

Question 14 asks respondents to rate the importance of the factors in Question 13 in determining their payments from health plans. This question was posed using two different scales: a 10-point numerical scale with endpoint anchors and a fully labeled, 4-point verbal "importance" scale.

14a. Next, I would like you to rate the importance of [**(If code 1 to two or more in #13 A-C, read:)** these factors/**(If code 1 to ONLY ONE in #13 A-C, read:)** this factor] in determining the payments you receive. Using any number from one-to-ten, where 1 is not important and 10 is very important, how important are **(read A-C, as appropriate)** in determining the payments you receive?

14b. **(If code 1 to TWO OR MORE in #13 A-C, read:)** For each of the factors you mentioned, tell me whether it is a very important, moderately important, not very important, or not at all important in determining the payments you receive? How about **(read and rotate A-C, as appropriate)**?

A. **(If code 1 in #13-A, ask:)** Satisfaction surveys
B. **(If code 1 in #13-B, ask:)** Quality of care measures
C. **(If code 1 in #13-C, ask:)** Results of practice profiling

Very few respondents answered affirmatively to Question 13 and continued to Question 14. One physician who did said that s/he did not have any real difficulty with or preference on the scales.

Recommendation: Gallup cannot reasonably suggest an approach to these questions because so few respondents qualified for them. The choice of scales does not seem to be a hurdle for respondents.

4.1.2.7 Questions 15, 15a, and 16

Questions 15 and 15a ask respondents for their net income during 2002. These questions have been used on previous rounds of the Physician Survey and are being used here as screeners and to provide context for Question 16.

15. During 2002, 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 you work for more than one practice, 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. **(INTERVIEWER NOTE: If "Refused", say:)** This information is important to a complete understanding of community health care patterns and will be used only in aggregate form to ensure your confidentiality of the information. (Open ended **and code actual number)** **(If response is greater than $1 million, verify)**

15a. **(If code "DK" in #15, read:)** Would you say that it was **(read 01-04)**?
(If code "RF" in #15, read:) Would you be willing to indicate if it was **(read 01-04)**?

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)
99 (Refused)

A few physicians were leery of providing their actual net income and felt that responses would be more honest if ranges were used, as in Question 15a. Most did not have trouble providing an income amount, but thought that ranges would be easier.

Salaried physicians who are eligible for bonuses or incentive plans, or any type of supplemental payments were asked Question 16 regarding what proportion of their net income was from their salary. Others skipped to Question 17.

16. During 2002, about what percent of your net income from medical practice was from the salaried portion of your compensation?

Respondents were comfortable estimating responses to Question 16 and indicated that inserting the income amount provided in Question 15 into Question 16 would not make a notable difference since the questions are asked sequentially.

Recommendation: While respondents did not indicate that auto-filling the net income figure from Question 15 into Question 16 was necessary, in the longer, full-length survey, it may do more to lessen respondent burden. The additional skip patterns (for physicians who do not provide a response in Question 15) and CATI programming that this would require is not overly complicated. Therefore, Gallup recommends using the auto-fill option for the pretest.

4.1.2.8 Question 17

Primary care physicians were asked Question 17 about gatekeepers. For all others, the interview was complete at this point. Question 17 is new to the Physician Survey, but has been used on the Young Physicians Survey (YPS). The definition of a gatekeeper was added for this test.

17. Some insurance plans require patients to go through specific physicians, sometimes called gatekeepers, to obtain services. For roughly what percent of your patients do you serve in this role?

Inclusion of the definition of gatekeepers in the question wording was helpful to respondents. According to one respondent, unless physicians are not in any HMOs, they would be familiar with the term, but reminding them of the strict definition is useful.

Recommendation: Gallup suggests keeping the definition of gatekeeper in Question 17.

4.2 Group B

The Group B interview included sections on charity care, physician productivity, consumer information, cost sharing, case mix, coordination and patient safety, threat to quality, and electronic prescriptions.

4.2.1 Charity Care

4.2.1.1 Questions 1 and 1a

1. 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. Your best estimate would be fine.

If respondents indicated that they had provided at least one hour of charity care during the last month, they continued to Question 1a. Otherwise, they skipped to the Physician Productivity section.

1a. **(If code 01-97 in #1, ask:)** Where do you typically provide charity care? In your main practice, on-call at a hospital emergency department, in another practice or clinic, or somewhere else?

Respondents did not have trouble answering Questions 1 and 1a and did not provide any recommendations for improving the list of categories.

4.2.2 Physician Productivity

4.2.2.1 Questions 2 and 3

Primary care physicians continued on with Question 2. Specialists skipped to Question 4.

2. Thinking of your last complete week of practice, about how many hours did you spend in direct patient care activities? **(INTERVIEWER NOTE: Direct patient care includes seeing patients, performing surgery, patient record keeping, and related office work, travel time connected to seeing patients)**

The only comment on this question was that many physicians would not consider time spent record keeping, nor possibly travel time connected to seeing patients as direct patient care. Including the Interviewer Note in the question wording would clarify this issue.

3. During that week, how many patient visits did you personally have in each of the following settings? Please count as one visit each time you saw a patient. How about **(read and rotate A-D)**?

   A. In the office
   B. In outpatient clinics
   C. In nursing homes and other extended care facilities
   D. On hospital rounds

The only difficulty encountered with Question 3 was for physicians whose offices are located in an outpatient clinic. One physician in this situation suggested altering category B to read "outpatient clinics other than your main practice." In general however, the respondents did not think that a definition of "outpatient clinics" was necessary.

Otherwise, respondents considered this question to be very easy and were extremely confident in their responses.

Most physicians calculated the number of patient visits by estimating the typical number of patients seen per day and multiplying it by the number of days providing the service that week.

Recommendation: Based on the ease with which the physicians responded to this question, Gallup feels that anchoring the number of patient encounters in the number of hours spent in each setting (as in the AMA PCPS version) is not necessary and may, in fact, add undue complication to the question. Therefore, Gallup suggests using the wording from the cognitive interviews in the Round 4 pretest with the addition of an interviewer note clarifying how to allocate visits if the respondent's office is also an outpatient clinic.

4.2.3 Consumer Information

4.2.3.1 Question 4

4. During the last month, for what percentage of your patients did you order tests, procedures, or prescriptions suggested by patients that you would not otherwise have ordered?

Physicians recommended including examples to clarify the categories.

Recommendation: Gallup suggests adding parenthetical examples of which treatments should be classified as "tests" and which as "procedures" for the interviewers to reference as necessary.

4.2.3.2 Question 4a

Respondents who indicated that they did not order any tests, procedures, or prescriptions suggested by patients that they would not otherwise have ordered skipped to the section on Cost Sharing. Others continued with Question 4a.

4a. During the last month, which service suggested by patients did you order most often: diagnostic tests and procedures, therapeutic procedures, including surgery, prescriptions, or something else?

Physician respondents did not have difficulty with this question and were very interested in the issue of the impact of direct consumer advertising on patients.

Physicians recommended including referrals to specialists in this question, or breaking the question into five different yes/no questions rather than one asking for the most common request.

Recommendation: Gallup suggests adding referrals to specialists as a distinct category in this question. Depending on the level of interest in the issue of consumer information, breaking the question into distinct yes/no questions would yield interesting data.

4.2.4 Cost Sharing

4.2.4.1 Question 5

5. Patients with health insurance often have out-of-pocket costs for co-payments and deductibles. The next questions concern the relationship between these costs and clinical decisions. **(Read and rotate A-C)**

   A. If a generic option is available, how often do you prescribe a generic over a brand name drug, never, rarely, sometimes, usually, or always?
   B. If there is uncertainty about a patient's diagnosis, how often do you consider an insured patient's out-of-pocket costs in deciding whether to recommend additional testing, never, rarely, sometimes, usually, or always?
   C. If there is a choice between outpatient and inpatient care, how often do you consider an insured patient's out-of-pocket costs in making this decision, never, rarely, sometimes, usually, or always?

Respondents' awareness of patients' out-of-pocket costs for co-payments and deductibles varied considerably. However, most indicated that they do not take those costs into

consideration unless the patient directly expresses concern. Regardless, however, the physician would follow their clinical judgment and what they consider to be the appropriate course of action for the patient's well being.

Some respondents believed that the suggestion that they may be placing costs above clinical concerns could be considered insulting because it calls their clinical judgment into question. Most were not offended by the questions, however.

Respondents did not have any difficulty with the terminology used in this set of questions.

Recommendation: Gallup suggests that the social desirability bias may taint the value of the responses to these questions. While some physicians did admit taking patient costs into consideration, none indicated that they would base their clinical decisions on anything other than what they believed to be the correct medical steps.

4.2.5 Case Mix

4.2.5.1 Question 6

6. On a different subject, about what percentage of your patients do you have a hard time speaking with or understanding because you speak different languages?

Respondents were very comfortable answering this question. They recommended retaining both "speaking" and "understanding" in the question wording or substituting "communicating with."

Recommendation: Gallup suggests that the slight simplification of substituting "communicating with" would not alter the meaning of the question. We recommend considering this modification for the Round 4 pretest.

4.2.6 Care Coordination and Patient Safety

4.2.6.1 Question 7

7. Does the hospital where most of your patients are treated have computerized systems to order tests and medications?

The question was clear to respondents, but was not strictly applicable to several who do not admit patients to the hospital with any frequency or regularity. Others were not absolutely certain about the correct answer. It was suggested that only physicians who do daily rounds would know.

Recommendation: Gallup suggests that this question be included in the Round 4 pretest with a "not applicable" response option.

4.2.6.2 Question 8

8. Medical errors include dispensing of incorrect medication doses, surgical mistakes, or human error in interpreting results of diagnostic tests. Some errors harm patients, some are caught before they can cause any harm, and others may occur but don't cause any harm. Does the hospital where most of your patients are treated have a system for anonymously reporting medical errors?

Again, as with Question 7, a few respondents could not provide a confident response because they do not admit patients to a hospital often. Others indicated that such systems might be in place, but that until you had a reason to be involved in it, you may not be explicitly aware of it.

One recommendation was to include "laboratory errors" to the list of medical mistakes. Physicians indicated that lab errors are one of the most common medical mistakes.

Respondents understood a system for anonymously reporting medical errors in a few different ways: one that lawyers will not be involved in, one that is kept in confidence between an oversight committee and the physician in question, and one in which the identities of the physician in question and the person who reports the error remain confidential.

Recommendation: Gallup suggests removing the second sentence from the question wording for the Round 4 pretest.

4.2.6.3 Question 9

9. Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. What percentage of your patients who were hospitalized last year had a hospitalist involved in their inpatient care?

Respondents were familiar with the term "hospitalist" and did not have difficulty answering the question. One recommendation was to reiterate that hospitalists do not have practices outside the hospital.

Recommendation: Gallup suggests that Question 9 should be included in the Round 4 pretest in its current form.

4.2.7 Quality of Care

4.2.7.1 Question 10

10. Now, I am going to list several problems that may threaten physicians' ability to provide quality care. For each problem, tell me whether it is a major threat, a minor threat, or not a threat to your ability to provide quality care. How about **(read and rotate A-H)**?

    A. Inadequate time with patients during office visits
    B. Patients' inability to pay for needed care
    C. Rejections of care decisions by insurance companies
    D. Lack of qualified specialists in your area
    E. Not getting timely reports from other physicians and facilities
    F. Difficulties communicating with patients due to language or cultural barriers
    G. Difficulties maintaining continuing relationships with patients
    H. Medical errors in hospitals

Respondents did not have trouble responding to this set of questions. A few indicated that it would be helpful to clarify whether the questions are referring to occurrences at the office or in the hospital or both (where not already provided).

Malpractice and litigation threats were mentioned as additional complications to physicians' ability to provide quality care.

A few respondents suggested using a scale for this question or offering a mid-point between major and minor threat.

Recommendation: Gallup suggests including this set of questions in the Round 4 pretest to further explore whether respondents are focusing on the prevalence or intensity of the problems.

4.2.8 Electronic Prescriptions

4.2.8.1 Question 11

11. Finally, I have a few questions about electronic prescriptions. In your practice, are computers or other forms of information technology used to write prescriptions?

Most respondents do not use electronic prescriptions, although they are familiar with the practice and enthusiastic about adopting it. Those who do use them were extremely positive about their value.

Respondents indicating that they use e-prescriptions continued with the next set of questions. Others skipped to Question 11f.

11a. **(If code 1 in #11, ask:)** For what percentage of your patients do you write electronic prescriptions?

11b. Does the system you use for electronic prescriptions provide information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

11c. Could you describe the system you use to write electronic prescriptions and obtain information on drug interactions?

11d. Is the drug interaction information you obtain from this system tailored specifically to your individual patients?

11e. Could you describe the system you use to write electronic prescriptions?

11f. In your practice are computers or other forms of information technology used to obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

11g. Could you describe the system you use to obtain information on drug interactions?

Many physicians use technology such as specialized palm pilots to obtain information on potential drug interactions. They were very positive about the value of these devices and indicated encouraging associates to learn how to operate them.

Recommendation: Gallup suggests pursuing this line of questioning. Overall, respondents found this technology to be very valuable.

Appendix A.
Group A Survey Instrument

CRT

FINANCE,RWJ58819
F819

FIELD FINAL – NOVEMBER 21, 2003
(Columns are ABSOLUTE)

THE GALLUP ORGANIZATION

PROJECT REGISTRATION #140157
ROBERT WOOD JOHNSON _____ APPROVED BY CLIENT
City Center: Washington D.C.
2003 Physician Testing - Group A _____ APPROVED BY PROJECT MANAGER
McComb/Richter
Brenda Sonksen, Specwriter
November, 2003 n=20

I.D.#: _____(1-6)

**AREA CODE AND TELEPHONE NUMBER:

_____ _____
_____ (649 - 658)

**INTERVIEW TIME:

_____ _____
_____ (716 - 721)

(NOTE: All interviews are recorded. The recording begins when the respondent answers the phone. This statement is read after the "Continue" response is entered after the Introduction and before the first question) This call will be recorded for quality assurance.

1 (Continue)
2 (Refused) - **(Thank and Terminate)** _____(984)

Sa. SCHIP STATE: **(Code from fone file)**

1 Yes
2 No _____(99)

Sb. SPECIALTY: **(Code from fone file)** **(SURVENT NOTE: Show on Introduction Screen)**

_____ _____
_____ (108 - 122)

Sc. STATE: **(Code from fone file)**

01	Alabama - SC	30	Montana - W
02	Alaska - W	31	Nebraska - NC
04	Arizona - W	32	Nevada - W
05	Arkansas - SC	33	New Hampshire - NE
06	California - W	34	New Jersey - NE
08	Colorado - W	35	New Mexico - W
09	Connecticut - NE	36	New York - NE
10	Delaware - SC	37	North Carolina - SC
11	Washington D.C. - SC	38	North Dakota - NC
12	Florida - SC	39	Ohio - NC
13	Georgia - SC	40	Oklahoma - SC
15	Hawaii - W	41	Oregon - W
16	Idaho - W	42	Pennsylvania - NE
17	Illinois - NC	44	Rhode Island - NE
18	Indiana - NC	45	South Carolina - SC
19	Iowa - NC	46	South Dakota - NC
20	Kansas - NC	47	Tennessee - SC
21	Kentucky - SC	48	Texas - SC
22	Louisiana - SC	49	Utah - W
23	Maine - NE	50	Vermont - NE
24	Maryland - SC	51	Virginia - SC
25	Massachusetts - NE	53	Washington - W
26	Michigan - NC	54	West Virginia - SC
27	Minnesota - NC	55	Wisconsin - NC
28	Mississippi - SC	56	Wyoming - W
29	Missouri - NC		

_____ _____
_____ (93) (94)

Sd. COUNTY: **(Code from fone file)**

_____ _____
_____ (-)

Se. DOCTOR TYPE: **(Code from fone file)**

1 MD
2 DO _____(107)

Sf. DOCTOR NAME: **(Code from fone file)**

_____ _____
_____ (63 - 90)

Sg. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ (108 - 112)

Sh. ZIP CODE: **(Code from fone file)**

_____ _____
_____ (100 - 105)

Si. SCHIP PROGRAM: **(Code from fone file)**

01 **(If code 1 in Sa AND code 01 in Sc:)** AL SCHIP
02 **(If code 1 in Sa AND code 04 in Sc:)** KidsCare
03 **(If code 1 in Sa AND code 08 in Sc:)** CHP+
04 **(If code 1 in Sa AND code 09 in Sc:)** HUSKY Program
05 **(If code 1 in Sa AND code 10 in Sc:)** Delaware Healthy Children's Program
06 **(If code 1 in Sa AND code 13 in Sc:)** Peach Care for Kids
07 **(If code 1 in Sa AND code 20 in Sc:)** HealthWave
08 **(If code 1 in Sa AND code 28 in Sc:)** MC SCHIP
09 **(If code 1 in Sa AND code 30 in Sc:)** MC+ for Kids
10 **(If code 1 in Sa AND code 32 in Sc:)** Nevada Check-Up
11 **(If code 1 in Sa AND code 37 in Sc:)** NC SCHIP
12 **(If code 1 in Sa AND code 41 in Sc:)** OR SCHIP
13 **(If code 1 in Sa AND code 42 in Sc:)** PA SCHIP
14 **(If code 1 in Sa AND code 48 in Sc:)** Texas Healthy Steps
15 **(If code 1 in Sa AND code 49 in Sc:)** UT SCHIP
16 **(If code 1 in Sa AND code 50 in Sc:)** VT SCHIP
17 **(If code 1 in Sa AND code 53 in Sc:)** WA SCHIP
18 **(If code 1 in Sa AND code 54 in Sc:)** WV SCHIP
19 **(If code 1 in Sa AND code 56 in Sc:)** WY SCHIP

_____ _____
_____ (97) (98)

INTRODUCTION #1:

Hello, this is _____ with The Gallup Organization. I'd like to invite you to help us test some new survey questions for the fourth round of the Robert Wood Johnson Foundation's Physician Survey. 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 purpose of this interview is to get your feedback on the items being considered for the survey and to find out if any parts of the questions are confusing, ambiguous, or inappropriate. We will not be asking you the entire survey, but simply testing new items. Generally, I will ask you a survey question, and then will ask you some follow-ups about how you interpreted the question. The interview will take about 40 minutes and we are providing an honorarium of $100 as a small token of our appreciation. 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 is convenient for you.

1 Respondent available - **(Continue)**

7 Respondent not available – **(Set time to call back; Restart with Introduction #2)**

8 (Soft Refusal)

9 (Hard Refusal) - **(Thank and Terminate)** _____(1001)

(READ:) I apologize in advance if it seems as if I'm skipping around from topic to topic. As I mentioned, we will not be asking you the entire survey, but simply testing new items. So please bear with me on the subject matter! Please feel free to jump in at any point with your own observations about the questions and how they could be improved. Some of the questions I ask will not have any follow-ups to them. I will be taping these conversations but only so I can write a report of the overall results. Your individual responses will never be associated with you. Do you have any questions before we begin?

(All in Read, Skip to A1)

INTRODUCTION #2: (Scheduled Interview)

Hello, this is _____ with The Gallup Organization. Thank you for agreeing to help us test out some new survey questions for the fourth round of the Robert Wood Johnson Foundation's Physician Survey. The purpose of this interview is to get your feedback on the items being considered for the survey and to find out if any parts of the questions are confusing, ambiguous, or inappropriate. I apologize in advance if it seems as if I'm skipping around from topic to topic. We will not be asking you the entire survey, but simply testing new items. So please bear with me on the subject matter! Generally, I will ask you a survey question, and then will ask you some follow-ups about how you interpreted the question. Please feel free to jump in at any point with your own observations about the questions and how they could be improved. Some of the questions I ask will not have any follow-ups to them. I will be taping these conversations but only so I can write a report of the overall results. Your individual responses will never be associated with you. Do you have any questions before we begin?

1 Respondent available - **(Continue)**

7 Respondent not available – **(Set time to call back)**

8 (Soft Refusal)

9 (Hard Refusal) - **(Thank and Terminate)** _____(1002)

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? **(If respondent works part-time for a Federal Agency, ask:)** Do you consider this (Federal Agency) your main practice?

1 Yes - **(Continue)**

2 No - **(Skip to A2)**

3 (Retired) - **(Thank and Terminate, and Set to Failed Screener)**

4 Out of country - **(Thank and Terminate, and Set to Failed Screener)**

5 Institutionalized - **(Thank and Terminate, and Set to Failed Screener)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1003)

(If code 1 in A1,
(READ:) 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)**

A2. **(If code 2 in A1, ask:)** 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)** _____(1004)

(If code 1 in A2,
(READ:) 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)**

A3. **(If code 2 in A2, ask:)** During a TYPICAL week, do you provide direct patient care for at least twenty hours a week? **(If necessary, read:)** Direct patient care includes seeing patients and performing surgery. **(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.

1 Yes - **(Skip to S1a)**

2 No - **(Continue)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1005)

(If code 2 in A3,
(READ:) 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)**

S1a. Are you a full owner, a part owner, or not an owner of your primary practice? **(INTERVIEWER NOTE: A shareholder of the practice in which they work should be coded as 2-Part owner)**

1 Full owner
2 Part owner
3 Not an owner
8 (DK)
9 (Refused) _____(1006)

S1. Which of the following best describes this practice? Is it **(read 06-16, then 01)**? **(INTERVIEWER NOTE: A free-standing clinic includes non-hospital-based ambulatory care, surgical, and emergency care centers)**

01 OR, something else **(Thank and Terminate)**
02 (DK) **(Thank and Terminate)**
03 (Refused) **(Thank and Terminate)**
04 HOLD
05 HOLD

06 A practice owned by one physician (solo practice)
07 A two physician-owned practice
08 A group practice of three or more physicians
09 A group model HMO
10 A staff model HMO

11-
15 HOLD

16 A freestanding clinic

_____ _____
(1007) (1008)

S1b. QUOTAS: **(Autocode from responses in S1)**

1 **(If code 06 in S1:)** Solo practice (n=5)
2 **(If code 07-10 or 16 in S1:)** Group/Staff/Clinic (n=15) _____(1009)

S2. Are you a primary care physician? **(Probe:)** By primary care physician, we mean are you in general family practice, general pediatrics, or general internal medicine.

1 Yes
2 No
8 (DK)
9 (Refused) _____(1010)

(READ:) These first few questions are about access to medical services.

(SURVENT NOTE: Ask #1 and #1a, as appropriate, for each item before going to the next item)

(F8)

1. During the last 12 months, were you unable to obtain any of the following services for your patients when you thought they were medically necessary? How about **(read and rotate A-E)**?

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

   A. Referrals to high quality specialists _____(1301)

   B. High quality ancillary services, such as physical therapy, home health care, nutritional counseling, and so forth _____(1302)

   C. Non-emergency hospital admissions _____(1303)

   D. High quality diagnostic imaging services _____(1304)

   E. High quality outpatient mental health services _____(1305)

1a. **(For each code 1 in #1 A-E, ask:)** During the last 12 months, for what percentage of your patients who needed **(read and rotate A-E, as appropriate)**, were you unable to obtain the service? (Open ended **and code actual percentage)**

000 None
101 1% or less
102 (DK)
103 (Refused)

A. Referrals to high quality specialists

_____ _____
_____ (1306 - 1308)

B. High quality ancillary services, such as physical therapy, home health care, nutritional counseling, and so forth

_____ _____
_____ (1309 - 1311)

C. Non-emergency hospital admissions

_____ _____
_____ (1312 - 1314)

D. High quality diagnostic imaging services

_____ _____
_____ (1315 - 1317)

E. High quality outpatient mental health services

_____ _____
_____ (1318 - 1320)

(READ:) Okay, now I'm going to ask you a few follow-up questions.

C1a. How confident are you in the responses you just provided? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No
05 HOLD

_____ _____
_____ (1321) (1322)

C1b. The question asked you to think about your inability to obtain services for your patients over the last 12 months. Would you have been able to provide more accurate information if we had asked about the last month instead of the last 12 months?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1323)

C1c. Do you have any recommendations for how to improve these questions about access to medical services? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/No recommendations
05 HOLD

_____ _____
_____ (1324) (1325)

(If code 001-100 in #1a A, C, or E, Continue; Otherwise, Skip to #3)

(F8A)

2. I'm going to ask the next question to you in two different ways and then get your feedback on which is a better way to ask the question. **(Read and rotate a-b)**

a. **[VERSION 1]**
I am now going to read some reasons why you might be unable to obtain various services. Using any number from one-to-ten, where 1 is not important and 10 is very important, rate each of the following reasons for your being unable to obtain **(read a-c)**. How about **(read A-C)**?

10	Very important	04	
09		03	
08		02	
07		01	Not important
06		98	(DK)
05		99	(Refused)

a. **(If code 001-100 in #1a-A, ask:)** Referrals to high quality specialists

A. There aren't enough qualified service providers or facilities in my area

_____ _____ _____
(1326) (1327)

B. Health plan networks and administrative barriers limit patient access

_____ _____ _____
(1328) (1329)

C. Patients lack health insurance or have inadequate insurance coverage

_____ _____ _____
(1330) (1331)

2. (Continued:)

b. **(If code 001-100 in #1a-C, ask:)** Non-emergency hospital admissions

A. There aren't enough qualified service providers or facilities in my area

_____ (1332) (1333)

B. Health plan networks and administrative barriers limit patient access

_____ (1334) (1335)

C. Patients lack health insurance or have inadequate insurance coverage

_____ (1336) (1337)

c. **(If code 001-100 in #1a-E, ask:)** High quality outpatient mental health services, when you think it is medically necessary

A. There aren't enough qualified service providers or facilities in my area

_____ (1338) (1339)

B. Health plan networks and administrative barriers limit patient access

_____ (1340) (1341)

C. Patients lack health insurance or have inadequate insurance coverage

_____ (1342) (1343)

2. (Continued:)

b. **[VERSION 2]**
Now I am going to read some reasons why you might be unable to obtain various services. For each one, tell me whether it a very important, moderately important, not very important, or not at all important reason for your being unable to obtain **(read a-c)**. How about **(read A-C)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

a. **(If code 001-100 in #1a-A, ask:)** Referrals to high quality specialists

A. There aren't enough qualified service providers or facilities in my area _____(1344)

B. Health plan networks and administrative barriers limit patient access _____(1345)

C. Patients lack health insurance or have inadequate insurance coverage _____(1346)

b. **(If code 001-100 in #1a-C, ask:)** Non-emergency hospital admissions

A. There aren't enough qualified service providers or facilities in my area _____(1347)

B. Health plan networks and administrative barriers limit patient access _____(1348)

C. Patients lack health insurance or have inadequate insurance coverage _____(1349)

2. (Continued:)

c. **(If code 001-100 in #1a-E, ask:)** High quality outpatient mental health services, when you think it is medically necessary

A. There aren't enough qualified service providers or facilities in my area _____(1350)

B. Health plan networks and administrative barriers limit patient access _____(1351)

C. Patients lack health insurance or have inadequate insurance coverage _____(1352)

(READ:) Okay, now I will ask you a few follow-up questions.

C2a. What did you think about the two different scales? One was a 10-point scale, and the other was a scale with adjectives. [**(If necessary, read:)** very important, moderately important, not very important, and not at all important.] Do you have a preference for one over the other? Explain why. (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No preference
05 HOLD

_____ _____
_____ (1353) (1354)

C2b. Is a scale even appropriate for this question, or would it be better to just choose which of the three options best described why you were unable to obtain the service?

1 Scale is appropriate
2 Better to choose option

8 (DK)
9 (Refused) _____(1355)

(F9D)

3. 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 **(read A-E, as appropriate)**?

4 All
3 Most
2 Some
1 No new patients/None

8 (DK)
9 (Refused)

A. New patients who are insured through Medicare, including Medicare managed care patients _____(1356)

B. **(If code 06 in Sc, ask:)** New patients who are insured through MediCAL, including MediCAL managed care patients _____(1357)

C. **(If code 04 in Sc, ask:)** New patients who are insured through AHCCCS (Say: Access) _____(1358)

D. **(If code 01-03, 05, or 07-56 in Sc, ask:)** New patients who are insured through Medicaid, including Medicaid managed care patients _____(1359)

E. **(If code 1 in Sa, ask:)** New patients who are insured by a **(response in Si)** _____(1360)

(If code 1 in Sa, Continue;
Otherwise, Skip to Note before #4)

C3a. Now, a few follow-up questions. Are you aware of **(response in Si)** and how it differs from Medicaid?

1 Yes - **(Continue)**

2 No **(Skip to Note before #4)**
8 (DK) **(Skip to Note before #4)**
9 (Refused) **(Skip to Note before #4)** _____(1361)

C3b. **(If code 1 in C3a, ask:)** Does your practice's policy of accepting new patients differ between **(response in Si)** and Medicaid?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1362)

(If code 1 or 2 in #3-A, Continue; Otherwise, Skip to Note before #5)

(F9A2)
4. I am going to read some reasons why physician practices may be limiting or not accepting new Medicare patients. For each one, tell me whether it a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in #3-A, read:)** not accepting/**(If code 2 in #3-A, read:)** limiting] new Medicare patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

5 (Does not apply to my practice) - **(Skip to Note before #5)**
8 (DK)
9 (Refused)

A. Billing requirements _____(1363)

B. Concern about a Medicare audit _____(1364)

C. Inadequate reimbursement _____(1365)

D. Full panel _____(1366)

E. Medicare patients have high clinical burden _____(1367)

C4a. Are there any other reasons why your practice is not accepting new Medicare patients or accepting only some new Medicare patients? **(If Yes, ask:)** What other reasons? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/No other reasons
05 HOLD

_____ _____
(1368) (1369)

C4b. Did you have any difficulty with the scale on the Medicare questions? [**(If necessary, read:)** The scale was very important, moderately important, not very important, and not at all important.] Do you have any recommendations for improvement? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No difficulty/No recommendations
05 HOLD

_____ _____
(1370) (1371)

C4c. I asked about billing requirements as a reason for not accepting new Medicare patients. Does the term "billing requirements" get at administrative burden or is it something else in your mind? What are you thinking of? (Open ended and code)

01 Something else (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

06 Administrative burden

_____ _____
(1372) (1373)

C4d. I mentioned concerns over a Medicare audit as a reason for not accepting new Medicare patients. Does this survey need to explain what a Medicare audit is? If so, how would you define it? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No, no need to explain
05 HOLD

_____ _____
_____ (1374) (1375)

C4e. I asked about full panel as a reason for not accepting new Medicare patients. Does this survey need to explain what a full panel is? If so, how would you describe it? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No, no explanation needed
05 HOLD

_____ _____
_____ (1376) (1377)

(If code 1 or 2 in #3-B OR #3-D, Continue; Otherwise, Skip to Read before #6)

(F9B2)

5. Next, I am going to read some reasons why physician practices may be limiting or not accepting new [**(If code 06 in Sc, read:)** MediCal/**(Otherwise, read:)** Medicaid] patients. Again, tell me whether each one is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in #3-D, read:)** not accepting/**(If code 2 in #3-D, read:)** limiting] new Medicaid patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

5 (Does not apply to my practice) - **(Skip to Read before #6)**

8 (DK)
9 (Refused)

A. Billing requirements _____(1378)

B. Delayed reimbursement _____(1379)

C. Inadequate reimbursement _____(1380)

D. Full panel _____(1381)

E. Medicaid patients have high clinical burden _____(1382)

C5a. Are there any other reasons why your practice is not accepting Medicaid patients or only accepting some new Medicaid patients? **(If Yes, ask:)** What other reasons? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/No other reasons
05 HOLD

_____ _____
(1383) (1384)

C5b. Did you have any difficulty with the scale on these questions? [**(If necessary, read:)** The scale was very important, moderately important, not very important, and not at all important.] Do you have any recommendations for improvement? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No difficulty/No recommendations
05 HOLD

_____ (1385) (1386)

C5c. I mentioned billing requirements as a reason for not accepting or limiting new Medicaid patients. Does the term "billing requirements" get at administrative burden or is it something else in your mind? What are you thinking of? (Open ended and code)

01 Something else (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

06 Administrative burden

_____ (1387) (1388)

C5d. I mentioned full panel as a reason for not accepting or limiting new Medicaid patients. Do we need to explain what a full panel is? If so, how would you describe it? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No, no explanation needed
05 HOLD

_____ (1389) (1390)

(READ:) Now I'd like to ask you some questions about practice revenues.

(G3)
6. 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% or less
DK (DK)
RF (Refused)

_____ _____
_____ (1391 - 1393)

(If code 001-100 in #6, Continue; Otherwise, Skip to Note before #8)

(G3a)
7. Global capitation typically covers hospital, specialist, and primary care services, whereas primary care capitation only covers primary care services. What percentage of the practice's capitated revenues is **(read A-B)** capitation?

000 None
001 1% or less
100 100%/All
DK (DK)
RF (Refused)

A. Global

_____ _____
_____ (1394 - 1396)

B. Primary Care

_____ _____
_____ (1397 - 1399)

C7a. How easy or difficult was this second question for you? Why do you say that? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1401) (1402)

C7b. How confident are you of your percentage responses? Were they actual numbers or just a guess?

1 Actual numbers
2 Just a guess

8 (DK)
9 (Refused) _____(1403)

C7c. Do you think that your answers would change significantly if you or a member of your practice checked your administrative records?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1404)

C7d. Is the definition of global and primary care capitation clear? [**(If necessary, read:)** Global capitation typically covers hospital, specialist, and primary care services, whereas primary care capitation only covers primary care services.]

1 Yes
2 No
8 (DK)
9 (Refused) _____(1405)

C7e. **(SURVENT NOTE: RECORD ONLY)** Does the sum of #7 A and B equal 100%?

1 Yes
2 No _____(1406)

C7f. Are prescription drugs included in global capitation?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1407)

C7g. Do you have any recommendations for how to improve the capitation revenue question? **(If Yes, ask:)** What recommendations? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/No recommendations
05 HOLD

_____ _____
_____ (1408) (1409)

(If code 07, 08, 09, 10, or 16 in S1, Continue; Otherwise, Skip to Note before #13)

(READ:) Now I'd like to ask you some questions about how you get paid.

(H1)
8. Are you a salaried physician?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1410)

(H4)
8a. Are you 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) _____(1411)

(If code 1 in #8a, Skip to #10; Otherwise, Continue)

(H4A)
9. Are you eligible to receive end-of-year adjustments, returns on withholds, or any type of supplemental payments, either from this practice or from health plans? **(If necessary, read:)** Withhold is a percentage of the capitation or fee-for-service payment that is retained by the health plan. Withhold funds may be distributed to physicians as bonuses at the end of the contract year if they have not been expended on health care services.

1 Yes
2 No
8 (DK)
9 (Refused) _____(1412)

C9a. Were any of these terms confusing to you? Can we improve upon them in any way? Do we need to provide definitions of them, or have definitions available? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No, not confusing
05 HOLD

_____ _____
_____ (1413) (1414)

(H5)

10. 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 when determining your pay. When your pay is determined, does the practice consider **(read and rotate A-E)**?

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 _____(1415)

B. Results of satisfaction surveys completed by your own patients _____(1416)

C. Specific measures of quality of care, such as rates of preventive care services for your patients _____(1417)

D. Results of practice profiling 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.)** _____(1418)

E. The overall financial performance of your practice, but not your own productivity _____(1419)

C10a. **(If code 1 in #10-E, ask:)** In answering this question, how difficult was it to differentiate between your own productivity and your practice's performance? Was it **(read 4-1)**?

4 Very difficult
3 Somewhat difficult
2 Not too difficult
1 Not difficult at all

8 (DK)
9 (Refused) _____(1420)

C10b. How does the practice's overall performance affect individual compensation? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1421) (1422)

(If code 1 to ANY in #10 A-E, Continue; Otherwise, Skip to #15)

(H6)
11. I'm going to ask the next question to you in two different ways and then get your feedback on which is a better way to ask the question. **(Read and rotate a-b)**

[Version 1]

a. Next, I would like you to rate the importance of [**(If code 1 to two or more in #10 A-E, read:)** these factors/**(If code 1 to ONLY ONE in #10 A-E, read:)** this factor] in determining your compensation. Using any number from one-to-ten, where 1 is not important and 10 is very important, how important is **(read A-E, as appropriate)** in determining your compensation?

10	Very important	04	
09		03	
08		02	
07		01	Not important
06		98	(DK)
05		99	(Refused)

A. **(If code 1 in #10-A, ask:)** Your own productivity

_____ _____ _____
(1423) (1424)

B. **(If code 1 in #10-B, ask:)** Satisfaction surveys

_____ _____ _____
(1425) (1426)

C. **(If code 1 in #10-C, ask:)** Quality of care measures

_____ _____ _____
(1427) (1428)

11. (Continued:)

D. **(If code 1 in #10-D, ask:)** Results of practice profiling

_____ _____
_____ (1429) (1430)

E. **(If code 1 in #10-E, ask:)** Overall practice performance

_____ _____
_____ (1431) (1432)

[Version2]

b. For each of the factors you mentioned, tell me whether it is a very important, moderately important, not very important, or not at all important in determining your compensation? How about **(read and rotate A-E, as appropriate)**?

(If code 1 to ONLY ONE in #10 A-E, read:) Is **(read A-E, as appropriate)** a very important, moderately important, not very important, or not at all important factor in determining your compensation?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

A. **(If code 1 in #10-A, ask:)** Your own productivity _____(1433)

B. **(If code 1 in #10-B, ask:)** Satisfaction surveys _____(1434)

11. (Continued:)

C. **(If code 1 in #10-C, ask:)** Quality of care measures _____(1435)

D. **(If code 1 in #10-D, ask:)** Results of practice profiling _____(1436)

E. **(If code 1 in #10-E, ask:)** Overall practice performance _____(1437)

C11a. What did you think about the two different scales? One was a ten-point scale, and the other was a scale with adjectives. [**(If necessary, read:)** The scale was very important, moderately important, not very important, and not at all important.] Did you have a preference for one over the other? Which was easier to use? Explain why. (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1438) (1439)

C11b. How easy or difficult was it for you to rate the relative importance of these factors? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1440) (1441)

C11c. Do you have any recommendations for how to improve this question? **(If Yes, ask:)** What other recommendations? (Open end)

01 Other (list)
02 (DK)
03 (Refused)
04 No/No recommendations
05 HOLD

_____ _____
_____ (1442) (1443)

(H6A)
12. **(If code 1 in #10-A, ask:)** Now, I am going to ask you to rate the importance of various factors used in determining your productivity. For each one, tell me whether it is very important, moderately important, not very important, or not at all important? How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

A. Number of patients seen _____(1444)

B. Panel size _____(1445)

C. Gross billings _____(1446)

D. Revenues _____(1447)

E. RBRVS [Resource Based Relative Value Scale] _____(1448)

C12a. How does your practice make you aware of the importance of these factors in determining your productivity? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1449) (1450)

C12b. Would it be simpler to rate the importance of each factor or to rank order the factors from most important to least important?

1 Scale
2 Rank order

8 (DK)
9 (Refused) _____(1451)

C12c. Do any of the factors need more explanation than others? Which ones? [**(If necessary, read:)** Number of patients seen, panel size, gross billings, revenues, RBRVS) **(Allow three responses)**

01 Other (list)
02 (DK)
03 (Refused)
04 No/None
05 HOLD

06 Number of patients seen
07 Panel size
08 Gross billings
09 Revenues
10 RBRVS

_____ 1st Resp: _____ _____ (1452) (1453)

_____ 2nd Resp: _____ _____ (1454) (1455)

_____ 3rd Resp: _____ _____ (1456) (1457)

C12d. Does your practice use other types of relative value scales besides RBRVS? [**(If necessary, read:)** RBRVS is Resource Based Relative Value Scale.]

1 Yes - **(Continue)**

2 No **(Skip to #15)**
8 (DK) **(Skip to #15)**
9 (Refused) **(Skip to #15)** _____(1458)

C12e. **(If code 1 in C12d, ask:)** Which types of relative value scales are used in your practice? (Open ended) **(Allow three responses)**

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ 1st Resp: _____ (1459) _____ (1460)

_____ 2nd Resp: _____ (1461) _____ (1462)

_____ 3rd Resp: _____ (1463) _____ (1464)

(All in C12e, Skip to #15)

(If code 06 in S1 AND code 1 in S1a, Continue; Otherwise, Skip to #15)

(H7)
13. Do any health plans consider the following factors in determining the payments you receive? **(Read and rotate A-C)**

1 Yes
2 No

8 (DK)
9 (Refused)

A. Results of satisfaction surveys completed by your own patients _____(1465)

B. Specific measures of quality of care, such as rates of preventive care services for your patients _____(1466)

C. Results of practice profiling comparing your pattern of using medical resources to treat patients with that of other physicians _____(1467)

(If code 1 to ANY in #13 A-C, Continue; Otherwise, Skip to #15)

(H8)

14. I'm going to ask the next question to you in two different ways and then get your feedback on which is a better way to ask the question. **(Read and rotate a-b)**

[Version 1]

a. Next, I would like you to rate the importance of [**(If code 1 to two or more in #13 A-C, read:)** these factors/**(If code 1 to ONLY ONE in #13 A-C, read:)** this factor] in determining the payments you receive. Using any number from one-to-ten, where 1 is not important and 10 is very important, how important are **(read A-C, as appropriate)** in determining the payments you receive?

10	Very important	04	
09		03	
08		02	
07		01	Not important
06		98	(DK)
05		99	(Refused)

A. **(If code 1 in #13-A, ask:)** Satisfaction surveys

_____ _____ _____
(1468) (1469)

B. **(If code 1 in #13-B, ask:)** Quality of care measures

_____ _____ _____
(1470) (1471)

C. **(If code 1 in #13-C, ask:)** Results of practice profiling

_____ _____ _____
(1472) (1473)

14. (Continued:)

[Version 2]

b. **(If code 1 to TWO OR MORE in #13 A-C, read:)** For each of the factors you mentioned, tell me whether it is a very important, moderately important, not very important, or not at all important in determining the payments you receive? How about **(read and rotate A-C, as appropriate)**?

(If code 1 to ONLY ONE in #13 A-C, read:) Is/Are **(read A-C, as appropriate)** a very important, moderately important, not very important, or not at all important factor in determining the payments you receive?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

A. **(If code 1 in #13-A, ask:)** Satisfaction surveys _____(1474)

B. **(If code 1 in #13-B, ask:)** Quality of care measures _____(1475)

C. **(If code 1 in #13-C, ask:)** Results of practice profiling _____(1476)

C14a. What did you think about the two different scales? One was a ten-point scale, and the other was a scale with adjectives. Did you have a preference for one over the other? Explain why. (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1477) (1478)

C14b. How easy or difficult was it for you to assess the relative importance of these factors? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1479) (1480)

(H10)
15. During 2002, 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 you work for more than one practice, 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. **(INTERVIEWER NOTE: If "Refused", say:)** This information is important to a complete understanding of community health care patterns and will be used only in aggregate form to ensure your confidentiality of the information. (Open ended **and code actual number)** **(If response is greater than $1 million, verify)**

0000000 None - **(Skip to Note before #16)**

0000001-
9999999 9,999,999+ - **(Skip to Note before #16)**

DK (DK) **(Continue)**
RF (Refused) **(Continue)**

_____ _____
_____ (1501 - 1507)

(H10a)
15a. **(If code "DK" in #15, read:)** Would you say that it was **(read 01-04)**?
(If code "RF" in #15, read:) Would you be willing to indicate if it was **(read 01-04)**?

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)
99 (Refused)

_____ _____
_____ (1508) (1509)

(If code 1 in #8 AND Code 1 in #8a OR #9, Continue; Otherwise, Skip to Note before #17)

(H10SAL)
16. During 2002, about what percent of your net income from medical practice was from the salaried portion of your compensation? (Open ended **and code actual percent)**

000 None
101 1% or less
102 (DK)
103 (Refused)

_____ _____
_____ (1510 - 1512)

(If code 0000000-9999999 in #15, Continue; Otherwise, Skip to Note before #17)

C16a. Would this question be any easier for you to answer if we included your response to the previous question in this item? For example, we could ask, "During 2003, about what percent of your **(response in #15)** dollars from medical practice was from the salaried portion of your compensation?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1513)

C16b. How confident are you that your response to the income question is accurate? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1514) (1515)

(If code 1 in S2, Continue;
Otherwise, Skip to Validate and Thank)

(H10b1)
17. Some insurance plans require patients to go through specific physicians, sometimes called gatekeepers, to obtain services. For roughly what percent of your patients do you serve in this role? (Open ended **and code actual percent)**

000 None
101 1% or less
102 (DK)
103 (Refused)

_____ _____
_____ (1516 - 1518)

(If code 001-100 in #17, Continue;
Otherwise, Skip to Validate and Thank)

17a. Can your own compensation be adversely affected by the number of referrals you make on behalf of your patients covered by gatekeeper arrangements?

1 Yes
2 No
8 (DK)
9 (Refused) _____(1519)

C17b. How helpful was the definition of gatekeeper? [**(If necessary, read:)** Gatekeeper was defined as when insurance plans require patients to go through specific physicians to obtain services.] (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1520) (1521)

C17c. Was there anything confusing about the question? **(If Yes, ask:)** What was confusing? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/Nothing confusing
05 HOLD

_____ _____
_____ (1522) (1523)

C17d. Is there anything you'd change about this question to make it better? **(If Yes, ask;)** What would you change? (Open ended)

01 Other (list)
02 (DK)
03 (Refused)
04 No/Would not change
05 HOLD

_____ _____
_____ (1524) (1525)

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

01 Other (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

_____ _____
_____ (1526) (1527)

19. I just need to verify your name and mailing address so we can send you your incentive check.

FIRST NAME:

_____ _____
_____ (1601 - 1640)

LAST NAME:

_____ _____
_____ (1641 - 1680)

ADDRESS #1:

_____ _____
_____ (1701 - 1740)

ADDRESS #2:

_____ _____
_____ (1741 - 1780)

CITY:

_____ _____
_____ (2001 - 2040)

STATE:

_____ _____
_____ (2041) (2042)

ZIP CODE:

_____ _____
_____ (2043 - 2047)

(VALIDATE PHONE NUMBER AND THANK RESPONDENT BY SAYING:)

Again, this is _____, with The Gallup Organization of _____. I would like to thank you for your time. Our mission is to "help people be heard" and your opinions are important to Gallup in accomplishing this.

D1. PHYSICIAN NAME: **(Code from fone file)**

_____ _____
_____ (-)

D2. PREFERRED PROFESSIONAL MAILING ADDRESS: **(Code from fone file)**

_____ _____
_____ (-)

D3. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ (-)

D4. TELEPHONE NUMBER: **(Code from fone file)**

_____ _____
_____ (-)

INTERVIEWER I.D.# _____ (571-574)

jlw\2003\RWJ\RWJ Physician Testing Group A 0311

Appendix B.
Group B Survey Instrument

INDEPTH

FINAL DRAFT – DECEMBER 4, 2003

THE GALLUP ORGANIZATION

PROJECT REGISTRATION #140157
ROBERT WOOD JOHSON _____ APPROVED BY CLIENT
City Center: Washington D.C.
2003 Physician Testing - Group B _____ APPROVED BY PROJECT MANAGER
McComb/Richter
December, 2003 n=15

I.D.#: _____(1-6)

**AREA CODE AND TELEPHONE NUMBER:

_____ _____
_____ (649 - 658)

**INTERVIEW TIME:

_____ _____
_____ (716 - 721)

(NOTE: All interviews are recorded. The recording begins when the respondent answers the phone. This statement is read after the "Continue" response is entered after the Introduction and before the first question) This call will be recorded for quality assurance.

1 (Continue)
2 (Refused) - **(Thank and Terminate)** _____(984)

Sa. SPECIALTY: **(Code from call record card)**

_____ _____
_____ (-)

Sb. STATE: **(Code from call record card)**

01	Alabama - SC	30	Montana - W
02	Alaska - W	31	Nebraska - NC
04	Arizona - W	32	Nevada - W
05	Arkansas - SC	33	New Hampshire - NE
06	California - W	34	New Jersey - NE
08	Colorado - W	35	New Mexico - W
09	Connecticut - NE	36	New York - NE
10	Delaware - SC	37	North Carolina - SC
11	Washington D.C. - SC	38	North Dakota - NC
12	Florida - SC	39	Ohio - NC
13	Georgia - SC	40	Oklahoma - SC
15	Hawaii - W	41	Oregon - W
16	Idaho - W	42	Pennsylvania - NE
17	Illinois - NC	44	Rhode Island - NE
18	Indiana - NC	45	South Carolina - SC
19	Iowa - NC	46	South Dakota - NC
20	Kansas - NC	47	Tennessee - SC
21	Kentucky - SC	48	Texas - SC
22	Louisiana - SC	49	Utah - W
23	Maine - NE	50	Vermont - NE
24	Maryland - SC	51	Virginia - SC
25	Massachusetts - NE	53	Washington - W
26	Michigan - NC	54	West Virginia - SC
27	Minnesota - NC	55	Wisconsin - NC
28	Mississippi - SC	56	Wyoming - W
29	Missouri - NC		

_____ _____
_____ ( ) ( )

Sc. COUNTY: **(Code from call record card)**

_____ _____
_____ (-)

Sd. DOCTOR TYPE: **(Code from call record card)**

1 MD
2 DO _____( )

Se. DOCTOR NAME: **(Code from call record card)**

_____ _____
_____ (-)

Sf. PRIMARY SPECIALTY: **(Code from call record card)**

_____ _____
_____ (-)

Sg. ZIP CODE: **(Code from call record card)**

_____ _____
_____ (-)

INTRODUCTION #1:

Hello, this is _____ with The Gallup Organization. I'd like to invite you to help us test some new survey questions for the fourth round of the Robert Wood Johnson Foundation's Physician Survey. 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 purpose of this interview is to get your feedback on the items being considered for the survey and to find out if any parts of the questions are confusing, ambiguous, or inappropriate. We will not be asking you the entire survey, but simply testing new items. Generally, I will ask you a survey question, and then will ask you some follow-ups about how you interpreted the question. The interview will take about 20 to 30 minutes and we are providing an honorarium of $100 as a small token of our appreciation. 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 is convenient for you.

1 Respondent available - **(Continue)**

7 Respondent not available – **(Set time to call back; Restart with Introduction #2)**

8 (Soft Refusal)

9 (Hard Refusal) - **(Thank and Terminate)**

(READ:) I apologize in advance if it seems as if I'm skipping around from topic to topic. As I mentioned, we will not be asking you the entire survey, but simply testing new items. So please bear with me on the subject matter! Please feel free to jump in at any point with your own observations about the questions and how they could be improved. Some of the questions I ask will not have any follow-ups to them. I will be taping these conversations but only so I can write a report of the overall results. Your individual responses will never be associated with you. Do you have any questions before we begin?

(All in Read, Skip to A1)

INTRODUCTION #2: (Scheduled Interview)

Hello, this is _____ with The Gallup Organization. Thank you for agreeing to help us test out some new survey questions for the fourth round of the Robert Wood Johnson Foundation's Physician Survey. The purpose of this interview is to get your feedback on the items being considered for the survey and to find out if any parts of the questions are confusing, ambiguous, or inappropriate. I apologize in advance if it seems as if I'm skipping around from topic to topic. We will not be asking you the entire survey, but simply testing new items. So please bear with me on the subject matter! Generally, I will ask you a survey question, and then will ask you some follow-ups about how you interpreted the question. Please feel free to jump in at any point with your own observations about the questions and how they could be improved. Some of the questions I ask will not have any follow-ups to them. I will be taping these conversations but only so I can write a report of the overall results. Your individual responses will never be associated with you. Do you have any questions before we begin?

1 Respondent available - **(Continue)**

7 Respondent not available – **(Set time to call back)**

8 (Soft Refusal)

9 (Hard Refusal) - **(Thank and Terminate)**

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? **(If respondent works part-time for a Federal Agency, ask:)** Do you consider this (Federal Agency) your main practice?

1 Yes - **(Continue)**

2 No - **(Skip to A2)**

3 (Retired) - **(Thank and Terminate)**

4 Out of country - **(Thank and Terminate)**

5 Institutionalized - **(Thank and Terminate)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)**

(If code 1 in A1,
(READ:) 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)**

A2. **(If code 2 in A1, ask:)** Are you currently a resident or fellow?

1 Yes - **(Continue)**

2 No - **(Skip to A3)**

3 (DK) **(Thank and Terminate)**
4 (Refused) **(Thank and Terminate)**

(If code 1 in A2,
(READ:) 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)**

A3. **(If code 2 in A2, ask:)** During a TYPICAL week, do you provide direct patient care for at least twenty hours a week? **(If necessary, read:)** Direct patient care includes seeing patients and performing surgery. **(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.

1 Yes - **(Skip to S1)**

2 No - **(Continue)**

3 (DK) **(Thank and Terminate)**
4 (Refused) **(Thank and Terminate)**

(If code 2 in A3,
(READ:) 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)**

S1. We have your primary specialty listed as **(response from call record card)**. Is this correct? **(If necessary, read:)** We define primary specialty as that in which the most hours are spent weekly.

1 Yes
2 No
3 (DK)
4 (Refused)

(If code 2-4 in S1, Continue;
Otherwise, Skip to Read before #1)

S2. What is your primary specialty? (Open ended)

(READ:) This first question is about charity care.

(B6)
1. 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. Your best estimate would be fine.

00 None - **(Skip to Note after C1c)**

01-97 97+ - **(Continue)**

98 (DK) **(Skip to Note after C1c)**
99 (Refused) **(Skip to Note after C1c)**

(B6a)
1a. **(If code 01-97 in #1, ask:)** Where do you typically provide charity care? In your main practice, on-call at a hospital emergency department, in another practice or clinic, or somewhere else?

(READ:) Now, I will ask you the follow-up questions to see how you thought about the question.

C1a. Were you able to pick just one setting where you typically provide charity care or did you want to pick more than one?

C1b. In what other settings do you provide charity care?

C1c. Can you think of any ways the charity care question could be improved? (Open ended)

(If primary care, Continue;
Otherwise, Skip to Read before #4)

(READ:) These next two questions are about physician productivity.

(B3d)

2. Thinking of your last complete week of practice, about how many hours did you spend in direct patient care activities? **(INTERVIEWER NOTE: Direct patient care includes seeing patients, performing surgery, patient record keeping, and related office work, travel time connected to seeing patients)**

(B3f)

3. During that week, how many patient visits did you personally have in each of the following settings? Please count as one visit each time you saw a patient. How about **(read and rotate A-D)**?

   A. In the office

   B. In outpatient clinics

   C. In nursing homes and other extended care facilities

   D. On hospital rounds

(If "0/None" to ALL in #3 A-D, Skip to Read before #4; Otherwise, Continue)

(READ:) Now, a few follow-up questions.

C3a. How did you calculate your answers to the patient visit questions? For example, did you estimate the number of hours in each setting and the average number of patients seen per hour? Did you estimate the typical number of patients seen per day and multiply by the number of days providing this service that week? Or something else?

01 Something else (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

06 Estimate number of hours in each setting and average number of patients see per hour
07 Estimate typical number of patients per day and multiplied by number of days proving that service that week

C3b. How easy or difficult was it for you to come up with your answers?

C3c. How confident are you in the response you just gave me?

C3d. Were any of the items confusing or needing a definition? Do you think other physicians would find examples of outpatient clinics helpful or is this too obvious to mention? (Open ended)

(READ:) These next few questions are about medical services requested by patients.

(B9)
4. During the last month, for what percentage of your patients did you order tests, procedures, or prescriptions suggested by patients that you would not otherwise have ordered?

(If no numeric response given, Skip to #5; If numeric response given, Continue)

(B9a)
4a. During the last month, which service suggested by patients did you order most often: diagnostic tests and procedures, therapeutic procedures, including surgery, prescriptions, or something else?

C4a. Were any of the terms ambiguous or confusing? Any clarifications needed?

C4b. Are there any other services we should ask about? **(If Yes, ask:)** What other services? (Open ended)

C4c. How could it be improved? (Open ended) **(INTERVIEWER NOTE: Re-read #4a, if necessary)** During the last month, which service suggested by patients did you order most often: diagnostic tests and procedures, therapeutic procedures, including surgery, prescriptions, or something else?

(B12)
5. Patients with health insurance often have out-of-pocket costs for co-payments and deductibles. The next questions concern the relationship between these costs and clinical decisions. **(Read and rotate A-C)**

   A. If a generic option is available, how often do you prescribe a generic over a brand name drug, never, rarely, sometimes, usually, or always?

   B. If there is uncertainty about a patient's diagnosis, how often do you consider an insured patient's out-of-pocket costs in deciding whether to recommend additional testing, never, rarely, sometimes, usually, or always?

   C. If there is a choice between outpatient and inpatient care, how often do you consider an insured patient's out-of-pocket costs in making this decision, never, rarely, sometimes, usually, or always?

[Deleted Read]

C5a. How often do you actually know your insured patients' out-of-pocket costs for co-payments and deductibles?

C5b. How do you determine whether or not to consider an insured patient's out-of-pocket costs in making a clinical decision?

C5c. How truthful do you think physicians will be when answering these questions? Do you think physicians will feel threatened by the assumption they are placing cost above clinical concerns?

C5d. Is there anything you'd recommend to improve the out-of-pocket expense questions? **(If Yes, ask:)** What would you recommend?

(B16)
6. On a different subject, about what percentage of your patients do you have a hard time speaking with or understanding because you speak different languages?

C6a. Did you make a distinction between "speaking with" and "understanding" or in the future can we limit the question to "do you have a hard time understanding"?

C6b. How confident are you in the response you just gave me?

(READ:) These next questions are about coordination of care and patient safety.

(D6)
7. Does the hospital where most of your patients are treated have computerized systems to order tests and medications?

(Question C7a deleted)

C7b. Do you think most physicians will know this?

C7c. Do you send most of your patients to one hospital?

1 Yes - **(Skip to #8)**

2 No - **(Continue)**

3 (DK) **(Skip to #8)**
4 (Refused) **(Skip to #8)**

5 (Do not admit or treat patients in a hospital) - **(Skip to #10)**

C7d. **(If code 2 in C7c, ask:)** Was it difficult for you to think of a single hospital?

(D6a)
8. Medical errors include dispensing of incorrect medication doses, surgical mistakes, or human error in interpreting results of diagnostic tests. Some errors harm patients, some are caught before they can cause any harm, and others may occur but don't cause any harm. Does the hospital where most of your patients are treated have a system for anonymously reporting medical errors?

1 Yes
2 No
3 (DK)
4 (Refused)

C8a. What did you think of the definition of medical errors? Is there anything you would change about the definition? **(INTERVIEWER NOTE: Re-read first sentence of #8, if necessary)** Medical errors include dispensing of incorrect medication doses, surgical mistakes, or human error in interpreting results of diagnostic tests.

C8b. Did the sentence explaining the impact of medical errors make any difference in how you responded? **(INTERVIEWER NOTE: Re-read second sentence of #8, if necessary)** Some errors harm patients, some are caught before they can cause any harm, and others may occur but don't cause any harm.

C8c. In your own words, what does it mean to have an "anonymous system for reporting medical errors"?

C8d. Do you think most physicians would know about the systems for reporting medical errors used in the hospital they use most?

(D6b)
9. Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. What percentage of your patients who were hospitalized last year had a hospitalist involved in their inpatient care?

C9a. What did you think of the definition of "hospitalist"? Is there anything you would change or add to the definition? Do you think most physicians are familiar with this specialty? **(INTERVIEWER NOTE: Re-read first sentence of #9, if necessary)** Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients.

C9b. How confident are you in the response you just gave me?

(H10d)

10. Now, I am going to list several problems that may threaten physicians' ability to provide quality care. For each problem, tell me whether it is a major threat, a minor threat, or not a threat to your ability to provide quality care. How about **(read and rotate A-H)**?

    A. Inadequate time with patients during office visits

    B. Patients' inability to pay for needed care

    C. Rejections of care decisions by insurance companies

    D. Lack of qualified specialists in your area

    E. Not getting timely reports from other physicians and facilities

    F. Difficulties communicating with patients due to language or cultural barriers

    G. Difficulties maintaining continuing relationships with patients

    H. Medical errors in hospitals

C10a. Are there any other problems we didn't mention that threaten your ability to provide quality care? **(If Yes, ask:)** What problems?

C10b. What were you thinking about when you decided whether each problem was a major or minor threat? Were you thinking about how often in happens? How serious of a problem it is? Both?

C10c. What types of "facilities" were you thinking of when we asked about "not getting timely reports from other physicians and facilities?"

(D1E)
11. Finally, I have a few questions about electronic prescriptions. In your practice, are computers or other forms of information technology used to write prescriptions?

1 Yes - **(Continue)**

2 No **(Skip to #11f)**
3 (DK) **(Skip to #11f)**
4 (Refused) **(Skip to #11f)**

(D1E1)
11a. **(If code 1 in #11, ask:)** For what percentage of your patients do you write electronic prescriptions?

(D1E2)
11b. Does the system you use for electronic prescriptions provide information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

1 Yes - **(Continue)**

2 No **(Skip to #11e)**
3 (DK) **(Skip to #11e)**
4 (Refused) **(Skip to #11e)**

11c. Could you describe the system you use to write electronic prescriptions and obtain information on drug interactions?

(D1E2a)
11d. Is the drug interaction information you obtain from this system tailored specifically to your individual patients?

1 Yes
2 No
3 (DK)
4 (Refused)

(All in #11d, Skip to #11h)

11e. Could you describe the system you use to write electronic prescriptions?

(All in #11e, Skip to #11h)

(D1E3a)
11f. In your practice are computers or other forms of information technology used to obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

1 Yes - **(Continue)**

2 No **(Skip to #11h)**
3 (DK) **(Skip to #11h)**
4 (Refused) **(Skip to #11h)**

11g. Could you describe the system you use to obtain information on drug interactions?

11h. Were any of the questions ambiguous or difficult to understand? Do you have any suggestions for improving them?

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

13. I just need to verify your name and mailing address so we can send you your incentive check.

FIRST NAME:

LAST NAME:

ADDRESS #1:

ADDRESS #2:

CITY:

STATE:

ZIP CODE:

(VALIDATE PHONE NUMBER AND THANK RESPONDENT BY SAYING:)

Again, this is _____, with The Gallup Organization of _____. I would like to thank you for your time. Our mission is to "help people be heard" and your opinions are important to Gallup in accomplishing this.

D1. PHYSICIAN NAME: **(Record from call record card)**

D2. PREFERRED PROFESSIONAL MAILING ADDRESS: **(Record from call record card)**

D3. PRIMARY SPECIALTY: **(Record from call record card)**

D4. TELEPHONE NUMBER: **(Record from call record card)**

INTERVIEWER I.D.# _____ (571-574)

REVISIONS

12/4/03 Revised: Wording on #10

Added: #11-#11h

Renumbered: #11 to #12 and #12 to #13

jlw\2003\RWJ\RWJ Physician Testing Group B 0311

Appendix C.
Letter from HSC President, Paul Ginsberg

CENTER for STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

December 1, 2003

Dear Doctor:

I am writing to ask you to participate in a telephone interview to help us evaluate new questions for the next round of the Community Tracking Study's Physician Survey. The survey focuses on changes in the health care system and the practice of medicine and how these changes are affecting patients and physicians. The interview is being conducted by the Gallup Organization for The Center for Studying Health System Change (HSC), a nonpartisan health services research organization that receives its funding from The Robert Wood Johnson Foundation; for more information about us, please visit our web site at http://www.hschange.org/.

The Community Tracking Study includes surveys of physicians, employers, and the general public to provide data for analysis of health policy issues. Recent studies conducted by HSC and available from our web site illustrate how our research is used to inform the health policy debate:

- In their annual essay on the health care system, HSC Vice president Len Nichols and I explore the trade-offs inherent in containing health care costs and expanding health insurance coverage to the uninsured.

- Hospitals and physicians alike can raise prices to private insurers to offset payment reductions from Medicare and other government health programs if market conditions are right, according to a *Health Affairs* article that clashes with traditional health care economic theory.

- The fallout from rapidly rising medical malpractice insurance premiums is prompting some physicians to refer more patients to already crowded emergency departments, refuse to provide on-call emergency department coverage and decline elective referrals, according to a study released by HSC in September, 2003.

Next year, we will begin the fourth round of our physician survey. To ensure that new questions are reliable, we conduct pilot tests with a small number of physicians to evaluate question wording. These pilot interviews, which normally take from 30 to 45 minutes, are an integral part of the survey development process.

A professional interviewer from The Gallup Organization will arrange for a convenient time for you to complete the interview. As a token of our appreciation for your help, we offer an honorarium of $100. If you have any further questions about the study, please call Christine McComb (202/715-3141), Gallup's survey director. I know you are extremely busy and appreciate your willingness to help inform the public debate on health care.

Sincerely yours,

Paul B Ginsburg

600 MARYLAND AVE SW · SUITE 550 · WASHINGTON, DC 20024-2512 · TEL: 202.484.5261 · FAX: 202.484.9258 · WWW.HSCHANGE.ORG

HSC, FUNDED EXCLUSIVELY BY THE ROBERT WOOD JOHNSON FOUNDATION, IS AFFILIATED WITH MATHEMATICA POLICY RESEARCH, INC.

ADVANCE LETTERS AND HSC FACT SHEET

DATE

Dear Colleague:

A few years ago, you participated in the Community Tracking Study Physician Survey, a project sponsored by The Robert Wood Johnson Foundation and conducted by The Gallup Organization for the Center for Studying Health System Change (HSC). The survey focuses on changes in the health care system and the practice of medicine and how these changes are affecting patients and physicians. As a practicing physician, you experience the effects of these changes on a daily basis. That is why your perceptions and experiences are such a critical component of HSC's research program.

Using data from the physician surveys and other sources, researchers provide sound analysis on a growing body of topics of importance to physicians, other providers, and policy makers. To give you a sense of the range of issues addressed by HSC, I have enclosed some material that includes a brief description of HSC and a list of recent articles that may be of interest to you. You can view these and other studies by visiting the HSC web site at www.hschange.org.

Since the main objective of the Community Tracking Study is to understand changes in the health care system, we conduct follow-up interviews with physicians who participated in previous rounds.

A professional interviewer from Gallup will be contacting you shortly to ask you to participate in the fourth round of the survey, and I hope that you will agree to do so. The telephone interview takes only about 20 minutes and will be conducted at a time convenient for you. If you would like to contact Gallup directly to set up an appointment, please call Donna Stetler at 1-800-274-5447.

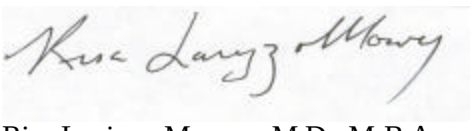
Several physician organizations have supported the survey and urged members to participate:

American Medical Association
American Osteopathic Association
American College of Surgeons
American College of Physicians
American Academy of Family Physicians
American Academy of Pediatrics
American Psychiatric Association

Although we cannot compensate you for your time, we offer an honorarium of $25 as a token of our appreciation. I hope we can count on your participation again. If you have any questions about the study, you may call Kelly Hunt at The Robert Wood Johnson Foundation at 1-800-719-9419.

Thank you in advance for your time and cooperation. I know you are extremely busy and appreciate your willingness to help inform the public debate on health care.

Sincerely,



Risa Lavizzo-Mourey, M.D., M.B.A.

RLM:pb
Attachment (1)

DATE

Dear Colleague:

As a fellow physician concerned about changes in American health care, I would like to ask you to take a few minutes to participate in a very important nation-wide survey of physicians sponsored by The Robert Wood Johnson Foundation (RWJF). The Community Tracking Physician Survey focuses on changes in the health care system and the practice of medicine, and how these changes are affecting patients and physicians such as you. The survey is conducted by experienced professional interviewers from The Gallup Organization for The Center for Studying Health System Change (HSC), an independent, non-partisan research organization funded by RWJF.

Using data from the physician surveys and other sources, researchers provide sound analysis on a growing body of topics of importance to physicians, other providers, and policy makers. To give you a sense of the range of issues addressed by HSC, I have enclosed some material that includes a brief description of HSC and a list of recent articles that may be of interest to you. You can view these and other studies by visiting the HSC web site at www.hschange.org.

For your information, the following physician organizations support the survey and urge members to participate:

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American Osteopathic Association
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American Academy of Family Physicians
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American Psychiatric Association

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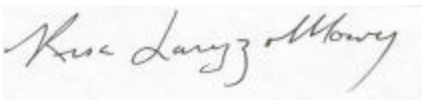
Thank you in advance for your time and cooperation. I know you are extremely busy and appreciate your willingness to help inform the public debate on health care.

Sincerely,



Risa Lavizzo-Mourey, M.D., M.B.A.

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Using data from the physician surveys and other sources, researchers provide sound analysis on a growing body of topics of importance to physicians, other providers, and policy makers. To give you a sense of the range of issues addressed by HSC, I have enclosed some material that includes a brief description of HSC and a list of recent articles that may be of interest to you. You can view these and other studies by visiting the HSC web site at www.hschange.org.

A professional interviewer from Gallup will be contacting you shortly to ask you to participate in the third round of the survey and I hope you will agree to do so. The telephone interview takes about 20 minutes and will be conducted at a time convenient for you. If you would like to contact Gallup directly to set up an appointment, please call Donna Stetler at 1-800-274-5447.

For your information, the following physician organizations support the survey and urge members to participate:

American Medical Association
American Osteopathic Association
American College of Surgeons
American College of Physicians
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American Academy of Pediatrics
American Psychiatric Association

Although we cannot compensate you for your time, we have enclosed an honorarium of $25 as a token of our appreciation. I hope we can count on your participation. If you have any questions about the study, please call Kelly Hunt at The Robert Wood Johnson Foundation at 1-800-719-9419.

Thank you in advance for your time and cooperation. I know you are extremely busy and appreciate your willingness to help inform the public debate on health care.

Sincerely,

Risa Lavizzo-Mourey, M.D., M.B.A.

RLM:pb
Attachments (2)

CENTER for STUDYING HEALTH SYSTEM CHANGE

Providing Insights that Contribute to Better Health Policy

Who We Are and What We Do

Founded in 1995, the Center for Studying Health System Change (HSC) is a nonpartisan policy research organization focused on the cost, quality and accessibility of health care in the United States. The center's team of researchers explores the policy implications of these factors. Instead of advocating for particular policies, HSC serves as an honest broker of information for policy makers, the news media, employers, health care providers, insurers and the public. HSC is funded principally by The Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research Inc., a leader in evaluating the effectiveness of local, state and federal health, human services and educational programs.

HSC's main research tool is the Community Tracking Study (CTS), which consists of national surveys of consumer households and physicians in 60 nationally and geographically representative communities across the country. HSC also conducts intensive site visits to 12 of these communities. The household survey is conducted by Mathematica Policy Research and the physician survey by The Gallup Organization. Led by Paul B. Ginsburg, Ph.D., and Len Nichols, Ph.D., both nationally known health economists and health policy experts, HSC researchers combine quantitative and qualitative research from the surveys and site visits to provide policy makers with a picture of changing health care market dynamics and the implications for health care policy.

Recent Studies of Particular Interest to Physicians

- "Growing Physician Investment in Specialty Hospitals and Ambulatory Surgical Centers," *Health Affairs*, March/April 2004.
- "Physicians' Responses to Financial Pressures in Private Practice," *Health Affairs*, March/April 2004.
- *Consequences of Rising Medical Malpractice Insurance Premiums on Patient Access to Health Care and Costs*, Issue Brief No. 68, September 2003.
- "Physicians' Views of Formularies and Implications for the Medicare Drug Benefit Design," *Health Affairs*, January/February 2004.
- *Behind the Times: Physician Incomes, 1995-99*, Data Bulletin No. 24, March 2003.
- "Trends in Hospital Relationships with Physicians," *Health Services Research*, February 2003.
- "Changes in Career Satisfaction Among Physicians," *JAMA*, Jan. 22, 2003.
- Trends in Physicians' Acceptance of New Medicare Patients, Issue Brief No. 55, September 2002.

CRT

HARD COPY REQUIRED

FINANCE,RWJ59687
F687
ROUND #4

FIELD FINAL – MAY 26, 2004
(Columns are ABSOLUTE)
(Revisions 7/13, 9/2)

THE GALLUP ORGANIZATION

PROJECT REGISTRATION #140157
THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE (RWJ)
City Center: Washington, D.C.
Physicians Study - Round #4
Larsen/McComb/Richter
Brenda Sonksen, Specwriter
July, 2004 n=7,000

__X__ APPROVED BY CLIENT

__X__ APPROVED BY PROJECT MANAGER

I.D.#: _____(1-6)

**AREA CODE AND TELEPHONE NUMBER:

_____ _____

_____
(649 - 658)

**INTERVIEW TIME:

_____ _____

_____
(716 - 721)

(NOTE: All interviews are recorded. The recording begins when the respondent answers the phone. This statement is read after the "Continue" response is entered after the Introduction and before the first question) This call will be recorded for quality assurance.

1 (Continue)
2 (Refused) - **(Thank and Terminate)** ___

SPECIALTY: **(Code from fone file) **(SURVENT NOTE: Show on Introduction screen)**

SPCLTY

_____ _____
_____ (5

STATE: **(Code from fone file)

01	Alabama - SC	30	Montana - W
02	Alaska - W	31	Nebraska - NC
04	Arizona - W	32	Nevada - W
05	Arkansas - SC	33	New Hampshire - NE
06	California - W	34	New Jersey - NE
08	Colorado - W	35	New Mexico - W
09	Connecticut - NE	36	New York - NE
10	Delaware - SC	37	North Carolina - SC
11	Washington D.C. - SC	38	North Dakota - NC
12	Florida - SC	39	Ohio - NC
13	Georgia - SC	40	Oklahoma - SC
15	Hawaii - W	41	Oregon - W
16	Idaho - W	42	Pennsylvania - NE
17	Illinois - NC	44	Rhode Island - NE
18	Indiana - NC	45	South Carolina - SC
19	Iowa - NC	46	South Dakota - NC
20	Kansas - NC	47	Tennessee - SC
21	Kentucky - SC	48	Texas - SC
22	Louisiana - SC	49	Utah - W
23	Maine - NE	50	Vermont - NE
24	Maryland - SC	51	Virginia - SC
25	Massachusetts - NE	53	Washington - W
26	Michigan - NC	54	West Virginia - SC
27	Minnesota - NC	55	Wisconsin - NC
28	Mississippi - SC	56	Wyoming - W
29	Missouri - NC		

_____ _____
_____ (58) (59)

COUNTY: **(Code from fone file)

_____ _____
_____ (6

SECTION A
INTRODUCTION AND SCREENING; LOCATION; BOARD CERTIFICATION; SATISFACTION

S1. DOCTOR TYPE: **(Code from fone file)**
DOCTYP

1 MD
2 DO _____(63)

S1b. REPLICATE NUMBER: **(Code from fone file)**
REPLICAT

[SET BY JOHN SELIX]

S1c. PANEL: **(Code from fone file)**
PANEL

1 New
2 Re-interview
3 Non-respondent _____(64)

(There are no questions S1d-S1f)

S2. DOCTOR NAME: **(Code from fone file)**

_____ _____
_____
(65 - 105)

S3. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ (5

S4. SITE NUMBER: **(Code from fone file)**

_____ _____
_____ (1

S5. SITE TYPE: **(Code from fone file)**
STYPE

1 High intensity
2 Low intensity/National _____(150)

S6. ZIP CODE: **(Code from fone file)**
ZIP

_____
(151 - 155)

S6a. PRESEND CHECK EXPERIMENT: **(Code from fone file)**
PRECHK

1 Yes
2 No _____(156)

(Question Sa deleted)

(Question Si deleted) HOLD _____(1101-1102)

(SURVENT NOTE: Display Doctor's name at top of screen)

**(If code 1 or 3 in S1c, Continue;
Otherwise, Skip to Introduction #2)**

INTRODUCTION #1
HELLO1

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 minutes and we are providing an honorarium of $25 as a small token of our appreciation. 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.

0 Gatekeeper soft refusal

1 Respondent available - **(Skip to A1)**

2 Gatekeeper not available - **(Set time to call back)**

3 No longer works/Lives here - **(Skip to S8)**

4 Never heard of respondent - **(Skip to S7)**

5 Gatekeeper hard refusal

6 Answering service/Can't ever reach physician at this number - **(Skip to S11)**

7 Physician not available - **(Set time to call back)**

8 Physician soft refusal

9 Physician hard refusal _____(1052)

INTRODUCTION #2

HELLO2

Hello, Dr. **(name from fone file)**, my name is _____, from The Gallup Organization. You should have received a letter from the Robert Wood Johnson Foundation indicating that Gallup would be calling you again to participate in the fourth round of the study of changes in the health care systems in communities across the nation. The study concerns how these changes are affecting physicians, their practices, and the health care they provide to their patients.

The interview will take about twenty minutes, and we are again providing an honorarium of $25 as a small token of our appreciation. 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.

0 Gatekeeper soft refusal

1 Respondent available - **(Skip to A1)**

2 Gatekeeper not available - **(Set time to call back)**

3 No longer works/Lives here - **(Skip to S8)**

4 Never heard of respondent - **(Continue)**

5 Gatekeeper hard refusal

6 Answering service/Can't ever reach physician at this number - **(Skip to S11)**

7 Physician not available - **(Set time to call back)**

8 Physician soft refusal

9 Physician hard refusal _____(1052)

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

VPHONE

1 Yes - **(Thank and Terminate; Skip to S11)**

2 No - **(READ:)** I am sorry to have bothered you. - **(Reset to Introduction)**

3 (DK) **(Thank and Terminate; Skip to Directory Assistant)**

4 (Refused) **(Thank and Terminate; Skip to Directory Assistant)** _____(2418)

S8. **(If code 3 in Introduction, 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)?

DIFFADR

1 Yes - **(Skip to S10)**

2 No/Unknown **(Continue)**
3 (DK) **(Continue)**
4 (Refused) **(Continue)**

5 (Retired) - **(Thank and Terminate)** ___

S9. **(If code 2, 3, or 4 in S8, ask:)** Do you happen to know if the doctor is still in this area, or is (he/she) in another city?

WHERE

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)** _____(2420)

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

NWPHONE

WORK PHONE NUMBER:

_____ _____
_____ (24
NWHPHON

HOME PHONE NUMBER:

_____ _____
_____ (24
NWADDR

STREET ADDRESS:

_____ _____
_____ (28
NWCITY

CITY:

_____ _____
_____ (25
NWSTATE

STATE:

_____ _____
_____ (2431) (2432)
NWZIP

ZIP CODE:

_____ _____
_____ (24

(All in S10, Thank and Terminate;
Call new number and Reset to Introduction;
If BLANK in WORK PHONE NUMBER and
HOME PHONE NUMBER in S10, Continue)

S11. ***(FDIRECTA)*** **(If code 1, 3, or 4 in S7, OR code 6 in Introduction, OR code 1, 3, or 4 in S9, OR 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)**

(Name from fone file)

DIRPHONE

1 New number - **(Enter on next screen)**

2 No number/Match - **(Thank and Terminate; Save Case ID)** _____(894)

(All in S11, call new number, and Reset to Introduction)

CLOCK:

_____ _____

_____

(-)

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? **(If respondent works part-time for a Federal Agency, ask:)** Do you consider this (Federal Agency) your main practice?

FEDEMP

1 Yes - **(Continue)**

2 No - **(Skip to A2)**

3 Retired - **(Thank and Terminate, and Set to "Failed Screener")**

4 Out of country **(Thank and Terminate, and Set to "Failed Screener")**

5 Institutionalized **(Thank and Terminate, and Set to "Failed Screener")**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1053)

(If code 1 in A1, READ:) 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)**

A2. Are you currently a resident or fellow?

RESFEL

1 Yes - **(Continue)**

2 No - **(Skip to A3)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1054)

(If code 1 in A2, READ:) 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)**

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

FULLTIM

1 Yes - **(Skip to Note before A5)**

2 No - **(Continue)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1055)

(If code 2 in A3, READ:) 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)**

[Deleted Note]

(Questions A3a-A4a deleted)

(If BLANK in **COUNTY, Skip to A5a; Otherwise, Continue)

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.)**

LOCCHK

1 Yes - **(Skip to Note before A5b)**

2 No **(Continue)**
8 (DK) **(Continue)**
9 (Refused) **(Continue)** ___

A5a. **(If code 2, 8, or 9 in A5 OR If BLANK in **COUNTY, ask:)** In what county and state is the practice located. (Open ended) **(VERIFY SPELLING)**

DK (DK)
RF (Refused)

SCNTY

COUNTY:

_____ _____
_____ (28

SSTATE

STATE:

_____ _____
_____ (2859) (2860)

(If code 15 or 02 in A5a - State, Continue; Otherwise, Skip to A5b)

(READ:) We are not interviewing physicians in your state at this time. So it appears that we do not need any further information from you, but we thank you for your cooperation. - **(Thank and Terminate)**

A5b. What is the zip code of your practice? (Open ended **and code all five digits of zip code)**

SZIP

99998 (DK)
99999 (Refused)

_____ _____
_____ (16

(If code 2 in S1c, Skip to A7; Otherwise, Continue)

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 all four digits of year)** **(SURVENT NOTE: Force interviewers to enter FOUR DIGITS)**

YRBGN

DK (DK)
RF (Refused)

_____ _____
_____ (16

(If code 999 in S3, Skip to A8; Otherwise, Continue)

A7. We have your primary specialty listed as **(response in S3)**. Is this correct? **(If necessary, say:)** We define primary specialty as that in which the most hours are spent weekly.

SPCCOR

1 Yes - **(Autocode response in S3 into A8)**

2 No - **(Continue)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1065)

A8. **(If code 2 or BLANK in A7, ask:)** What is your primary specialty? **(If necessary, say:)** 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 codeable response)**

NWSPEC

(If code 1 in S1 [MD-AMA LIST])

301	Abdominal Radiology	(AR)
202	AIDS/HIV Specialist	
001	Allergy	(A)
133	Adolescent Medicine Pediatrics	(ADL)
127	Addiction Medicine	(ADM)
132	Addiction Psychiatry	(ADP)
002	Allergy & Immunology	(AI)
003	Allergy & Immunology/ Diagnostic Laboratory Immunology	(ALI)
005	Aerospace Medicine	(AM)
085	Adolescent Medicine (Internal Medicine)	(AMI)
006	Anesthesiology	(AN)
007	Pain Management	(APM)
026	Abdominal Surgery	(AS)
103	Anatomic Pathology	(ATP)
104	Bloodbanking/Transfusion Medicine	(BBK)
190	Cardiovascular Surgery	(CDS)
008	Critical Care Medicine (Anesthesiology)	(CCA)
050	Clinical Cytogenetics	(CCG)
191	Craniofacial Surgery	(CFS)
128	Critical Care Medicine (Internal Medicine)	(CCM)
086	Critical Care Pediatrics	(CCP)
027	Critical Care Surgery	(CCS)
009	Cardiovascular Disease	(CD)
051	Clinical Genetics	(CG)
054	Child Neurology	(CHN)
010	Child & Adolescent Psychiatry	(CHP)
049	Clinical Biochemical Genetics	(CCG)
105	Clinical Pathology	(CLP)
052	Clinical Molecular Genetics	(CMG)
055	Clinical Neurophysiology	(CN)
011	Colon & Rectal Surgery	(CRS)
401	Cosmetic Surgery	(CS)
124	Cardiothoracic Surgery	(CTS)
012	Dermatology	(D)
164	Dermatologic Surgery	(DS)
013	Clinical & Laboratory Dermatological Immunology	(DDL)
035	Diabetes	(DIA)

A8. (Continued:)

106	Dermatopathology	(DMP)	
014	Diagnostic Radiology		(DR)
015	Emergency Medicine	(EM)	
308	Internal Medicine/Emergency Medicine	(MEM)	
036	Endocrinology, Diabetes & Metabolism	(END)	
302	Epidemiology	(EP)	
016	Sports Medicine (Emergency Medicine)	(ESM)	
402	Endovascular Surgical Neuroradiology	(ESN)	
140	Medical Toxicology (Emergency Medicine)	(ETX)	
303	Flex Residents	(FLX)	
403	Family Medicine		(FM)
018	Forensic Pathology	(FOP)	
019	Family Practice		(FP)
020	Geriatric Medicine (Family Practice)	(FPG)	
078	Facial Plastic Surgery	(FPS)	
021	Sports Medicine (Family Practice)	(FSM)	
022	Gastroenterology	(GE)	
061	Gynecological Oncology	(GO)	
023	General Practice	(GP)	
024	General Preventive Medicine	(GPM)	
029	General Surgery		(GS)
062	Gynecology		(GYN)
037	Hematology		(HEM)
038	Hepatology		(HEP)
107	Hematology Pathology		(HMP)
030	Head & Neck Surgery	(HNS)	
136	Hematology/Oncology	(HO)	
070	Hand Surgery Orthopedics		(HSO)
101	Hand Surgery Plastic		(HSP)
031	Hand Surgery	(HSS)	
201	Hospitalists	(HOS)	
039	Clinical Cardiac Electrophysiology		(ICE)
040	Infectious Diseases	(ID)	
004	Immunology		(IG)
041	Clinical & Laboratory Immunology (IM)	(ILI)	
042	Internal Medicine	(IM)	
194	Interventional Cardiology		(IC)
043	Geriatric Medicine (IM)	(IMG)	
044	Sports Medicine		(ISM)
309	Sports Medicine (Physical Medicine and Rehabilitation) (IM)	(PMM)	
129	Legal Medicine	(LM)	
138	Medical Management	(MDM)	
063	Maternal & Fetal Medicine		(MFM)
304	Maxillofacial Radiology	(MXR)	
053	Medical Genetics	(MG)	

108 Medical Microbiology (MM)
195 Internal Medicine/Family Practice (IFP)

A8. (Continued:)

137	Internal Medicine/Pediatrics	(MPD)	
099	Public Health & General Preventive Medicine	(MPH)	
056	Neurology	(N)	
310	Internal Medicine/Neurology	(MN)	
311	Neurology/Physical Medicine and Rehabilitation		(NPR)
058	Critical Care Medicine (Neurosurgery)	(NCC)	
404	Neurodevelopmental Disability		(NDN)
045	Nephrology		(NEP)
057	Nuclear Medicine	(NM)	
109	Neuropathology	(NP)	
087	Neonatal/Perinatal Medicine	(NPM)	
117	Nuclear Radiology	(NR)	
305	Neurology/Diagnostic Radiology/ Neuroradiology	(NRN)	
059	Neurological Surgery		(NS)
060	Pediatric Neurosurgery	(NSP)	
046	Nutrition	(NTR)	
405	Neuropsychiatry		(NUP)
071	Adult Reconstructive Orthopedics	(OAR)	
064	Obstetrics & Gynecology	(OBG)	
065	Obstetrics		(OBS)
066	OB Critical Care Medicine		(OCC)
134	Foot & Ankle Orthopedics		(OFA)
068	Occupational Medicine	(OM)	
406	Oral and Maxillofacial Surgery		(OMF)
072	Musculoskeletal Oncology		(OMO)
047	Medical Oncology	(ON)	
073	Pediatric Orthopedics	(OP)	
069	Ophthalmology	(OPH)	
074	Orthopedic Surgery	(ORS)	
028	Other Specialty		(OS)
075	Sports Medicine (Orthopedic Surgery)	(OSM)	
076	Orthopedic Surgery of the Spine	(OSS)	
079	Otology	(OT)	
197	Otology/Neurotology	(NO)	
080	Otolaryngology	(OTO)	
077	Orthopedic Trauma	(OTR)	
082	Psychiatry		(P)
312	Psychiatry/Family Practice	(FPP)	
313	Internal Medicine/Psychiatry	(MP)	
130	Clinical Pharmacology	(PA)	
147	Pulmonary Critical Care Medicine	(PCC)	
110	Chemical Pathology	(PCH)	
111	Cytopathology	(PCP)	
088	Pediatrics		(PD)

089	Pediatric Allergy	(PDA)
306	Pediatric Anesthesiology (Pediatrics)	(PAN)
098	Pediatric Cardiology	(PDC)

A8. (Continued:)

198	Pediatric Cardiothoracic Surgery	(PCS)	
193	Pediatric Emergency Medicine	(EMP)	
090	Pediatric Endocrinology	(PDE)	
145	Pediatric Infectious Diseases		(PDI)
081	Pediatric Otolaryngology		(PDO)
091	Pediatric Pulmonology	(PDP)	
192	Pediatrics/Psychiatry/Child & Adolescent Ps	(CPP)	
118	Pediatric Radiology	(PDR)	
032	Pediatric Surgery	(PDS)	
139	Medical Toxicology (Pediatrics)	(PDT)	
144	Pediatric Emergency Medicine	(PE)	
017	Pediatric Emergency Medicine (Pediatrics)	(PEM)	
135	Forensic Psychiatry	(PFP)	
092	Pediatric Gastroenterology	(PG)	
093	Pediatric Hematology/Oncology		(PHO)
112	Immunopathology		(PIP)
094	Clinical & Laboratory Immunology (Pediatrics)	(PLI)	
143	Palliative Medicine	(PLM)	
100	Physical Medicine & Rehab		(PM)
314	Internal Medicine/Physical Medicine & Rehabilitation	(MPM)	
200	Physical Medicine & Rehabilitation (Pediatrics)	(PMP)	
142	Pain Medicine	(PMD)	
407	Sports Medicine (Physical Medicine and Rehabilitation)	(PMM)	
095	Pediatric Nephrology		(PN)
146	Pediatric Opthalmology	(PO)	
113	Pediatric Pathology	(PP)	
096	Pediatric Rheumatology	(PPR)	
102	Plastic Surgery/Cosmetic Surgery	(PS)	
199	Pharmaceutical Medicine	(PHM)	
307	Public Health	(PH)	
408	Plastic Surgery within the Head and Neck		(PSH)
097	Sports Medicine (Pediatrics)	(PSM)	
114	Anatomic/Clinical Pathology	(PTH)	
141	Medical Toxicology (Preventive Medicine)	(PTX)	
116	Pulmonary Diseases	(PUD)	
196	Internal Medicine/Preventive Medicine	(IPM)	
083	Psychoanalysis	(PYA)	
084	Geriatric Psychiatry		(PYG)
119	Radiology	(R)	
067	Reproductive Endocrinology	(REN)	

048	Rheumatology	(RHU)
115	Radioisotopic Pathology	(RIP)
120	Neuroradiology	(RNR)

A8. (Continued:)

123	Radiation Oncology	(RO)	
121	Radiological Physics		(RP)
409	Pediatric Rehabilitation		(RPM)
150	Spinal Cord Injury	(SCI)	
149	Sleep Medicine	(SM)	
151	Surgical Oncology	(SO)	
148	Selective Pathology	(SP)	
033	Trauma Surgery	(TRS)	
152	Transplant Surgery	(TTS)	
125	Urology	(U)	
025	Undersea Medicine	(UM)	
126	Pediatric Urology	(UP)	
131	Unspecified	(US)	
122	Vascular & Interventional Radiology	(VIR)	
165	Vascular Medicine	(VM)	
034	Vascular Surgery	(VS)	
210	Developmental & Behavioral Pediatrics	(DBP)	
159	Proctology		(PRO)
124	Thoracic Surgery	(TS)	

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (10

(If code 2 in S1 [DO-AOA LIST])

301	Abdominal Radiology	AR	
202	AIDS/HIV Specialist		
002	Allergy and Immunology	AI	
003	Allergy-Diagnostic Lab Immunology	ALI	
004	Immunology		IG
005	Preventive Medicine-Aerospace Medicine	AM	
006	Anesthesiology	AN	
006	Anesthesiology	CAN	
006	Anesthesiology	IRA	
006	Anesthesiology	OBA	
006	Anesthesiology	PAN	
007	Pain Management		APM
007	Pain Management		PMR
008	Critical Care-Anesthesiology	CCA	
009	Cardiovascular Diseases-Cardiology		C
009	Cardiovascular Diseases-Cardiology		CVD
009	Cardiovascular Diseases-Cardiology		IC

190	Cardiovascular Surgery	CDS	
191	Craniofacial Surgery		CFS
010	Pediatric Psychiatry		CHP

A8. (Continued:)

010	Pediatric Psychiatry		PDP
011	Colon & Rectal Surgery	CRS	
012	Dermatology	D	
015	Emergency Medicine	EM	
014	Diagnostic Radiology		DR
308	Internal Medicine/Emergency Medicine	MEM	
015	Emergency Medicine	EMS	
015	Emergency Medicine	FEM	
015	Emergency Medicine	IEM	
302	Epidemiology	EP	
016	Sports Medicine (Emergency Medicine)	ESM	
017	Pediatric Emergency Medicine	PEM	
303	Flex Residents	FLX	
018	Forensic Pathology	FOP	
019	Family Practice		FP
019	Family Practice		UFP
020	Geriatrics-General or Family Practice	GFP	
020	Geriatrics-General or Family Practice	GGP	
021	Sports Medicine-Family or General Practice	SFP	
021	Sports Medicine-Family or General Practice	SGP	
022	Gastroenterology	GE	
023	General Practice	GP	
024	Preventive Medicine	PVM	
025	Undersea Medicine	UM	
026	Abdominal Surgery	AS	
027	Critical Care-Surgery or Trauma	CCS	
027	Critical Care-Surgery or Trauma	CCT	
028	Other Specialty		OS
029	Surgery-General		S
030	Head & Neck Surgery	HNS	
031	Hand Surgery	HS	
031	Hand Surgery	HSS	
201	Hospitalists		
032	Pediatric Surgery	PDS	
033	Traumatic Surgery	TRS	
034	Vascular Surgery-General or Peripheral	GVS	
034	Vascular Surgery-General or Peripheral	PVS	
036	Endocrinology	END	
037	Hematology		HEM
039	Cardiac Electrophysiology		ICE
040	Infectious Diseases	ID	
041	Diag Lab Immunology-Int Med	ILI	
042	Internal Medicine	IM	
194	Interventional Cardiology		IC
195	Internal Medicine/Family Practice	IFP	

042 Internal Medicine IP

A8. (Continued:)

043	Geriatrics-Internal Medicine	GER	
309	Geriatrics-Internal Medicine	GIM	
044	Sports Medicine (Physical Medicine & Rehabilitation)		PMM
044	Sports Medicine		ISM
044	Sports Medicine		PMS
044	Sports Medicine		RMS
044	Sports Medicine		SM
045	Nephrology		NEP
046	Nutrition	NTR	
047	Oncology	ON	
048	Rheumatology	RHU	
050	Clinical Cytogenetics	CCG	
051	Clinical Genetics	CG	
053	Medical Genetics	IMG	
054	Pediatric or Child Neurology	CHN	
054	Pediatric or Child Neurology	PDN	
055	Clinical Neurophysiology		CN
056	Neurology	N	
310	Internal Medicine/Neurology	MN	
311	Neurology/Physical Medicine & Rehab		NPR
056	Neurology	NMD	
056	Neurology	NP	
056	Neurology	NPN	
305	Neurology/Diagnostic Radiology/ Neuroradiology	NRN	
057	Nuclear Medicine	NI	
057	Nuclear Medicine	NM	
057	Nuclear Medicine	NV	
058	Critical Care-Neuro Surgery	NCC	
059	Neurological Surgery		NS
061	Gynecological Oncology	GO	
062	Gynecology		GS
062	Gynecology		GYN
063	Maternal & Fetal Medicine		MFM
304	Maxillofacial Radiology	MXR	
064	Obstetrics & Gynecology	OBG	
064	Obstetrics & Gynecology	OGS	
065	Obstetrics		OBS
066	Critical Care-Obstetrics & Gynecology	OCC	
067	Reproductive Endocrinology	RE	
068	Occupational Medicine	OCM	
068	Occupational Medicine	OM	
069	Ophthalmology	COR	
069	Ophthalmology	OAS	
069	Ophthalmology	OCR	
069	Ophthalmology	OGL	

069	Ophthalmology	OPH
069	Ophthalmology	VRS

A8. (Continued:)

070	Hand Surgery-Orthopedic Surg	HSO	
071	Adult Reconstructive Orthopedics	OAR	
072	Musculoskeletal Oncology		OMO
073	Pediatric Orthopedics	OP	
074	Orthopedic Surgery	AJI	
074	Orthopedic Surgery	OR	
074	Orthopedic Surgery	ORS	
075	Sports Medicine-Orthopedic Surgery		OSM
076	Orthopedic Surgery-Spine		OSS
078	Facial Plastic Surgery	OPL	
080	Otolaryngology or Rhinology	OTL	
080	Otolaryngology or Rhinology	OTR	
080	Otolaryngology or Rhinology	RHI	
197	Otology/Neurotology	NO	
081	Pediatric Otolaryngology		PDO
082	Psychiatry		P
312	Psychiatry/Family Practice	FPP	
313	Psychiatry/Internal Medicine	MP	
083	Psychoanalysis	PYA	
084	Geriatric Psychiatry		PYG
085	Adolescent Medicine-Family or General Practice	AFP	
085	Adolescent Medicine-Family or General Practice	AGP	
086	Pediatric Intensive Care		PIC
087	Neonatology	NE	
088	Pediatrics		PD
089	Pediatric Allergy & Immunology		PAI
306	Pediatric Anesthesiology (Pediatrics)	PAN	
091	Pediatric Pulmology Medicine	PDX	
198	Pediatric Cardiothoracic Surgery	PCS	
092	Pediatric Gastroenterology	PG	
093	Pediatric Hematology-Oncology		PHO
094	Pediatric Diag Lab Immunology		PLI
095	Pediatric Nephrology		PNP
192	Pediatrics/Psychiatry/Child & Adolescent Ps	CPP	
096	Pediatric Rheumatology	PPR	
097	Sports Medicine - Pediatrics	PSM	
098	Pediatric Cardiology		PDC
099	Preventive Medicine, Epidemiology or Public Health	EPI	
099	Preventive Medicine, Epidemiology or Public Health	OE	
099	Preventive Medicine, Epidemiology or Public Health	PH	
099	Preventive Medicine, Epidemiology		

or Public Health	PHP

A8. (Continued:)

199	Pharmaceutical Medicine	PHM	
100	Physical Medicine & Rehabilitation		PM
100	Physical Medicine & Rehabilitation		IAR
100	Physical Medicine & Rehabilitation		PDR
314	Internal Medicine/Physical Medicine & Rehabilitation	MPM	
100	Physical Medicine & Rehabilitation		RM
200	Physical Medicine & Rehabilitation (Pediatrics)		PMP
101	Hand Surgery-Plastic Surg		HSP
102	Plastic Surgery		OOP
102	Plastic Surgery		PLR
103	Anatomic Pathology	AP	
104	Blood Banking-Transfusion Medicine		BBT
104	Blood Banking-Transfusion Medicine		LBM
105	Clinical Pathology	CLP	
106	Dermatopathology	DPT	
107	Hematology-Pathology		HEP
108	Medicine Microbiology	MMB	
109	Neuropathology	NPT	
110	Chemical Pathology	CP	
111	Cytopathology	CY	
112	Immunopathology		IPT
113	Pediatric Pathology	PP	
114	Anatomic/Clinical Pathology	APL	
114	Anatomic/Clinical Pathology	PTH	
115	Radioisotopic Pathology	RIP	
307	Public Health	PH	
196	Internal Medicine/Preventive Medicine	IPM	
116	Pulmonary Diseases	PUD	
116	Pulmonary Diseases	PUL	
117	Nuclear Radiology	NR	
118	Pediatric Radiology	PRD	
119	Radiology	DUS	
119	Radiology	R	
119	Radiology	RI	
119	Radiology	RT	
119	Radiology	RTD	
120	Neuroradiology	NRA	
121	Radiological Physics		RP
122	Angiography & Intervent'l Radiology		ANG
122	Angiography & Intervent'l Radiology		SCL
123	Radiation Oncology	RO	
123	Radiation Oncology	TR	
124	Cardiovascular or Thoracic Cardiovascular Surgery		CVS
124	Cardiovascular or Thoracic		

A8. (Continued:)

125	Urology	U	
125	Urology	URS	
126	Pediatric Urology	UP	
127	Addictive Diseases	ADD	
128	Critical Care-Medicine	CCM	
129	Legal Medicine	LM	
130	Clinical Pharmacology	PA	
131	Unknown Blank		
133	Adolescent Medicine	ADL	
134	Orthopedic Foot & Ankle Surg	OFA	
135	Forensic Psychiatry	FPS	
136	Hematology & Oncology	HEO	
137	Internal Med-Pediatrics	IPD	
139	Toxicology		TX
142	Psychosomatic Medicine	PYM	
145	Pediatric Infectious Diseases		PID
146	Pediatric Ophthalmology	PO	
147	Pulmonary-Critical Care	PUC	
153	MOHS Micrographic Surgery		DMS
154	Hair Transplant		HT
155	Osteo Manipulative Treat +1	OM1	
156	Osteopathic Manipulative Medicine	OMM	
157	Sports Medicine - OMM	OMS	
158	Osteo Manipulative Medicine	OMT	
159	Proctology		PRO
160	Internship		IN
161	Retired	RET	
162	Transitional Year	TY	
209	Nuclear Cardiology	NC	
210	Developmental & Behavioral Pediatrics	DBP	
159	Proctology		PRO
124	Thoracic Surgery	TS	
410	Clinical Neurophysiology		CN
411	Hematology/Oncology	HO	
413	Nutrition	NTR	
414	Pulmonary Critical Care Medicine	PCC	
415	Pediatric Infectious Disease	PDI	
416	Pediatric Nephrology		PN
417	Spinal Cord Injury Medicine	SCI	

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____

_____ (1

(If code 003, 005-007, 013-014, 018, 025, 028, 057, 099, 103-115, 117-122, 129-131, 135, 138-141, 148, 160-162, 209, 301-307, or 402 in A8, Continue; Otherwise, Skip to Note before A9)

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)**

(If code 201 in A8, Skip to A17; If code 042, 088, 137, or 195 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, 142, 143, 147, 149, 194, 196, 199, 308, 310, 313, 314, or 414 in A8, Skip to A9a; If code 017, 049-054, 063, 086-087, 089-094, 095-098, 133, 144-145, 192, 193, 200, 210, 409, 415, or 416 in A8, Skip to A9b; Otherwise, Skip to A15)

A9. **(If code 042, 088, 137, or 195 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)**

GENSUB

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)** _____(1069)

A9a. **(If code 001-002, 004, 009, 012, 015-016, 020-022, 024, 035-041, 043-048, 055-056, 085, 116, 128, 136, 142, 143, 147, 149, 194, 196, 199, 308, 310, 313, 314, OR 414 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)**

SIPNPED

1 Subspecialty
2 General internal medicine (or general family practice)
3 General pediatrics

8 (DK)
9 (Refused) _____(2720)

(All in A9a, Skip to A15)

A9b. **(If code 017, 049-054, 063, 086-087, 089-098, 133, 144-145, 192, 193, 200, 210, 409, 415, or 416 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)**

SIPPED

1 Subspecialty
2 General internal medicine (General Family Practice)
3 General pediatrics

8 (DK)
9 (Refused) _____(1357)

(All in A9b, Skip to A15)

A10. **(If code 2 in A9, ask:)** And what is that subspecialty? **(If "More than one", say:)** We're interested in the one in which you spend the most hours weekly. (Open ended **and code from hard copy)** **(CHECK SPELLING)**

SUBSPC

(If code 1 in S1 [MD-AMA LIST])

301	Abdominal Radiology	(AR)
202	AIDS/HIV Specialist	
001	Allergy	(A)
133	Adolescent Medicine Pediatrics	(ADL)
127	Addiction Medicine	(ADM)
132	Addiction Psychiatry	(ADP)
002	Allergy & Immunology	(AI)
003	Allergy & Immunology/ Diagnostic Laboratory Immunology	(ALI)
005	Aerospace Medicine	(AM)
085	Adolescent Medicine (Internal Medicine)	(AMI)
006	Anesthesiology	(AN)
007	Pain Management	(APM)
026	Abdominal Surgery	(AS)
103	Anatomic Pathology	(ATP)
104	Bloodbanking/Transfusion Medicine	(BBK)
190	Cardiovascular Surgery	(CDS)
008	Critical Care Medicine (Anesthesiology)	(CCA)
050	Clinical Cytogenetics	(CCG)
191	Craniofacial Surgery	(CFS)
128	Critical Care Medicine (Internal Medicine)	(CCM)
086	Critical Care Pediatrics	(CCP)
027	Critical Care Surgery	(CCS)
009	Cardiovascular Disease	(CD)
051	Clinical Genetics	(CG)
054	Child Neurology	(CHN)
010	Child & Adolescent Psychiatry	(CHP)
049	Clinical Biochemical Genetics	(CCG)
105	Clinical Pathology	(CLP)
052	Clinical Molecular Genetics	(CMG)
055	Clinical Neurophysiology	(CN)
011	Colon & Rectal Surgery	(CRS)
401	Cosmetic Surgery	(CS)
124	Cardiothoracic Surgery	(CTS)
012	Dermatology	(D)
164	Dermatologic Surgery	(DS)
013	Clinical & Laboratory Dermatological Immunology	(DDL)
035	Diabetes	(DIA)

A10. (Continued:)

106	Dermatopathology	(DMP)	
014	Diagnostic Radiology		(DR)
015	Emergency Medicine	(EM)	
308	Internal Medicine/Emergency Medicine	(MEM)	
036	Endocrinology, Diabetes & Metabolism	(END)	
302	Epidemiology	(EP)	
016	Sports Medicine (Emergency Medicine)	(ESM)	
402	Endovascular Surgical Neuroradiology	(ESN)	
140	Medical Toxicology (Emergency Medicine)	(ETX)	
303	Flex Residents	(FLX)	
403	Family Medicine		(FM)
018	Forensic Pathology	(FOP)	
019	Family Practice		(FP)
020	Geriatric Medicine (Family Practice)	(FPG)	
078	Facial Plastic Surgery	(FPS)	
021	Sports Medicine (Family Practice)	(FSM)	
022	Gastroenterology	(GE)	
061	Gynecological Oncology	(GO)	
023	General Practice	(GP)	
024	General Preventive Medicine	(GPM)	
029	General Surgery		(GS)
062	Gynecology		(GYN)
037	Hematology		(HEM)
038	Hepatology		(HEP)
107	Hematology Pathology		(HMP)
030	Head & Neck Surgery	(HNS)	
136	Hematology/Oncology	(HO)	
070	Hand Surgery Orthopedics		(HSO)
101	Hand Surgery Plastic		(HSP)
031	Hand Surgery	(HSS)	
201	Hospitalists	(HOS)	
039	Clinical Cardiac Electrophysiology		(ICE)
040	Infectious Diseases	(ID)	
004	Immunology		(IG)
041	Clinical & Laboratory Immunology (IM)	(ILI)	
042	Internal Medicine	(IM)	
194	Interventional Cardiology		(IC)
043	Geriatric Medicine (IM)	(IMG)	
044	Sports Medicine		(ISM)
309	Sports Medicine (Physical Medicine and Rehabilitation) (IM)	(PMM)	
129	Legal Medicine	(LM)	
138	Medical Management	(MDM)	
063	Maternal & Fetal Medicine		(MFM)
304	Maxillofacial Radiology	(MXR)	
053	Medical Genetics	(MG)	

108 Medical Microbiology (MM)
195 Internal Medicine/Family Practice (IFP)

A10. (Continued:)

137	Internal Medicine/Pediatrics	(MPD)	
099	Public Health & General Preventive Medicine	(MPH)	
056	Neurology	(N)	
310	Internal Medicine/Neurology	(MN)	
311	Neurology/Physical Medicine and Rehabilitation		(NPR)
058	Critical Care Medicine (Neurosurgery)	(NCC)	
404	Neurodevelopmental Disability		(NDN)
045	Nephrology		(NEP)
057	Nuclear Medicine	(NM)	
109	Neuropathology	(NP)	
087	Neonatal/Perinatal Medicine	(NPM)	
117	Nuclear Radiology	(NR)	
305	Neurology/Diagnostic Radiology/ Neuroradiology	(NRN)	
059	Neurological Surgery		(NS)
060	Pediatric Neurosurgery	(NSP)	
046	Nutrition	(NTR)	
405	Neuropsychiatry		(NUP)
071	Adult Reconstructive Orthopedics	(OAR)	
064	Obstetrics & Gynecology	(OBG)	
065	Obstetrics		(OBS)
066	OB Critical Care Medicine		(OCC)
134	Foot & Ankle Orthopedics		(OFA)
068	Occupational Medicine	(OM)	
406	Oral and Maxillofacial Surgery		(OMF)
072	Musculoskeletal Oncology		(OMO)
047	Medical Oncology	(ON)	
073	Pediatric Orthopedics	(OP)	
069	Ophthalmology	(OPH)	
074	Orthopedic Surgery	(ORS)	
028	Other Specialty		(OS)
075	Sports Medicine (Orthopedic Surgery)	(OSM)	
076	Orthopedic Surgery of the Spine	(OSS)	
079	Otology	(OT)	
197	Otology/Neurotology	(NO)	
080	Otolaryngology	(OTO)	
077	Orthopedic Trauma	(OTR)	
082	Psychiatry		(P)
312	Psychiatry/Family Practice	(FPP)	
313	Internal Medicine/Psychiatry	(MP)	
130	Clinical Pharmacology	(PA)	
147	Pulmonary Critical Care Medicine	(PCC)	
110	Chemical Pathology	(PCH)	
111	Cytopathology	(PCP)	
088	Pediatrics		(PD)

089	Pediatric Allergy	(PDA)
306	Pediatric Anesthesiology (Pediatrics)	(PAN)
098	Pediatric Cardiology	(PDC)

A10. (Continued:)

198	Pediatric Cardiothoracic Surgery	(PCS)	
193	Pediatric Emergency Medicine	(EMP)	
090	Pediatric Endocrinology	(PDE)	
145	Pediatric Infectious Diseases		(PDI)
081	Pediatric Otolaryngology		(PDO)
091	Pediatric Pulmonology	(PDP)	
192	Pediatrics/Psychiatry/Child & Adolescent Ps	(CPP)	
118	Pediatric Radiology	(PDR)	
032	Pediatric Surgery	(PDS)	
139	Medical Toxicology (Pediatrics)	(PDT)	
144	Pediatric Emergency Medicine	(PE)	
017	Pediatric Emergency Medicine (Pediatrics)	(PEM)	
135	Forensic Psychiatry	(PFP)	
092	Pediatric Gastroenterology	(PG)	
093	Pediatric Hematology/Oncology		(PHO)
112	Immunopathology		(PIP)
094	Clinical & Laboratory Immunology (Pediatrics)	(PLI)	
143	Palliative Medicine	(PLM)	
100	Physical Medicine & Rehab		(PM)
314	Internal Medicine/Physical Medicine & Rehabilitation	(MPM)	
200	Physical Medicine & Rehabilitation (Pediatrics)	(PMP)	
142	Pain Medicine	(PMD)	
407	Sports Medicine (Physical Medicine and Rehabilitation)	(PMM)	
095	Pediatric Nephrology		(PN)
146	Pediatric Opthalmology	(PO)	
113	Pediatric Pathology	(PP)	
096	Pediatric Rheumatology	(PPR)	
102	Plastic Surgery/Cosmetic Surgery	(PS)	
199	Pharmaceutical Medicine	(PHM)	
307	Public Health	(PH)	
408	Plastic Surgery within the Head and Neck		(PSH)
097	Sports Medicine (Pediatrics)	(PSM)	
114	Anatomic/Clinical Pathology	(PTH)	
141	Medical Toxicology (Preventive Medicine)	(PTX)	
116	Pulmonary Diseases	(PUD)	
196	Internal Medicine/Preventive Medicine	(IPM)	
083	Psychoanalysis	(PYA)	
084	Geriatric Psychiatry		(PYG)
119	Radiology	(R)	
067	Reproductive Endocrinology	(REN)	

048	Rheumatology	(RHU)
115	Radioisotopic Pathology	(RIP)
120	Neuroradiology	(RNR)

A10. (Continued:)

123	Radiation Oncology	(RO)	
121	Radiological Physics		(RP)
409	Pediatric Rehabilitation		(RPM)
150	Spinal Cord Injury	(SCI)	
149	Sleep Medicine	(SM)	
151	Surgical Oncology	(SO)	
148	Selective Pathology	(SP)	
033	Trauma Surgery	(TRS)	
152	Transplant Surgery	(TTS)	
125	Urology	(U)	
025	Undersea Medicine	(UM)	
126	Pediatric Urology	(UP)	
131	Unspecified	(US)	
122	Vascular & Interventional Radiology	(VIR)	
165	Vascular Medicine	(VM)	
034	Vascular Surgery	(VS)	
210	Developmental & Behavioral Pediatrics	(DBP)	
159	Proctology		(PRO)
124	Thoracic Surgery	(TS)	

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (10

(If code 2 in S1 [DO-AOA LIST])

301	Abdominal Radiology	AR	
202	AIDS/HIV Specialist		
002	Allergy and Immunology	AI	
003	Allergy-Diagnostic Lab Immunology	ALI	
004	Immunology		IG
005	Preventive Medicine-Aerospace Medicine	AM	
006	Anesthesiology	AN	
006	Anesthesiology	CAN	
006	Anesthesiology	IRA	
006	Anesthesiology	OBA	
006	Anesthesiology	PAN	
007	Pain Management		APM
007	Pain Management		PMR
008	Critical Care-Anesthesiology	CCA	
009	Cardiovascular Diseases-Cardiology		C
009	Cardiovascular Diseases-Cardiology		CVD
009	Cardiovascular Diseases-Cardiology		IC

190	Cardiovascular Surgery	CDS	
191	Craniofacial Surgery		CFS

A10. (Continued:)

010	Pediatric Psychiatry		CHP
010	Pediatric Psychiatry		PDP
011	Colon & Rectal Surgery	CRS	
012	Dermatology	D	
015	Emergency Medicine	EM	
014	Diagnostic Radiology		DR
308	Internal Medicine/Emergency Medicine	MEM	
015	Emergency Medicine	EMS	
015	Emergency Medicine	FEM	
015	Emergency Medicine	IEM	
302	Epidemiology	EP	
016	Sports Medicine (Emergency Medicine)	ESM	
017	Pediatric Emergency Medicine	PEM	
303	Flex Residents	FLX	
018	Forensic Pathology	FOP	
019	Family Practice		FP
019	Family Practice		UFP
020	Geriatrics-General or Family Practice	GFP	
020	Geriatrics-General or Family Practice	GGP	
021	Sports Medicine-Family or General Practice	SFP	
021	Sports Medicine-Family or General Practice	SGP	
022	Gastroenterology	GE	
023	General Practice	GP	
024	Preventive Medicine	PVM	
025	Undersea Medicine	UM	
026	Abdominal Surgery	AS	
027	Critical Care-Surgery or Trauma	CCS	
027	Critical Care-Surgery or Trauma	CCT	
028	Other Specialty		OS
029	Surgery-General		S
030	Head & Neck Surgery	HNS	
031	Hand Surgery	HS	
031	Hand Surgery	HSS	
201	Hospitalists		
032	Pediatric Surgery	PDS	
033	Traumatic Surgery	TRS	
034	Vascular Surgery-General or Peripheral	GVS	
034	Vascular Surgery-General or Peripheral	PVS	
036	Endocrinology	END	
037	Hematology		HEM
039	Cardiac Electrophysiology		ICE
040	Infectious Diseases	ID	
041	Diag Lab Immunology-Int Med	ILI	
042	Internal Medicine	IM	
194	Interventional Cardiology		IC

195 Internal Medicine/Family Practice IFP

A10. (Continued:)

042	Internal Medicine	IP	
043	Geriatrics-Internal Medicine	GER	
309	Geriatrics-Internal Medicine	GIM	
044	Sports Medicine (Physical Medicine & Rehabilitation)		PMM
044	Sports Medicine		ISM
044	Sports Medicine		PMS
044	Sports Medicine		RMS
044	Sports Medicine		SM
045	Nephrology		NEP
046	Nutrition	NTR	
047	Oncology	ON	
048	Rheumatology	RHU	
050	Clinical Cytogenetics	CCG	
051	Clinical Genetics	CG	
053	Medical Genetics	IMG	
054	Pediatric or Child Neurology	CHN	
054	Pediatric or Child Neurology	PDN	
055	Clinical Neurophysiology		CN
056	Neurology	N	
310	Internal Medicine/Neurology	MN	
311	Neurology/Physical Medicine & Rehab		NPR
056	Neurology	NMD	
056	Neurology	NP	
056	Neurology	NPN	
305	Neurology/Diagnostic Radiology/ Neuroradiology	NRN	
057	Nuclear Medicine	NI	
057	Nuclear Medicine	NM	
057	Nuclear Medicine	NV	
058	Critical Care-Neuro Surgery	NCC	
059	Neurological Surgery		NS
061	Gynecological Oncology	GO	
062	Gynecology		GS
062	Gynecology		GYN
063	Maternal & Fetal Medicine		MFM
304	Maxillofacial Radiology	MXR	
064	Obstetrics & Gynecology	OBG	
064	Obstetrics & Gynecology	OGS	
065	Obstetrics		OBS
066	Critical Care-Obstetrics & Gynecology	OCC	
067	Reproductive Endocrinology	RE	
068	Occupational Medicine	OCM	
068	Occupational Medicine	OM	

A10. (Continued:)

069	Ophthalmology	COR	
069	Ophthalmology	OAS	
069	Ophthalmology	OCR	
069	Ophthalmology	OGL	
069	Ophthalmology	OPH	
069	Ophthalmology	VRS	
070	Hand Surgery-Orthopedic Surg	HSO	
071	Adult Reconstructive Orthopedics	OAR	
072	Musculoskeletal Oncology		OMO
073	Pediatric Orthopedics	OP	
074	Orthopedic Surgery	AJI	
074	Orthopedic Surgery	OR	
074	Orthopedic Surgery	ORS	
075	Sports Medicine-Orthopedic Surgery		OSM
076	Orthopedic Surgery-Spine		OSS
078	Facial Plastic Surgery	OPL	
080	Otolaryngology or Rhinology	OTL	
080	Otolaryngology or Rhinology	OTR	
080	Otolaryngology or Rhinology	RHI	
197	Otology/Neurotology	NO	
081	Pediatric Otolaryngology		PDO
082	Psychiatry		P
312	Psychiatry/Family Practice	FPP	
313	Psychiatry/Internal Medicine	MP	
083	Psychoanalysis	PYA	
084	Geriatric Psychiatry		PYG
085	Adolescent Medicine-Family or General Practice	AFP	
085	Adolescent Medicine-Family or General Practice	AGP	
086	Pediatric Intensive Care		PIC
087	Neonatology	NE	
088	Pediatrics		PD
089	Pediatric Allergy & Immunology		PAI
306	Pediatric Anesthesiology (Pediatrics)	PAN	
091	Pediatric Pulmology Medicine	PDX	
198	Pediatric Cardiothoracic Surgery	PCS	
092	Pediatric Gastroenterology	PG	
093	Pediatric Hematology-Oncology		PHO
094	Pediatric Diag Lab Immunology		PLI
095	Pediatric Nephrology		PNP
192	Pediatrics/Psychiatry/Child & Adolescent Ps	CPP	
096	Pediatric Rheumatology	PPR	
097	Sports Medicine - Pediatrics	PSM	
098	Pediatric Cardiology		PDC

A10. (Continued:)

099	Preventive Medicine, Epidemiology or Public Health	EPI	
099	Preventive Medicine, Epidemiology or Public Health	OE	
099	Preventive Medicine, Epidemiology or Public Health	PH	
099	Preventive Medicine, Epidemiology or Public Health	PHP	
199	Pharmaceutical Medicine	PHM	
100	Physical Medicine & Rehabilitation		PM
100	Physical Medicine & Rehabilitation		IAR
100	Physical Medicine & Rehabilitation		PDR
314	Internal Medicine/Physical Medicine & Rehabilitation	MPM	
100	Physical Medicine & Rehabilitation		RM
200	Physical Medicine & Rehabilitation (Pediatrics)		PMP
101	Hand Surgery-Plastic Surg		HSP
102	Plastic Surgery		OOP
102	Plastic Surgery		PLR
103	Anatomic Pathology	AP	
104	Blood Banking-Transfusion Medicine		BBT
104	Blood Banking-Transfusion Medicine		LBM
105	Clinical Pathology	CLP	
106	Dermatopathology	DPT	
107	Hematology-Pathology		HEP
108	Medicine Microbiology	MMB	
109	Neuropathology	NPT	
110	Chemical Pathology	CP	
111	Cytopathology	CY	
112	Immunopathology		IPT
113	Pediatric Pathology	PP	
114	Anatomic/Clinical Pathology	APL	
114	Anatomic/Clinical Pathology	PTH	
115	Radioisotopic Pathology	RIP	
307	Public Health	PH	
196	Internal Medicine/Preventive Medicine	IPM	
116	Pulmonary Diseases	PUD	
116	Pulmonary Diseases	PUL	
117	Nuclear Radiology	NR	
118	Pediatric Radiology	PRD	
119	Radiology	DUS	
119	Radiology	R	
119	Radiology	RI	
119	Radiology	RT	
119	Radiology	RTD	
120	Neuroradiology	NRA	

A10. (Continued:)

121	Radiological Physics		RP
122	Angiography & Intervent'l Radiology		ANG
122	Angiography & Intervent'l Radiology		SCL
123	Radiation Oncology	RO	
123	Radiation Oncology	TR	
124	Cardiovascular or Thoracic Cardiovascular Surgery		CVS
124	Cardiovascular or Thoracic Cardiovascular Surgery		TS
125	Urology	U	
125	Urology	URS	
126	Pediatric Urology	UP	
127	Addictive Diseases	ADD	
128	Critical Care-Medicine	CCM	
129	Legal Medicine	LM	
130	Clinical Pharmacology	PA	
131	Unknown Blank		
133	Adolescent Medicine	ADL	
134	Orthopedic Foot & Ankle Surg	OFA	
135	Forensic Psychiatry	FPS	
136	Hematology & Oncology	HEO	
137	Internal Med-Pediatrics	IPD	
139	Toxicology		TX
142	Psychosomatic Medicine	PYM	
145	Pediatric Infectious Diseases		PID
146	Pediatric Ophthalmology	PO	
147	Pulmonary-Critical Care	PUC	
153	MOHS Micrographic Surgery		DMS
154	Hair Transplant		HT
155	Osteo Manipulative Treat +1	OM1	
156	Osteopathic Manipulative Medicine	OMM	
157	Sports Medicine - OMM	OMS	
158	Osteo Manipulative Medicine	OMT	
159	Proctology		PRO
160	Internship		IN
161	Retired	RET	
162	Transitional Year	TY	
209	Nuclear Cardiology	NC	
210	Developmental & Behavioral Pediatrics	DBP	
159	Proctology		PRO
124	Thoracic Surgery	TS	
410	Clinical Neurophysiology		CN
411	Hematology/Oncology	HO	
413	Nutrition	NTR	
414	Pulmonary Critical Care Medicine	PCC	
415	Pediatric Infectious Disease	PDI	
416	Pediatric Nephrology		PN

A10. (Continued:)

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (10

(If code 003, 005-007, 013-014, 018, 025, 028, 057, 099, 103-115, 117-122, 129-131, 135, 138-141, 148, 160-162, 209, 301-307, or 402 in A10, Continue; Otherwise, Skip to Note before A11)

(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)**

(If code 201 in A10, Skip to A17; Otherwise, Continue)

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

1 Yes
2 No
8 (DK)
9 (Refused) _____(1358)

(Question A12 deleted) HOLD _____(1630)

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

1 Yes
2 No
8 (DK)
9 (Refused) _____(1631)

(If code 2, 8, or 9 in A11 AND A13, Skip to A17; Otherwise, Skip to A19)

(Question A14 deleted) HOLD _____(1633)

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

BDCTPSP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1634)

(If code 1 in A15, Skip to A19; Otherwise, Continue)

(Question A16 deleted) HOLD _____(1636)

A17. Are you board certified in any specialty?

BDCTAY

1 Yes
2 No
8 (DK)
9 (Refused) _____(1078)

(Question A18 deleted) HOLD _____(1079)

A19. Many of the remaining questions are about your practice and your relationships with patients. Before we begin those questions, let me ask you: Thinking very generally about your satisfaction with your overall career in medicine, would you say that you are CURRENTLY **(read 5-1)**?

CARSAT

5 Very satisfied
4 Somewhat satisfied
3 Somewhat dissatisfied
2 Very dissatisfied, OR
1 Neither satisfied nor dissatisfied

8 (DK)
9 (Refused) _____(1080)

CLOCK:

_____ _____

SECTION B
UTILIZATION OF TIME; PRODUCTIVITY; INFORMATION BROUGHT BY PATIENTS; CASE MIX

TIME AND PRODUCTIVITY

B1. Approximately how many weeks did you practice medicine during 2003? Exclude time missed due to vacation, illness, and other absences. **(If necessary, say:)** 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. **(INTERVIEWER NOTE: Response refers to all practices, not just main practice)** (Open ended **and code actual number)**

WKSWRK

53-
97 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (10

B2. 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. **(INTERVIEWER NOTE: If necessary, read:)** Direct patient care includes time spent on patient record keeping, patient-related office work, and travel time connected with seeing patients. (Open ended **and code actual number) (INTERVIEWER NOTE: Response refers to all practices, not just main practice)**

HRSMD_A

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____

[Deleted Note]

B3. **(If code 001-168 in B2, ask:)** Of these **(response in B2)** hours, how many did you spend in direct patient care activities? Direct care of patients includes face-to-face contact with patients, as well as patient record keeping and office work, travel time connected with seeing patients, and communication with other physicians, hospitals, pharmacies, and other places on a patient's behalf. **(INTERVIEWER NOTE:)** **(If necessary, say:)** 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, say:)** 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, say:)** 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, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

HRSPT_A

169-
997 (BLOCK)

DK (DK) **(Skip to Note after B5)**
RF (Refused) **(Skip to Note after B5)**

_____ _____

_____
(1086 - 1088)

(If response in B3 = response in B2, Continue;
If response in B3 > response in B2, Skip to B4;
Otherwise, Skip to Note after B5)

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

ALLPAT

1 Yes - **(Skip to Note after B5)**

2 No - **(Continue)**

8 (DK) **(Skip to Note after B5)**
9 (Refused) **(Skip to Note after B5)** _____(1115)

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?

MEDPAT

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 Note after B5)**
8 (DK) **(Skip to Note after B5)**
9 (Refused) **(Skip to Note after B5)** _____(1116)

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)**

HRSMD_B

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (11

(If code 1 in B3b, Skip to Note after B5; Otherwise, Continue)

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, say:)** 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, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

HRSPT_B

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (11

(All in B3d, Skip to Note after B5)

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)**

HRSMD_C

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____

B5. And of those total [**(response in B4)**] hours, about how many did you spend in direct patient care activities? **(If necessary, say:)** 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, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

HRSPT_C

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (10

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8
OR If code 1, 8, or 9 in A9 OR
If code 042, 088, or 137 in A10 OR
If code 2 or 3 in A9a OR
If code 2 or 3 in A9b, Continue;
Otherwise, Skip to B6)

(Deleted CLOCK) HOLD ___
3560)

B5a. Again, thinking of your last complete week of work, how many patient visits did you personally have in each of the following settings? Please count as one visit each time you saw a patient. How about **(read and rotate A-D)**? (Open ended **and code actual number)** **(INTERVIEWER NOTE: The categories in this question are mutually exclusive. If a respondent works in an outpatient clinic but is asked the "in the office" item first and gives a number, code the number given for "in the office" into the "outpatient clinic" item and recode the response to "office" to 0)** **(SURVENT NOTE: Allow interviewers to verify responses over 400 in any category. In this instance, interviewer say:)** That's **(response in A-D, as appropriate)**, right? **(If respondent wants to change their response, allow interviewer to enter the new number in place of the old number.)**

000 None
997 997+
998 (DK)
999 (Refused)

OFFICEV

A. In the office

_____ _____

(3401 - 3403)

OUTPTV

B. In outpatient clinics

_____ _____

(3404 - 3406)

NURSHMV

C. In nursing homes and other extended care facilities

_____ _____

(3407 - 3409)

HOSPV

D. On hospital rounds

_____ _____

(3410 - 3412)

(Deleted CLOCK) HOLD

3416)

B6. 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)**

(If necessary, say:) EXCLUDE bad debt and time spent providing services under a discounted fee for service contract or seeing Medicare and [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL patients/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access") patients/**(Otherwise, read:)** Medicaid patients]. **(If necessary, read:)** By the LAST MONTH, we mean the last 4 weeks.

HRFREE

000 None
DK (DK)
RF (Refused)

_____ _____
_____ (25

(If code 000 in B6, Skip to B12; Otherwise, Continue)

B6a. Where do you typically provide charity care, **(read and rotate 1-3, then 4)**? **(INTERVIEWER NOTE: If respondent provides charity care in more than one place, ask for the one where they provide care most often.)**

LOCFREE

1 In your main practice
2 On-call at a hospital emergency department
3 In another practice or clinic
4 Or somewhere else

8 (DK)
9 (Refused) _____(3417)

(Questions B7-B11 deleted) HOLD _____(3207-3212)

HOLD _____(3256-3258)

HOLD _____(3418-3421)

HOLD _____(3215-3216)

CASE MIX

(Deleted CLOCK) HOLD _____(3422-3425)

B12. About what percentage of your patients has a chronic medical condition? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

CHRNPT

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____

_____
(3426 - 3428)

[Deleted Note]

(Question B13 deleted) HOLD _____(3429-3431)

B14. About what percentage of your patients are **(read and rotate A-C)**? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

BLCKPT

A. African-American or Black

_____ _____

_____
(3432 - 3434)

HISPPT

B. Hispanic or Latino

_____ _____

_____
(3435 - 3437)

ASIAPT

C. Asian or Pacific Islander

_____ _____

_____

(3438 - 3440)

B15. About what percentage of your patients do you have a hard time speaking with or understanding because you speak different languages? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

LANGPT

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____
_____
(3441 - 3443)

CLOCK:

_____ _____
_____ (21

SECTION C
TYPE AND SIZE OF PRACTICE

(Question CA deleted)

(READ:) Now, I would like to ask you a series of questions about the main practice in which you work.

C1. Are you a full owner, a part owner, or not an owner of this practice? **(INTERVIEWER NOTE: A shareholder of the practice in which they work should be coded as 2 - Part owner)**

OWNPR

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)**

_____(1104)

C2. **(If code 1 or 2 in C1, ask:)** Which of the following best describes this practice? Is it **(read 06-16, then 01)**? **(INTERVIEWER NOTE: A free-standing clinic includes non-hospital-based ambulatory care, surgical, and emergency care centers)**

TOPOWN

01	OR, something else (list)
02-05	HOLD
06	A practice owned by one physician (solo practice)
07	A two physician-owned practice
08	A group practice of three or more physicians (see AMA definition on card)
09	A group model HMO
10	A staff model HMO
11-15	HOLD
16	A free-standing clinic
98	(DK)
99	(Refused)

_____ _____
_____ (1105) (1106)

(If code 08 or 16 in C2, Continue; Otherwise, Skip to C7)

C2a. Is the practice a single-specialty or multi-specialty practice?

OWNNSPC

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1637)

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C2c; Otherwise, Continue)

C2b. Are any of the physicians in the practice in primary care specialties? **(Probe:)** By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

OWNPCP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1638)

(All in C2b, Skip to C7)

C2c. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics or general internal medicine?

OWNSPEC

1 Yes
2 No
8 (DK)
9 (Refused) _____(1639)

(All in C2c, Skip to C7)

C3. **(If code 3, 8, or 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, say:)** 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.

TOPEMP

01 OR, something else (do NOT list here) - **(Skip to C3b)**

02-05 HOLD

06 A practice owned by one physician (solo practice) - **(Skip to C7)**

07 A two physician-owned practice - **(Skip to C7)**

08 A group practice of three or more physicians (see) AMA definition on card) - **(Continue)**

09 A group model HMO **(Skip to C7)**

10 A staff model HMO **(Skip to C7)**

12 A medical school or university **(Skip to C6b)**

13 A non-government hospital or group of hospitals **(Skip to C6b)**

14 City, county or state government - **(Skip to C3a)**

16 A free-standing clinic - **(Continue)**

98 (DK) **(Skip to C3b)**

99 (Refused) **(Skip to C3b)**

_____ _____
(1107) (1108)

C3aa. **(If code 08 or 16 in C3, ask:)** Is the practice a single-specialty or multi-specialty practice?

EMPNSPC

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1640)

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C3ac; Otherwise, Continue)

C3ab. Are any of the physicians in the practice in primary care specialties? **(Probe:)** By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

EMPPCP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1641)

(All in C3ab, Skip to C7)

C3ac. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics or general internal medicine?

EMPSPEC

1 Yes
2 No
8 (DK)
9 (Refused) _____(1642)

(All in C3ac, Skip to C7)

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

OTHSET

1 Hospital
2 Clinic
3 Other (do NOT list)

8 (DK)
9 (Refused) _____(1198)

**(If code 1 in C3a, Skip to CX;
Otherwise, Skip to Note before C8a)**

C3b. **(If code 01, 98, or 99 in C3, ask:)** Are you employed by **(read 11-21, 22, 25, and 26, as appropriate, then 01)**?

EMPTYP

01 OR, something else (do NOT list here)

02-
10 HOLD

11 Other HMO, insurance company, or health plan
15 An integrated health or delivery system
17 A physician practice management company or other for-profit investment company
18 Community health center
19 Management Services Organization (MSO)
20 Physician-Hospital Organization (PHO)
21 Locum tenens
22 Foundation
25 Independent contractor
26 Industry clinic

98 (DK)
99 (Refused)

_____ _____
_____ (1199) (1200)

**(If code 01 in C3b, Continue;
If code 18, 98, or 99 in C3b, Skip to C7;
If code 22 in C3b, Skip to C3ca;
Otherwise, Skip to Note before C8a)**

C3c. What type of organization do you work for? (Open ended and code, **if possible; otherwise, ENTER VERBATIM RESPONSE)**

EMPTYP2

01 Other (list)

02-
05 HOLD

06 A practice owned by one physician (solo practice)
07 A two physician-owned practice
08 A group practice of three or more physicians (see) AMA definition on card)
09 A group model HMO
10 A staff model HMO
12 A medical school or university
13 A non-government hospital or group of hospitals
14 City, county or state government
16 A free-standing clinic
17 HOLD
18 Community health center
19-
21 HOLD
22 Foundation
25 Independent Contractor
26 Industry Clinic

98 (DK)
99 (Refused)

_____ _____
_____ (1643) (1644)

(If code 01, 25, or 26 in C3c, Skip to Note before C8a;
If code 06, 07, 09, 10, 18, 98, or 99 in C3c, Skip to C7;
If code 08, 16, or 22 in C3c, Continue;
If code 12 or 13 in C3c, Skip to C6b;
Otherwise, Skip to C3d)

C3ca. **(If code 08, 16, or 22 in C3c or code 22 in C3b, ask:)** Is the practice a single-specialty or multi-specialty practice?

EM2NSPC

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1097)

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C3cc; Otherwise, Continue)

C3cb. Are any of the physicians in the practice in primary care specialties? By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

EM2PCP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1098)

(All in C3cb, Skip to C7)

C3cc. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics, or general internal medicine?

EM2SPEC

1 Yes
2 No
8 (DK)
9 (Refused) _____(1099)

(All in C3cc, Skip to C7)

C3d. **(If code 14 in C3c, ask:)** Is this a hospital, clinic, or some other setting?

EM2HOSP

1 Hospital
2 Clinic
3 Other (do NOT list)

8 (DK)
9 (Refused) _____(1662)

**(If code 1 in C3d, Skip to CX;
Otherwise, Skip to Note before C8a)**

(Questions C4-C6a deleted)

[Deleted Note]

C6b. In which of the following settings do you spend most of your time seeing patients - in an office practice owned by the hospital or a university or medical school, on hospital staff, in the emergency room, in a hospital clinic, or somewhere else?

SETTING

01 Somewhere else (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

06 Office practice owned by the (hospital/ university/medical school)
07 On hospital staff
08 In emergency room
09 In a hospital clinic

_____ _____
_____ (3217) (3218)

**(If code 07 or 08 in C6b, Skip to CX;
If code 01, 02, 03, or 09 in C6b,
Skip to Note before C8a;
Otherwise, Continue)**

C7. How many physicians, including yourself, are in the 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)**

NPHYS

997 997+
DK (DK)
RF (Refused)

_____ _____
_____ (11

(Question C8 deleted) HOLD _____(1151-1153)

(If code 2 in S1c OR
If response in A6 is less than 2002, DK, or RF, Continue;
Otherwise, Skip to Note before C9)

C8a. The next question is about the overall level, that is, the quality and number of nurses, including RNs, LPNs, nurse aides, and assistants, who work in your practice. Compared with three years ago, is the overall level of nursing support in your practice much better, slightly better, about the same, slightly worse, or much worse?

NURSLEV

5 Much better
4 Slightly better
3 About the same
2 Slightly worse
1 Much worse

6 (DK)
7 (Refused) _____(1159)

(If code 1 or 2 in C8a, Continue;
Otherwise, Skip to Note before C9)

C8aa. Has the overall level of nursing support worsened mainly because you have fewer nurses, mainly because nursing quality has declined, or both about equally?

1 Fewer nurses
2 Nursing quality has declined
3 (Both about equally)
4 (DK)
5 (Refused) _____(1160)

(If code 06 in C6b, Skip to CX; If code 08 in C2 or C3 AND code 025-997 in C7, Continue; Otherwise, Skip to CX)

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

GRPHMO

1 Yes
2 No
8 (DK)
9 (Refused) _____(1154)

(Questions C10-C12 deleted)

CX. How would you describe your overall personal financial incentives in your practice? On balance, do these incentives favor reducing services to individual patients, favor expanding services to individual patients, or favor neither?

INCENT

1 Reducing services to individual patients **(Continue)**
2 Expanding services to individual patients **(Continue)**

3 Favor neither - **(Skip to CZ)**

8 (DK) **(Skip to CZ)**
9 (Refused) **(Skip to CZ)** _____(3271)

CY. **(If code 1 or 2 in CX, ask:)** Have these incentives [**(if code 1 in CX, say:)** reduced/**(if code 2 in CX, say:)** expanded] services a little, a moderate amount, or a lot?

EFINCNT

1 A little
2 A moderate amount
3 A lot

4 (None)
8 (DK)
9 (Refused) _____(3272)

CZ. The next question deals with your perception of competition among physicians. By competition among physicians, we mean pressure to undertake various activities to attract and retain patients. Now, thinking about your practice specifically, how would you describe the competitive situation your practice faces? Would you say very competitive, somewhat competitive, or not at all competitive?

COMPETE

3 Very competitive
2 Somewhat competitive
1 Not at all competitive

8 (DK)
9 (Refused) _____(3273)

CLOCK:

_____ _____
_____ (21

SECTION D
MEDICAL CARE MANAGEMENT; INFORMATION TECHNOLOGY; CARE MANAGEMENT; HOSPITAL SAFETY; SCOPE OF CARE

INFORMATION TECHNOLOGY

D1. The next question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients. In your practice, are computers or other forms of information technology used **(read and rotate A-H)**? **(INTERVIEWER NOTE: "Practice" refers to main practice)**

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

IT_TRT

A. To obtain information about treatment alternatives or recommended guidelines

IT_FORM

B. To obtain information on formularies _____(3228)

ITRMNDR

C. To generate reminders for you about preventive services _____(3229)

ITNOTES

D. To access patient notes, medication lists, or problem lists _____(3230)

ITPRESC

E. To write prescriptions _____(3231)

ITCLIN

F. For clinical data and image exchanges WITH OTHER PHYSICIANS ___

ITHOSP

F1. For clinical data and image exchanges WITH HOSPITALS AND LABORATORIES _____(3444)

D1. (Continued:)

ITCOMM

G. To communicate about clinical issues with patients by e-mail

ITDRUG

H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions _____(3251)

(If code 1 in D1-E, Continue; Otherwise, Skip to D3)

(Question D2 deleted)

(There are no questions D2a and D2b)

D2aa. What percentage of the prescriptions that you order are written electronically? (Open ended **and code actual percent)**

EPRESC

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____

_____
(3445 - 3447)

[Deleted Note]

(Questions D2ab-D2ad deleted) HOLD ___ 3450)

CARE MANAGEMENT

D3. What percentage of your patients have prescription coverage that includes the use of a formulary? **(INTERVIEWER NOTE: A formulary is a restriction on the types of prescription drugs insurance companies will cover)** (Open ended **and code actual percent)**

FORMLRY

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____

_____ (32

[Deleted Read]

(Question D4 deleted)

D4-A. How large an effect does 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 he/she uses his/her own guidelines, say:)** 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.] Would you say that the effect is **(read 5-0)**?

EFGUIDE

5 Very large
4 Large
3 Moderate
2 Small
1 Very small, OR
0 No effect at all

8 (DK)
9 (Refused) _____(1157)

D4-A1. **(If code 0 in D4-A, ask:)** Is that because you are not aware of guidelines that pertain to conditions you typically treat, or because you are aware of them, but they have no effect on conditions you treat?

AWRGUID

1 Not aware
2 Aware, no effect

8 (DK)
9 (Refused) _____(1158)

(D4-B, D4-B1, D4-C, D4-C1, and D5 deleted) HOLD _____(3242-3250)

(There is no question D6) HOLD ___ 3255)

HOSPITAL SAFETY

[Deleted CLOCK] HOLD ___

3283)

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR
If code 1, 8, or 9 in A9, OR
If code 042, 088, or 137 in A10, OR
If code 2 or 3 in A9a, OR
If code 2 or 3 in A9b, AND
If code 000, 998, or 999 in B5a-D, Skip to D7; Otherwise, Continue)

D6a. Does the hospital where most of your patients are treated have computerized systems to order tests and medications?

CPOEHSP

1 Yes
2 No
3 (Not applicable; Do not admit patients to hospital)
8 (DK)
9 (Refused) _____(3451)

D6b. Medical errors include events such as dispensing of incorrect medication doses, surgical mistakes, or error in interpreting results of diagnostic tests. Does the hospital where most of your patients are treated have a system for reporting medical errors, in which the person reporting the error remains anonymous? **(If necessary to clarify term "medical errors", read:)** Some errors harm patients, some are caught before they can cause any harm, and others may occur but don't cause any harm.

ERRREPT

1 Yes
2 No
3 (Not applicable; Do not admit patients to hospital)
8 (DK)
9 (Refused) _____(3452)

D7. Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. What percentage of your patients who were hospitalized last year had a hospitalist involved in their inpatient care? (Open ended **and code actual percent)**

HSPLST

000 None
101 Less than 1%
102 (DK)
103 (Refused)
104 (Not applicable/Do not admit patients to hospital)

_____ _____

(3453 - 3455)

[Deleted CLOCK] HOLD
(3284-
3287)

(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR
If code 1, 8 or 9 in A9, OR
If code 042, 088, or 137 in A10, OR
If code 2 or 3 in A9a, OR
If code 2 or 3 in A9b, Continue;
Otherwise, Skip to CLOCK before F1)

PCP SCOPE OF CARE, GATEKEEPING

(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.

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)**?

CMPEXPC

5 Much greater than it should be
4 Somewhat greater than it should be
3 About right
2 Somewhat less than it should be, OR
1 Much less than it should be

8 (DK)
9 (Refused) _____(1170)

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

SPECUSE

5 Increased a lot
4 Increased a little
3 Stayed about the same
2 Decreased a little, OR
1 Decreased a lot

8 (DK)
9 (Refused) _____(1171)

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, say:) The term "gatekeeper" is often used to refer to this role.

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

PCTGATE

000 None **(Skip to CLOCK before F1)**
001 1% or less **(Skip to CLOCK before F1)**

002-100 **(Skip to CLOCK before F1)**

DK (DK) **(Continue)**
RF (Refused) **(Continue)**

_____ _____
_____ (11

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

PGATE25

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 CLOCK before F1)**
9 (Refused) **(Skip to CLOCK before F1)** ___

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

PGATE50

1 Less than 50 percent of your patients
2 50 percent or more of your patients

8 (DK)
9 (Refused) _____(1176)

(All in D10b, Skip to CLOCK before F1)

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

PGATE10

1 Less than 10 percent of your patients
2 10 percent or more of your patients

8 (DK)
9 (Refused) _____(1177)

[Deleted Note]

(There are no questions D11, D12, or D13)

(Question D14 deleted) HOLD _____(3456)

CLOCK:

_____ _____
_____ (22

(There is no Section E)

SECTION F
PHYSICIAN-PATIENT INTERACTIONS; QUALITY; ABILITY TO OBTAIN SERVICES; COST SHARING; NEW PATIENTS

PERCEPTIONS OF QUALITY

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 necessary, say:)** As you answer, please think only about your main practice.] **(Read A-B, as appropriate, then read and rotate C-H, as appropriate)** Do you **(read 5-1)**? **(If necessary, say:)** We'd like you to think across all patients that you see in your practice.

5 Agree strongly
4 Agree somewhat
3 Neither agree nor disagree
2 Disagree somewhat, OR
1 Disagree strongly

7 (Doctor does not have office) [A only]
7 (Doctor does not have continuing relationship with patients) [H only]
8 (DK)
9 (Refused)

ATMOFF

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, say:)** We would like you to answer in general or on AVERAGE over all types of visits. _____(1308)

ATMOTH

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)**

CLNFREE

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

HIGHCAR

D. It is possible to provide high quality care to all of my patients ___

F1. (Continued:)

NEGINCN

E. I can make clinical decisions in the best interests of my patients without the possibility of reducing my income _____(1311)

(Items F and G deleted) HOLD _____(1312-1313)

PATREL

H. It is possible to maintain the kind of continuing relationships with patients over time that promote the delivery of high quality care

(There are no questions F2-F7)

ABILITY TO OBTAIN SERVICES

(Question F8 and F8a deleted)

[Deleted CLOCK] HOLD ___ 3465)

F8b. During the last 12 months, were you unable to obtain any of the following services for your patients when you thought they were medically necessary? How about **(read and rotate A-E, as appropriate)**?

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

OBREFSR

A. [**(If code 019, 020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or if code 042, 088, or 137 in A10, 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] _____(3457)

(Item B deleted) HOLD _____(3458)

OBHOSPR

C. Non-emergency hospital admissions _____(3459)

OBIMAGR

D. High quality diagnostic imaging services ___

E. **(If code 010, 019, 020, 023, 043, 062, 064-065, 082-085, 127, 132, 133, 210, 312, 313, 192, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or code 2 or 3 in A9a, or code 042, 088 or 137 in A10, OR code 2 or 3 in A9b, ask:)** High quality outpatient mental health services _____(3461)

[Deleted CLOCK] HOLD ___
3469)

F8c. Now, I am going to read some reasons why you might be unable to obtain various services. For each one, tell me whether it is a very important, moderately important, not very important, or not at all important reason for your being unable to obtain **(read A-C, as appropriate)**. How about **(read and rotate a-c)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

A. **(If code 1 in F8b-A, ask:)** [**(If code 019, 020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or if code 042, 088, or 137 in A10, 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]

REFPRVR

a. There aren't enough qualified service providers or facilities in my area ___

REFHPR

b. Health plan networks and administrative barriers limit patient access ___

REFINSR

c. Patients lack health insurance or have inadequate insurance coverage ___

B. **(If code 1 in F8b-C, ask:)** Non-emergency hospital admissions

HSPPRVR

a. There aren't enough qualified service providers or facilities in my area ___

HSPHPR

b. Health plan networks and administrative barriers limit patient access ___

HSPINSR

c. Patients lack health insurance or have inadequate insurance coverage ___

F8c. (Continued:)

C. **(If code 1 in F8b-E, ask:)** High quality outpatient mental health services, when you think it is medically necessary

MHPROVR

a. There aren't enough qualified service providers or facilities in my area ___

MHHPR

b. Health plan networks and administrative barriers limit patient access ___

MHINSR

c. Patients lack health insurance or have inadequate insurance coverage ___

COST SHARING

[Deleted CLOCK] HOLD ___
3482)

F8d. The next questions concern the impact of insured patients' out-of-pocket costs for co-payments and deductibles. **(Read and rotate A-C)**

5 Always
4 Usually
3 Sometimes
2 Rarely
1 Never

8 (DK)
9 (Refused)

GENERIC

A. If a generic option is available, how often do you prescribe a generic over a brand name drug? **(Read 5-1)**

DIAGCST

B. If there is uncertainty about a diagnosis, how often do you consider an insured patient's out-of pocket costs in deciding the types of tests to recommend? **(Read 5-1)** ___

IOPTCST

C. If there is a choice between outpatient and inpatient care, how often do you consider an insured patient's out-of-pocket costs? **(Read 5-1)** _____(3485)

[Deleted CLOCK] HOLD

3489)

NEW PATIENTS

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 **(read A-G, as appropriate)**? **(INTERVIEWER NOTE: Refers to entire practice not just to physician's own patients. 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)

NWMCARE

A. New patients who are insured through Medicare, including Medicare managed care patients ___

NWMCAID

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** New patients who are insured through MediCAL, including MediCAL managed care patients/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code AZ in A5a-STATE}, read:)** New patients who are insured through AHCCCS ("Access")/**(Otherwise, read:)** New patients who are insured through Medicaid, including Medicaid managed care patients _____(1322)

(Item B1 deleted) HOLD _____(3490)

NWPRIV

C. New patients who are insured through 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 _____(1324)

(Item D deleted) HOLD _____(3269)
(There are no Items E or F)

NWNPAY

G. New uninsured patients who are unable to pay your fees ___

(Question F10 deleted) HOLD _____(3270)

[Deleted CLOCK] HOLD ___ 3494)

(If code 1 or 2 in F9-A, Continue; Otherwise, Skip to Note before F12)

F11. I am going to read some reasons why physician practices may be limiting or not accepting new Medicare patients. For each one, tell me whether it is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in F9-A, read:)** not accepting/**(If code 2 in F9-A, read:)** limiting] new Medicare patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

MRBILL

A. Billing requirements, including paperwork, and filing of claims _____(3496)

MRAUDIT

B. Concern about a Medicare audit ___

MRREIMB

C. Inadequate reimbursement ___

MRNUFPT

D. Practice already has enough patients _____(3499)

MRPTBUR

E. Medicare patients have high clinical burden _____(3500)

(If code 1 or 2 in F9-B, Continue; Otherwise, Skip to CLOCK after F12)

F12. Next, I am going to read some reasons why physician practices may be limiting or not accepting new [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients. Again, tell me whether each one is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in F9-B, read:)** not accepting/**(If code 2 in F9-B, read:)** limiting] new [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

MDBILL
A. Billing requirements, including paperwork, and filing of claims _____(3501)

MDDELAY
B. Delayed reimbursement _____(3502)

MDREIMB
C. Inadequate reimbursement ___

MDNUFPT
D. Practice already has enough patients _____(3504)

MDPTBUR
E. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients have high clinical burden

CLOCK:

_____ _____
_____ (2216 - 2219)

SECTION G
PRACTICE REVENUE

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, say:)** We're asking about the patient care revenue of the practice in which you work, not just the revenue from the patients YOU see. **(INTERVIEWER NOTE: "Other public insurance" includes Champus, Champva, and Tricare)**

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

PMCR_A

A. Payments from all Medicare plans, including Medicare managed care

_____ _____
_____ (1325 - 1327)

PMCD_A

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** Payments from MediCAL or any other public insurance, including MediCAL managed care/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** Payments from AHCCCS ("Access") or any other public insurance/**(Otherwise, read:)** Payments from Medicaid or any other public insurance, including Medicaid managed care]

_____ _____
_____ (1328 - 1330)

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

G1a. I have recorded that the combined practice revenue from Medicare and [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** 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, say:)** 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% or less
DK (DK)
RF (Refused)

PMCR_B

A. Payments from all Medicare plans, including Medicare managed care

_____ _____
_____ (1334 - 1336)

PMCD_B

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid]

_____ _____
_____ (1337 - 1339)

(There is no question G2)

[Deleted Note]

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, say:)** 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)**

PCAP_A

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

_____ _____
_____ (2438 - 2440)

(There are no questions G3a-G5)

[Deleted Note]

(Question G5a deleted) HOLD _____(3509-3514)

(Question G5b deleted)

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:)** Your best estimate would be fine. **(If necessary, say:)** 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)**

NMC_A

00	None -	**(Skip to G7)**
01-19		**(Skip to G8)**
20-97		**(Skip to G6b)**
98	98+ contracts	**(Skip to G6b)**
DK	(DK)	**(Continue)**
RF	(Refused)	**(Continue)**

_____ _____
_____ (2458) (2459)

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

NMCCAT

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)	**(Skip to G8)**
9	(Refused)	**(Skip to G8)**

_____(2460)

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

CONPATS

1 Contracts - **(Skip to G8)**

2 Patients - **(Continue)**

8 (DK) **(Skip to G8)**
9 (Refused) **(Skip to G8)** _____(1340)

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

NMC_B

00 None - **(Continue)**

01-
97 **(Skip to G8)**

DK (DK) **(Skip to G8)**
RF (Refused) **(Skip to G8)**

_____ _____
_____ (1341) (1342)

G7. **(If code 00 in G6, or code 0 in G6a, or code 00 in G6c, 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, say:)** Managed care programs include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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)**

PMC_A

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

_____ _____
_____ (1343 - 1345)

(If code 00 in G6,
and G7 is LESS THAN response in G3, Continue;
If code 00 in G6a or G6c,
And G7 is LESS THAN response in G3, Continue;
Otherwise, Skip to CLOCK before Section H)

G7a. I may have recorded something incorrectly. I recorded that the percentage of practice revenue from all managed care is less than the percentage of practice revenue that is paid on a capitated or other prepaid basis. This seems inconsistent, so let me ask you again, what percent of patient care revenue received by the practice in which you work comes from all managed care combined? (Open ended **and code actual percent)** **(SURVENT: Show response in G7)**

PMC_F

000 None
101 Less than 1%
DK (DK)

RF (Refused)

_____ _____
_____ (2548 - 2550)

G7b. Let me also ask you 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? (Open ended **and code actual percent)** **(SURVENT: Show response in G3)**

PCAP_D

000 None
101 Less than 1%
DK (DK)
RF (Refused)

_____ _____
_____ (2551 - 2553)

(All in G7b, Skip to CLOCK before Section H)

G8. **(If code 02-97 in G6c, or code 1-3 in G6a, or code 02-97 in G6, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from these **(response in G6c/G6a/G6)** managed care contracts combined? [**(If code 001-100, DK, or RF in G3, say:)** 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, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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 G6c or G6, 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, say:)** Please include ALL revenue from this contract including, but not limited to, any payments made on a capitated or prepaid basis.] **(Probe once lightly:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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)**

G8. (Continued:)

(If code "DK" or "RF" in G6c, or code 8 or 9 in G6a, 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, say:)** Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis.] **(Probe once lightly:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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)**

PMC_B

000	None	**(Continue)**
001	1% or less	**(Continue)**
002-100		**(Continue)**
DK	(DK)	**(Skip to CLOCK before Section H)**
RF	(Refused)	**(Skip to CLOCK before Section H)**

_____ _____
_____ (2462 - 2464)

(If response in G8 is less than response in G3, Continue;
If response in G3 + response in G8=0, Skip to CLOCK before Section H;
If response in G8 > 000, Skip to G8d)

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)**?

FIXPMC

1 **(Response in G8)** percent from all managed care contracts - **(Continue)**

OR

2 **(Response in G3)** percent received on a capitated or prepaid basis - **(Skip to G8c)**

3 (Both) - **(Continue)**

4 (Neither) **(Skip to CLOCK before Section H)**
8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(2465)

**(If code 01-19 in G6, Skip to G8b;
If code 20-97 in G6,
AND code 1 in G6b, Skip to G8b;
If code 8, 9 or BLANK in G6a, AND
code DK, RF, or BLANK in G6c, Skip to G8d;
Otherwise, Continue)**

G8b. **(If code 1 or 3 in G8a, ask:)**
(If code 02-97 in G6c, or code 1-3 in G6a or code 02-97 in G6, 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 G6c or G6, 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)**

PMC_C

000 None - **(Skip to CLOCK before Section H)**

001 1% or less
DK (DK)
RF (Refused)

_____ _____
_____ (2466 - 2468)

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, say:)** 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)**

PCAP_B

000 None
001 1% or less

002-
100

DK (DK)
RF (Refused)

_____ _____
_____ (1352 - 1354)

G8d. **(If "specific" response in G8b/G8 = "specific" response in G8c/G3, ask:)** So, all of the practice's managed care revenue is paid on a capitated, or prepaid basis, is this correct?

ALLCAP

1 Yes - **(Skip to CLOCK before Section H)**

2 No - **(Continue)**

8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(1346)

G8e. **(If code 2 in G8d, ask:)** I have recorded that **(response in G8b/G8)** percent of the practice revenue is from managed care and that **(response in G8c/G3)** percent of the practice revenue is paid on a capitated or prepaid basis. Which of these is incorrect?

FIXCAP

1 Revenue from managed care - **(Continue)**

2 Revenue paid on capitated or prepaid basis - **(Skip to G8g)**

3 Both are correct - **(Skip to CLOCK before Section H)**

4 Neither are correct - **(Continue)**

8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(1347)

G8f. **(If code 1 or 4 in G8e, ask:)**
(If code 02-97 in G6c, or G6 or code 1-3 in G6a, ask:) What percentage of the patient care revenue received by the practice in which you work comes from these [**(response in G6c/G6)**] managed care contracts combined? **(If code 001-100, DK, or RF in G3, say:)** 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, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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)**

G8f. (Continued:)

(If code 01 in G6c or 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, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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 G6c or code 8 or 9 in G6a, 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, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** 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)**

PMC_D

000	None -	**(Skip to CLOCK before Section H)**
001	1% or less	**(Continue)**
002-100		**(Continue)**
DK	(DK)	**(Continue)**
RF	(Refused)	**(Continue)**

_____ _____
_____ (1161 - 1163)

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, say:)** 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)**

PCAP_C

000 None
001 1% or less

002-
100

DK (DK)
RF (Refused)

_____ _____
_____ (1191 - 1193)

[Deleted Note]

(There are no questions G9-G10)

(There is no question G11)

(There is no question G12)

CLOCK:

_____ _____
_____ (2224 - 2227)

SECTION H
PHYSICIAN COMPENSATION METHODS AND INCOME LEVEL

(If code 1 in C1, AND code 06 in C2, Skip to H15a; Otherwise, Continue)

(READ:) Now, I'm going to ask you a few questions about how your practice compensates you personally. **(If necessary, say:)** Please answer only about the main practice in which you work.

H1. Are you a salaried physician?
SALPAID

1 Yes - **(Skip to H3)**

2 No **(Continue)**
8 (DK) **(Continue)**
9 (Refused) **(Continue)** ___

H2. **(If code 2, 8, or 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?
SALTIME

1 Yes - **(Skip to H4)**

2 No **(Skip to H4)**
8 (DK) **(Skip to H4)**
9 (Refused) **(Skip to H4)** _____(2511)

H3. **(If code 1 in H1, ask:)** Is your base salary a fixed amount that will not change until your salary is re-negotiated or is it adjusted up or down during the present contract period depending on your performance or that of the practice? **(If necessary, say:)** 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.)**

SALADJ

1 Fixed amount
2 Adjusted up or down
8 (DK)
9 (Refused) _____(2512)

H4. Are you 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)**

BONUS

1 Yes - **(Skip to Note before H5)**

2 No **(Continue)**
8 (DK) **(Continue)**

9 (Refused) - **(Skip to Note before H5)** _____(2513)

H4a. **(If code 2 or 8 in H4, ask:)** Are you eligible to receive end-of-year adjustments, returns on withholds, or any type of supplemental payments, either from this practice or from health plans?

SUPLPAY

1 Yes
2 No
8 (DK)
9 (Refused) _____(3515)

(If code 1 in H2 OR code 1 in H3, Continue; Otherwise, Skip to H7)

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: **(INTERVIEWER NOTE: "Practice" refers to main practice)**

[**(If code 1 in H1, AND code 2 or 8-9 in H4 AND H4a, ask:)** When your salary is determined, does the practice consider **(read A-E)**?

(If code 1 in H1 AND code 1 in H4 OR H4a, ask:) When either your base salary or bonus is determined, does the practice consider **(read A-E)**?

(If code 1 in H2, AND code 2, 8, or 9 in H4 AND H4a, ask:) When your pay rate is determined, does the practice consider **(read A-E)**?

(If code 1 in H2, AND code 1 in H4 OR H4a, ask:) When either your pay rate or bonus is determined, does the practice consider **(read A-E)**?

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

SPROD_A

A. Factors that reflect your own productivity **(If necessary, say:)** 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.

SSAT_A

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS ___

SQUAL_A

C. Specific measures of quality of care, such as rates of preventive care services for your patients _____(2516)

SPROF_A

D. Results of practice profiling 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.) ___

H5. (Continued:)

SPERF_A

E. The overall financial performance of the practice **(INTERVIEWER NOTE: This item refers to the costs and revenues generated by all of the physicians in the practice)**

(If code 2, 8, or 9 to ALL in H5 A-E, Skip to H15a; Otherwise, Skip to Note before H7a)

(Question H6 deleted)

H7. **(If code 2, 8, or 9 in H2, or code 2, 8, or 9 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 practice in which you work consider **(read A-E)**? **(INTERVIEWER NOTE: "Practice" refers to main practice)**

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

SPROD_B

A. Factors that reflect YOUR OWN productivity **(If necessary, say:)** 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.

SSAT_B

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS ___

SQUAL_B

C. Specific measures of quality of care, such as rates of preventive care services for your patients _____(2521)

SPROF_B

D. 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)

H7. (Continued:)

SPERF_B

E. The overall financial performance of the practice **(INTERVIEWER NOTE: This item refers to the costs and revenues generated by all of the physicians in the practice)**

(If code 1 in H5-A or H7-A, H5-B or H7-B, H5-C or H7-C, H5-D or H7-D OR H5-E or H7-E, Continue; Otherwise, Skip to H15a)

[Deleted CLOCK] HOLD ___ 1648)

H7a. For each of the factors you mentioned, tell me whether it is very important, moderately important, not very important, or not at all important in determining your compensation? How about **(read and rotate A-E, as appropriate)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

IMPPROD

A. **(If code 1 in H5-A or H7-A, ask:)** Your own productivity _____(3518)

IMPPSAT

B. **(If code 1 in H5-B or H7-B, ask:)** Satisfaction surveys _____(3519)

IMPQUAL

C. **(If code 1 in H5-C or H7-C, ask:)** Quality of care measures ___

IMPPROF

D. **(If code 1 in H5-D or H7-D, ask:)** Results of practice profiling _____(3521)

IMPRPRF

E. **(If code 1 in H5-E or H7-E, ask:)** Overall practice performance

(There are no questions H8-H12)

[Deleted CLOCK] HOLD ___ 1652)

(Questions H13 and H14 deleted) HOLD _____(3523-3542)

H15a. During 2003, 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. Please include earnings from ALL practices, not just your main practice. **(If necessary, say:)** 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 respondent refuses, say:)** This information is important to a complete understanding of community health care patterns and will be used only in aggregate form to ensure your confidentiality of the information. (Open ended **and code actual number)** **(If response is > $1 million, verify)**

INCOME

0000000-9999999		**(Skip to H18)**
DK	(DK)	**(Continue)**
RF	(Refused)	**(Continue)**

_____ _____
_____ (25

H15b. **(If code DK in H15a, ask:)** Would you say that it was **(read 01-04)**?

(If code RF in H15a, ask:) Would you be willing to indicate if it was **(read 01-04)**?

INCCAT

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)

99 (Refused)

_____ _____

_____ (25

[Deleted Note]

(Questions H16 and H17 deleted) HOLD _____(3543-3548)

H18. Do you consider yourself to be of Hispanic origin, such as Mexican, Puerto Rican, Cuban, or other Spanish background? **(Probe Refusals with:)** I understand this question may be sensitive. We are trying to understand how physicians from different ethnic and cultural backgrounds perceive some of the changes that are affecting the delivery of medical care.

HISP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1659)

H19. What race do you consider yourself to be? **(If respondent hesitates, read 06-09)** **(Probe Refusals with:)** I understand this question may be sensitive. We are trying to understand how physicians from different ethnic and cultural backgrounds perceive some of the changes that are affecting the delivery of medical care.] (Open ended and code) **(INTERVIEWER NOTE: If respondent specifies a mixed race or a race not pre-coded, code as 01 - Other)**

RACE

01 Other (list)

02-
05 HOLD

06 White/Caucasian
07 African-American/Black
08 Native American (American Indian) or Alaska Native
09 Asian or Pacific Islander

98 (DK)
99 (Refused)

_____ _____
_____ (1660) (1661)

[Deleted CLOCK] HOLD ___

2640)

H20. Finally, I am going to list several problems that may limit physicians' ability to provide high quality care. For each one, tell me whether it is a MAJOR PROBLEM, MINOR PROBLEM, OR NOT A PROBLEM affecting your ability to provide high quality care. How about **(read and rotate A-H, as appropriate)**?

3 Major problem
2 Minor problem
1 Not a problem

8 (DK)
9 (Refused)

QNOTIME
A. Inadequate time with patients during office visits _____(3549)

QPRBPAY
B. Patients' inability to pay for needed care _____(3550)

QINSREJ
C. Rejections of care decisions by insurance companies _____(3551)

QNOSPEC
D. Lack of qualified specialists in your area _____(3552)

QNOREPT
E. Not getting timely reports from other physicians and facilities _____(3553)

QLANG
F. Difficulties communicating with patients due to language or cultural barriers ___

(Item G deleted) HOLD _____(3555)

QERRHSP
H. Medical errors in hospitals _____(3556)

CLOCK:

_____ _____
_____ (22

(SURVENT NOTE: If code 2 in S6a, Autocode 2 in I0)

I0. **(If code 1 in S6a, ask:)** Our records indicate that you have already received your $25 honorarium check. Did you receive the check?

CHECK

1 Yes
2 No
8 (DK)

9 (Refused) _____(3275)

SECTION I
ENDING

[Deleted Note]

I1. Let me verify that your name and address are **(read information from fone file/S4)**? **(ENTER ALL THAT ARE INCORRECT) (INTERVIEWER NOTE: Verify PRACTICE ADDRESS)**

*

1 First name is incorrect _____(2554)
2 Last name is incorrect
3 Address is incorrect
4 City is incorrect
5 State is incorrect
6 Zip code is incorrect
7 All information correct

FIRST NAME: **(Display from fone file)**

_____ _____

_____
(1801 - 1816)

LAST NAME: **(Display from fone file)**

_____ _____

_____
(1781 - 1800)

CSTREET

ADDRESS #1: **(Display from fone file)**

_____ _____

_____
(1841 - 1880)

CSTRET2

ADDRESS #2: **(Display from fone file)**

_____ _____

_____
(3013 - 3037)

CCITY

CITY: **(Display from fone file)**

_____ _____

(2682 - 2694)

CSTATE

I1. (Continued:)

STATE: **(Display from fone file)**

_____ _____
_____ (2707) (2708)

CZIP

ZIP CODE: **(Display from fone file)**

_____ _____

_____
(2709 - 2713)

[Deleted Note]

(Question I1a deleted) HOLD _____(2554)

HOLD _____(1781-1816)

(All in I1a, Skip to I4)

(There are no questions #I1a-#I2)

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

ADROKAY

1 **(Address from fone file)** - **(Skip to Note before #I5)**

2 **(If code 3-6 in #I1, say:)** **(Address in #I1)** - **(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)

PSTRET1

STREET ADDRESS #1:

_____ _____

_____

(2732 - 2761)

PSTRET2

STREET ADDRESS #2:

_____ _____

_____

(3088 - 3118)

PCITY

CITY:

_____ _____

_____

(2762 - 2791)

PSTATE

STATE:

_____ _____

_____ (2787) (2788)

PZIP

ZIP:

_____ _____

_____

(2789 - 2793)

(If code 08, 09, or 10 in C2, C3, or C3c, Continue; If code 1 or 2 in C3a, Continue; Otherwise, Skip to J4)

I5. What is the name of the practice we have been talking about during this interview? Include the names of government clinics as eligible responses to this question. **(If necessary, say:)** This information will help us to better understand the nature of physician organizations in your region. (Open ended)

PNAME

00001	Other (list)
00002	HOLD
00003	HOLD
00004	No/Yes mind giving
00005	HOLD
99998	(DK)
99999	(Refused)

_____ _____

(2812 - 2816)

[Deleted Note]

(Question I5a-I5b deleted)

(If code 2 in S1c, Continue; Otherwise, Skip to J4)

I6. Are you with the same medical practice that you were with in January, 2002, or have you changed practices since then? **(If respondent asks, say:)** We will consider you as being in the same practice if your practice changed addresses, clinics, offices, or partners, BUT kept the same parent organization. OR, if your old practice changed ownership; for example, if the practice was sold to an outside organization, but you stayed on under the new ownership. A new practice would be one where you terminated your relationship and joined a different one. **(If respondent has multiple practices and changed one but NOT all of them, say:)** We are interested in whether you are with the same main medical practice that you were with in January, 2002. By main practice, we mean the practice where you spend most of your time.

PRACCHG

1 Yes, same practice - **(Skip to J4)**

2 No, changed practice - **(Continue)**

8	(DK)	**(Skip to J4)**	
9	(Refused)	**(Skip to J4)**	_____(1666)

I7. **(If code 2 in I6, ask:)** In what month and year did you change medical practice? (Open ended **and code month and year)**

MTH_CHG

MONTH:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December

13 (DK)
14 (Refused)

_____ _____
_____ (1667) (1668)

YR_CHG

YEAR: **(SURVENT NOTE: Block all years expect those listed below)**

2002
2003
2004
2005

9998 (DK)
9999 (Refused)

_____ _____
_____
(1669 - 1672)

(There are no questions #I8-#I9)

CLOCK:

_____ _____
_____
(2229 - 2232)

SECTION J
SWEEP-UP

(There are no questions J1-J3)

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

COMMENT

0001 Other (list)
0002-
0003 HOLD
0004 No/Nothing
9998 (DK)
9999 (Refused)

_____ _____

_____
(2555 - 2558)

J5. INTERVIEWER CODE ONLY: **(INTERVIEWER NOTE: Do NOT offer to send study report to respondent. Encourage use of Center's Website, www.hschange.org, and encourage them to put their name on the Center's mailing list by using the Website. Respondents can receive electronic notices of the Center's research, including results of the physician survey when they become available, by signing up on the Center's Web site, www.hschange.org.)** Did respondent ask any of the following?

1 Yes
2 No

A. Center's Web site address so they can access it themselves ___

B. To be placed on the Center's mailing list _____(2821)

(There is no Item C) HOLD ___

J6. INTERVIEWER COMMENTS:

_____ _____

_____
(3118 - 3119)

CLOCK:

_____ _____

_____

(-)

(VALIDATE PHONE NUMBER AND THANK RESPONDENT BY SAYING:)

Again, this is _____, with The Gallup Organization of _____. I would like to thank you for your time. Our mission is to "help people be heard" and your opinions are important to Gallup in accomplishing this.

DESCRIPTIVE NAMES ONLY: NEED ACTUAL FONE FILE NAMES AND NUMBER OF COLUMNS!

1. MEDICAL EDUCATION: **(Code from fone file)**

_____ _____

_____

(-)

2. PHYSICIAN NAME: **(Code from fone file)**

_____ _____

_____

(-)

3. GENDER: **(Code from fone file)** ___

4. PREFERRED PROFESSIONAL MAILING ADDRESS: **(Code from fone file)**

_____ _____

_____

(-)

5. GEOGRAPHIC CODES (STATE, COUNTY, ZIP, MSA, CENSUS REGION OR DIVISION): **(Code from fone file)**

_____ _____

_____

(-)

6. BIRTH DATE: **(Code from fone file)**

_____ _____

_____

(182 - 189)

7. BIRTH PLACE: **(Code from fone file)**

_____ _____

_____

(-)

8. CITIZENSHIP AND VISA: **(Code from fone file)**

_____ _____

_____
(-)

9. LICENSURE DATE: **(Code from fone file)**

_____ _____

_____
(-)

10. NATIONAL BOARD COMPLETION DATE: **(Code from fone file)**

_____ _____

_____
(-)

11. MAJOR PROFESSIONAL ACTIVITY: **(Code from fone file)**

_____ _____

_____
(-)

12. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____

_____
(-)

13. SECONDARY SPECIALTY: **(Code from fone file)**

_____ _____

_____
(-)

14. PRESENT EMPLOYMENT: **(Code from fone file)**

_____ _____

_____
(-)

15. AMERICAN SPECIALTY BOARD CERTIFICATION: **(Code from fone file)**

_____ _____

_____
(-)

16. CURRENT AND FORMER MEDICAL TRAINING - (INSTITUTION, SPECIALTY, TRAINING DATES): **(Code from fone file)**

_____ _____

_____

(-)

17. CURRENT AND FORMER GOVERNMENT SERVICE: **(Code from fone file)**

_____ _____

_____
(-)

18. ECFMG CERTIFICATE: **(Code from fone file)**

_____ _____

_____
(-)

19. TYPE OF PRACTICE: **(Code from fone file)**

_____ _____

_____
(-)

20. TELEPHONE NUMBER: **(Code from fone file)**

_____ _____

_____
(-)

21. FAX NUMBER: **(Code from fone file)**

_____ _____

_____
(-)

INTERVIEWER I.D. #: _____(571-574)

REVISIONS

6/14/04	**Added:**	**Interviewer Note to I1, Note before I5a, I5a, I5b**
	Revised:	**Note after I4**
7/2/04	**Revised:**	**Wording in D2aa**
7/13/04	**Deleted:**	**Note before I1, Note after I1, I1a, Note after I1a, Note before I5a, I5a, I5b**

Revised: Note after I4

9/2/04 Added: Interviewer Note to B2

jlw\2004\RWJ\RWJ physician R4 0407

APPENDIX B

EQUATIONS USED FOR ROUND FOUR INCLUSION PROBABILITIES AND ESTIMATION OF SITE-LEVEL COUNTS OF ELIGIBLE PHYSICIANS

EQUATIONS USED FOR ROUND FOUR INCLUSION PROBABILITIES

A. BACKGROUND

The background presented in Section B of Chapter V is repeated here to help the reader to understand the appendix, along with the detailed equations. The basic sampling weights are based on selection probabilities of the fielded sample, before the nonresponse adjustments for this physician survey, and vary in complexity because of the longitudinal panel component of the survey.[1] To provide a simple example, the calculation of the probabilities of selection for basic weights is a simple product of conditional and unconditional probabilities for the Round One site sample (that is, the probability of a site selection multiplied by the probability of a physician selection *given* that the assigned site was selected).[2] In subsequent rounds, these calculations must reflect not only probabilities relating to the current round but also probabilities at previous rounds that describe the entire *path* that the sample physician followed to the current sample. Inclusion probabilities of a physician depend on which path is involved.

For Round Four, the situation can be viewed in several ways. To understand how the adopted method evolved, first consider that a physician could be included in the Round Four sample via any one of several paths conditional on Round Three status:

[1]The tracking of the changes in the attitudes of physicians is a key component to the Community Tracking Study. Because a high proportion of physicians are interviewed repeatedly across the rounds, the selection probabilities need to account for when the physician first entered the sampling frame. Cross-sectional surveys (with a new sample at each round) would not support the analytic objectives nor provide the precision desired for estimates of change between rounds, unless the sample size was substantially increased. Cross-sectional surveys require only the selection probability for the current round and these selection probabilities are substantially simpler to compute.

[2]To simplify this discussion of the basic selection probabilities, we will describe the adjustments for geographic error on the location of practice and the random assignment in the first three rounds of some sites to the high-intensity study later.

- Physician who was selected in Round Three, was eligible and completed the interview: a Round Three interview
- Physician who was selected in Round Three, did not complete the interview (for example, was ineligible, could not be located, or refused): a Round Three noninterview
- Physician who was in the Round Three sampling frame but was not selected in Round Three: a Round Three frame physician
- Physician who was not in the Round Three sampling frame: a *Round Four new frame* physician.

The probabilities for the four sampling paths are different for the primary care physicians and the specialists. Therefore, we have eight separate paths from Round Three to Round Four (four paths for the primary care physicians and for paths for the specialists).

In addition, if we consider the chain of events for the sample units representing the respondent domain alone for the Round Four population (relative to Rounds One, Two, and Three) we have fifteen possible routes for a physician to be selected in Round Four. The first eight relate to physicians on the Round One frame and the last seven cover those new to the frame in one of the subsequent rounds. These routes are presented in Table B.1.

The 15 possible routes along with survey disposition status are taken into account when computing the probabilities of being selected in Round Four. Usually the probabilities were determined either by the sampling rates of PCP or by those for specialists for a particular round and disposition category, but occasionally a physician would switch between the two practice classifications—a complication that needed to be accounted for in the selection probability calculations. Finally, while a physician is included in Round Four according to the probabilities associated with the path they followed, they could have been selected in Round Four via several other paths depending on whether or not they were selected in other rounds. Hence these

selection probabilities must also be accounted for to obtain the inclusion probability for a physician in Round Four.

B. ROUND FOUR COMPUTATIONAL METHODS

In this section, we outline the method used to calculate the Round Four weights, with the proposition that no restrictive assumptions are required.

1. Basic Inclusion Probabilities

At this point we should summarize some terminology used for the sample design and selection. Within the sites, four substrata were defined: primary care physicians or specialists crossed with *old* or *new* (*old* are those physicians on the previous survey frame and *new* refers to those new to the frame since the previous survey). For the physicians in the *old* stratum, we further define three *sampling classes*, from which independent samples are selected. These classes refer to three of the paths described above as Round Three (completed) Interview, Round Three Noninterview, and Round Three Frame and not selected for Round Three. When we refer to eight sampling classes, we are emphasizing that independent samples are selected for primary care physicians and specialists with four sampling classes each.

The Round Four weights were calculated using the fact that the probability of any physician being included from the Round Four frame was the sum of the probability of being selected in Round Three plus the probability of not being selected in Round Three times the respective conditional probabilities of selection in Round Four (this is valid for physicians for all sampling classes in the Round Four frame, except the new physicians in the Round Four

TABLE B.1

EVENT ROUTES THAT CAN LEAD TO A PHYSICIAN BEING IN ROUND FOUR SAMPLE

Group	Reference Code	Event Routes
In the Round One Sampling Frame		
	a	Selected in Round One, Round Two, and Round Three
	b	Selected in Round One, not selected in Round Two, and selected in Round Three
	c	Selected in Round One, not selected in Rounds Two or Three
	d	Selected in Rounds One and Two; and not selected in Round Three
	e	Not selected in Rounds One, Two, or Three
	f	Not selected in Round One, selected in Round Two but not in Round Three
	g	Not selected in Round One but selected in both Rounds Two and Three
	h	Not selected in Rounds One or Two, but selected in Round Three
Not In the Round One Sampling Frame*		
	i	Selected in Round Two and Round Three
	j	Selected in Round Two and not selected in Round Three
	k	Not selected in Rounds Two or Three
	l	Not selected in Round Two and selected in Round Three
	m	Selected in Round Three and was not in the Round Two frame
	n	Not selected Round Three and was not in the Round Two frame
	o	Not in the Round Three frame; new in Round Four

* Routes i, j, k, and l are new in Round Two.

frame). That is, the conditional probabilities for the eight sampling classes can be written as:[3]

$$P_{41} = P_{3j}*Ps_{41} + (1 - P_{3j}) * Ps_{43}$$

$$P_{42} = P_{3j}*Ps_{42} + (1 - P_{3j}) * Ps_{43}$$

$$P_{43} = P_{3j}*Ps_{41\text{-}2} + (1 - P_{3j}) * Ps_{43}$$

$$P_{44} = Ps_{44}$$

$$P_{45} = P_{3j}*Ps_{45} + (1 - P_{3j}) * Ps_{47}$$

$$P_{46} = P_{3j}*Ps_{46} + (1 - P_{3j}) * Ps_{47}$$

$$P_{47} = P_{3j}*Ps_{4,5\text{-}6} + (1 - P_{3j}) * Ps_{47}$$

$$P_{48} = Ps_{48,}$$

*w*here the conditional probabilities are defined as P_{ij}, i relates to Round (i=1, 2, 3, 4) and j relates to the sampling class of the physician in round i. (j=1,2,3,4 for primary care physicians and 5 through 8 for specialists). Note, that for P_{41} (the probability of selection in Round Four of a primary care physician who was a respondent in Round Three), a primary care physician could have been selected in Ro und Three from any of four sampling classes. Also, alternatively if they had not been selected in Round Three (with probability $1\text{-}P_{3j}$), they could still have been selected from the Round Four stratum three (that is stratum of physicians in the Round Three frame but not in the Round Three sample, called subsequently as the "pool").

For P_{4j} (the conditional probability of selecting the physician at Round Four for the sampling class j in Round Four) we have:

[3]The conditional reference relates to: conditional on the site containing the physician's address being selected.

- j = 1 or 5 if the physician had a completed interview in Round Three [these physicians would come from seven possible event routes, see routes with reference codes a, b, g, h, i, l, and m in Table B.1, above],
- j = 2 or 6 if the physician was a Round Three noninterview [event route codes a, b, g, h, i, l, and m],
- j = 3 or 7 if the physician was in the Round Three frame but not selected in Round Three [event route codes c, d, e, f, j, k, and n], or
- j = 4 or 8 if the physician was new in the Round Four frame [event route o].

There were also eight sampling classes each in Rounds Two and Three, depending on physician specialty classification and if the physician was selected in the previous round and completed the interview or did not complete the interview, if the physician was in the previous round frame and was not selected, or if they were new in the frame.[4] Therefore, P_{2j}, for example, is the conditional probability of selecting the physician at Round Two for the sampling class j in Round Two with:

- j = 1 or 5 if the physician had a complete interview in Round One (event route codes a, b, c, and d),
- j = 2 or 6 if the physician was a noninterview in Round One (event route codes a, b, c, and d),
- j = 3 or 7 if the physician was in the Round One frame and not selected in Round One (event route codes e, f, g, and h), or
- j = 4 or 8 if the physician was in the Round Two frame and was not in the Round One frame (event route codes i and j).

[4]Two of these sampling groups (4 and 8) are strata in the classical stratified sampling sense, but they are being referred to here as sampling classes. The primary care and specialist physicians are also valid strata, and each contain the four sampling classes, which are a classification based on survey outcome for purposes of varying sampling rates.

For the Round One probabilities, P_{1j} is the conditional probability of selecting the physician at Round One. We used only two strata in this round: primary care physicians (j = 1) and specialists (j = 2).

Within the specific sampling classes, the Ps_{ij} are the sampling probabilities in each round (i=1, 2, 3, 4), and sampling class j in Round i (j=1,…, 8 for Rounds Two and Three and j=1, 2 for Round One). The Ps_{ij} are computed by the equation:

$$Ps_{ij} = n_{ij} / N_{ij}$$

where n_{ij} are the sampled cases in round i and sampling class j, and N_{ij} are the population counts for round i and sampling class j.

$Ps_{i,1-2}$ is the weighted mean of the sampling probabilities of Round i and sampling classes 1 and 2 (sampled physicians classified by response status). This modification was required because physicians selected from sampling classes 3 and 7 involve an unknown probability of selection (that is if the physician were selected, they could have been either a respondent or a noninterview and subject to different sampling rates). The weighted mean of the two possibilities is used because the actual path is not known.

$$Ps_{i,1-2} = (n_{i1} + n_{i2})^{-1} * (n_{i1} * Ps_{i1} + n_{i2} * Ps_{i2})$$

For Round Three, we had computed P_{3j} for all physicians selected in Round Three; but we needed probabilities for those physicians selected in Round Four who were in the Round Three frame and were not selected in Round Three. First, we recall that the analogous probabilities for Round Two probabilities are:

$$P_{21} = P_{11} * Ps_{21} + (1 - P_{11}) * Ps_{23}$$

$$P_{22} = P_{11} * Ps_{22} + (1 - P_{11}) * Ps_{23}$$

$P_{23} = P_{11}*Ps_{2,1-2} + (1 - P_{11}) * Ps_{23}$

$P_{24} = Ps_{24}$

$P_{25} = P_{12}*Ps_{25} + (1 - P_{12}) * Ps_{27}$

$P_{26} = P_{12}*Ps_{26} + (1 - P_{12}) * Ps_{27}$

$P_{27} = P_{12}*Ps_{2,5-6} + (1 - P_{12}) * Ps_{27}$

$P_{28} = Ps_{28}$.

For the final set of conditional probabilities, P_{1j} had been computed for all physicians sampled in Round One and for those selected in Round Two (because the Round Two probabilities were a product of conditional probabilities in both rounds). For physicians selected in Round One, the probabilities are the simple sampling rates:

$P_{11} = Ps_{11,}$

$P_{12} = Ps_{12}$.

In contrast, the equations for calculating the P_{3j} in the Round Four conditional probabilities (P_{4j}) are considerably more complex because of the increase in number of paths by which a physician could possibly be included in the sample as the number of rounds increase. The equations, while they are essential for the calculation of the weights, become rather difficult to follow, hence we present a brief overview.

As noted above, the values for P_{3j} were calculated in Round Three for those selected in that round. Therefore, we must consider the conditional probabilities that lead to a physician being in the Round Four *pool* (in the Round Three frame but not selected in Round Three). We further reduce this to PCP physicians in a single site, understanding that different although analogous

calculations are needed for 120 cells (60 sites times 2 physician classifications, PCP and specialists).

Consider one of the *patterns*, or paths, by which a physician could be in the Round Three pool. We abbreviate it as R1R2$\underline{S3}$, where R1 is a respondent in Round One (so was selected in Round One), R2 indicates that they are also a respondent in Round Two, and $\underline{S3}$ refers to the fact they were $\underline{\text{not}}$ selected in Round Three (and hence were in the Round Four pool). There are thirteen such patterns, all of which have $\underline{S3}$ as the final node (R1$\underline{R2S3}$, $\underline{S1}$R2$\underline{S3}$**...,** where the underline stands for complement, for example $\underline{R2}$ is nonrespondent in Round Two). Each outcome stratum and survey round combination has a selection probability and response rate associated with it that is used to calculate the various sequence probabilities--whether or not the physician was selected, and the response outcome if they were selected. We obtain the inclusion probability for a physician with this particular pattern by summing the probabilities for the several paths within that general pattern. In addition to these 13 patterns, we also account for the fact that the physician could have been included in the Round Four sample if they had by chance been selected in Round Three (another 13 patterns).

2. Estimation Of Site-Level Counts Of Eligible Physicians

Site-level estimates of the number of eligible physicians with a practice in the site were relatively imprecise (that is relatively large sampling variances) because of the relatively small sample sizes, especially for the sites with small physician populations. In addition, the site-level estimates were affected by sometimes extremely unequal weights associated with physicians who had the practice location in the site after being selected in another site. We investigated various external sources of counts or estimates for use as benchmarks or in post-stratification or ratio-adjustments, but found no reliable estimates for populations sufficiently similar to the CTS

population of eligible physicians who have a practice in a CTS site. While no fixed totals were acceptable, HSC staff were knowledgeable about the trends and patterns of the physician population. We developed site-level estimates using the knowledge, experience and guidance of HSC staff and estimates of total counts of eligible physicians with a practice in a site computed by summing the non-response adjusted sampling weights for eligible physicians.

In Round One and Round Two, we used various measures to determine acceptable site-level estimates of eligible physicians. One method was to trim excessively large weights without redistribution of values trimmed. However, this estimate potentially introduces bias that is different among the sites. It reduced estimated totals for sites with large weights more than estimated totals for other sites (for example, the estimated totals for sites with large numbers of in-movers tend to be more seriously downward biased using this estimator).

Because reliable counts of the eligible physician population for post-stratification were not available at the site level, we developed a series of ratio estimators to seek more stable estimated totals that were consistent with estimates from prior rounds and the frame counts. Ratio estimators also are biased but the bias is typically small considering the potential for improved precision.

Six different estimators, five of them ratio estimators, were used to predict the number of eligible physicians for the Round Four Physician Survey at the site level. These five ratio estimators ($n_{4,1}$, $n_{4,2}$,…, $n_{4,5}$) use three different estimated percentages of eligible physicians by site and physician classification (PCP or specialist) as a percentage of frame counts. The estimates of the related ratios, P_{ik}, are:

- P_{tk} the proportion of the Round Four frame physicians who are eligible physicians, by site and physician classification (PCP or specialist), (k=1, 2,…, 120; 60 sites by two strata)

- P_{ok} the proportion of eligible physicians among the physicians on the Round Three frame, by site and physician classification (PCP or specialist)

- P_{nk} the proportion eligible physicians among those who were new to the frame in Round Four, by site and PCP/specialist.

The calculations of the estimated proportions (ratios) of the total Round Four frame count (t) who are eligible physicians, for a specific site and for PCPs, are:

$$\hat{P}_{tk} = \sum_l W_{kl} X_{kl} / \sum_l W_{kl}$$

where W_{kl} = Adjusted weight for site and PCP (k, $k = 1,...,120$) and physician(l) and
X_{kl} = 1 if eligible and 0 otherwise

The calculation of the estimated proportions for the Round Three sample (o), for a specific site and for PCPs, is:

$$\hat{P}_{ok} = \sum_l W_{kl} X_{kl} / \sum_l W_{kl}$$

where W_{kl} = Adjusted weight for site and PCP (k, k=1,...,120) and physician(l) and
X_{kl} = 1 if eligible and is in Round Three frame and 0 otherwise

The calculation of the estimated proportions for the new sample (n), say for a specific site and for PCPs are:

$$\hat{P}_{nk} = \sum_l W_{kl} X_{kl} / \sum_l W_{kl}$$

where W_{kl} = Adjusted weight for site and PCP (k, k=1,...,120) and physician(l) and
X_{kl} = 1 if eligible and is a new doctor in Round Four frame and 0 otherwise

The five estimators of the number of eligible physicians in Round Four by site and PCP/specialist are listed. The definitions for notation are:

N_{ik} is the number of physicians listed on the sampling frame in Round i (i=1,2,3,4) by site and PCP (k=1,…,120) and

n_{ik} is the number of eligibles previously estimated for Round i by site and physician classification (k, k=1,…,120).

For background information, the frame counts for each site increased from Round One to Round Two (with four exceptions) and they increased again from Round Two to Round Three and from Round Three to Round Four. But the number of eligible physicians decreased for a substantial number of the sites from Round One to Round Two and from Round Two to Round Three. In total, the number of PCP physicians on the frame increased by 8.4 percent from Round One to Round Two, by 13.2 percent from Round Two to Round Three, and by 12.9 from Round Three to Round Four. For specialists, the increases were 10 percent, 12.5 percent, and 8.7 percent, respectively.

The estimators to predict the number or eligible physicians by site and PCP/specialist are:

$n_{4,1k}$: This is an estimate of the number of eligible physicians in Round Four by site and physician classification (PCP or specialist) computed by multiplying the frame counts in Round Four by the overall percentage of eligible physicians

$$n_{4,1k} = N_{4k}\hat{P}_{tk}$$

$n_{4,2k}$: This is an estimate of the number of eligible physicians in Round Four by classifying the frame counts into two groups: the estimated number of eligible physicians in the Round Two frame and the new physicians entering the frame in Round Three and Round Four. This estimator assumes that the number of eligible physicians in Round Two frame is n_{2i} (the number estimated in Round Two) and the number of eligible physicians from the new physicians in the frame in Round Three and Round Four are estimated by the percentage of eligible physicians among the physicians new on the frame since Round Two.

$$n_{4,2k} = n_{2k} + (N_{4k} - N_{2k})\hat{P}_{nk}$$

$n_{4,3k}$: This estimate uses the same structure as the previous estimate ($n_{4,2k}$), but we do not assume that the number of eligible physicians in Round Two who are eligible in Round Four is still n_{2i}. In this estimate, the number of eligible physicians in Round Two is computed from the percentage of eligible physicians among the Round Four physicians who were on the Round Three frame. The number of eligible physicians entering the frames in Round Three and Round Four is estimated as previously.

$$n_{4,3k} = N_{2k}\hat{P}_{ok} + (N_{4k} - N_{2k})\hat{P}_{nk}$$

$n_{4,4k}$: This is an estimate in which the Round Three eligible physicians has added an estimate of the number of eligible physicians among those who are new to the frame in Round Four (the second term on the right hand side of the equation). This estimate will tend to have some upward bias because no direct allowance is made for the n_{3k} eligible physicians who may no longer be eligible in the site (for example death, retirement, and outmovers). Hence, this estimate relies on a ratio adjustment to all sites (post-stratification) to produce essentially unbiased estimators; that is, we assume proportional attrition among sites.

$$n_{4,4k} = n_{3k} + (N_{4k} - N_{3k})\hat{P}_{nk}$$

$n_{4,5k}$: This estimate uses the same structure as the last one ($n_{4,4k}$), but this estimate uses an estimate of eligible physicians who were on the Round Three frame using the Round Three proportion of eligible physicians rather than the actual value as of Round Three. The advantage this equation seems to have over $n_{4,4}$ is that we now have an explicit allowance for attrition of eligible physicians in Round Three frame.

$$n_{4,5k} = N_{3k}\hat{P}_{ok} + (N_{4k} - N_{3k})\hat{P}_{nk}$$

$n_{4,6k}$: This estimator is the *direct expansion* estimator. It is the sum of the response-adjusted weights for the Round Four eligible physicians. This is an unbiased estimator, but has relatively large variance. Because of larger variability in weights associated to non-response adjustments and inmovers, this estimator produces undesirably large totals for some sites.

$$n_{4,6k} = \sum_{l} W_{kl} \; X_{kl}$$

where W_{kl} = response-adjusted weight for site and physician type (k, $k=1,\ldots,120$) and physician (l) and $X_{kl} = 1$ for eligible physicians and $X_{kl} = 0$ otherwise.

The site weights were poststratified to the national total of eligible physicians for each estimator before taking the average number of physicians in each site. The national total was based on the adjusted weights for all sample physicians, not just those practicing within one of the 60 sites; the unbiased estimate for number of eligible physicians in the nation.[5] The total number of estimated eligible physicians in each site was again compared to the national number of eligible physicians after computing the average number of physicians in each site by physician classification (PCP or specialist) from the first five described estimators.

[5]The national estimate based on initial weights for those practicing within one of the 60 sites is slightly downward biased because inmovers from outside the 60 sites are not covered.

APPENDIX C

NONRESPONSE ANALYSIS

A. OVERVIEW

Nonresponse occurs in all surveys and to adjust for non-participation by sampled physicians, we used logistic regression models to compute propensity scores to adjust the survey weights for (1) locating the physician, and (2) the inability to interview all sampled physicians. We defined interview response as either a completed or ineligible interview (conceptually, the ineligible physician completed all portions of the interview for which he or she should or could respond). Separate locating and response models were developed for the three strata: Round Three interviews (*reinterviews*), Round Three noninterviews (*noninterviews*[1]), and for physicians not in Round Three sample (*new*[2]). The models are described in Chapter V. Here, we describe the main findings of the nonresponse analysis to illustrate various design, practice-related, and demographic factors related to the ability to locate and interview physicians.

B. CODING OF SURVEY DISPOSITIONS FOR WEIGHTING PURPOSES

Data collection was conducted using computer-assisted telephone interviewing (CATI) and the data collection management system (or tracking system) maintained a history of the outcome of each attempt to reach a physician who had a known telephone number. In addition, for those physicians who were determined to be ineligible prior to data collection (usually deceased physicians) or for whom a telephone number was never found, a separate tracking system maintained the results of physicians who were not assigned to the Telephone Center for data collection. We used data from both systems to prepare a final disposition code for each

[1]Round Three noninterviews include physicians who refused to respond, were ineligible or could not be located in Round Three.

[2]"New" physicians include physicians who were in the Round Three sampling frame but not selected for Round Three and physicians who first entered the sampling frame for Round Four.

physician in the sample. Table IV.1 (in chapter IV) provides a summary of call outcomes for the full released sample and for PCP and Specialists.

The overall weighted response rate was 52.4 percent compared to 58.6 percent in Round Three. The decreased rate is linked to increases in *unlocatable* and *end-of-study* categories (end-of-study are active cases designated for call-back or as "soft" refusals when the study ended). A factor that affected the location rate was access to the physician's Social Security number; an important identifier to locate a person. We did not have access to Social Security numbers in Round Four, but we did in prior rounds. The Round Four survey refusal rate was 18 percent compared to 19 for the site sample in Round Three; not located ("final tracing") was 9 percent in Round Four compared to 6 percent in Round Three; and end-of-study category was 15 percent compared to 12 percent in Round Three. The response rate for the PCPs (50.6) was slightly lower than the specialists (53.5).

In comparison to Round Three and Round Two, the fraction of the sample represented by located nonrespondents increased from 32 in Round Two, to 36 percent in Round Three, and increased further to 39 percent in Round Four.

In the next section, we show how geographic, demographic, practice, and survey characteristics affect the ability to locate physicians, and if they are located, the likelihood that the physician would agree to be interviewed.

C. FACTORS RELATED TO LOCATION AND RESPONSE

1. Background

Two factors determined physician participation. First, because this was a telephone survey, we had to obtain either a telephone number for the practice or the home of the sampled physician. Second, the physician had to agree to complete the survey. Here, we examine three

sets of characteristics that may be related to either locating or completing an interview with a physician:

1. Geographic differences.
2. Demographic and practice differences based on data available from the American Medical Association (AMA) and American Osteopathic Association (AOA) sampling frames for nearly all sampled physicians.
3. Round Three characteristics of reinterview and noninterview physicians.

Analysis of the relationships between these characteristics and our ability to locate and interview physicians was used to develop nonresponse adjustment procedures (see Chapter V). Here, we summarize locating and response patterns that may be helpful in planning future rounds of the survey.

For the nonresponse analysis, we selected the following characteristics from the AMA and AOA sample databases:

- Region[3]
- Metropolitan Statistical Area (MSA)
- Age
- Board certification in primary specialty
- Country of graduation from medical school: USA/Canada and others
- Gender
- Type of Practice (from AMA)[4]

[3]Region was based in the four census areas of the country: Northeast, North Central, South, and West.

[4]Present employment was based on the last time the physician provided this information to the AMA. Consequently, this variable is out of date for many physicians. Furthermore, a substantial fraction of physicians were coded by the AMA in a nonspecified "other" category, rather than the coded categories of solo practitioner, partner, group practice member, or HMO employee. Present employment was coded as: solo or partnership practice, group practice, and other.

- Specialty (coded).[5]
- Income for physicians interviewed in Round Three
- Disposition Code in Round Three for the noninterview physicians.[6]

2. Location and Response Rates by Strata

Location and response rates vary by strata (reinterviews, noninterviews, and new—see Table C.1). In this table, the weighted location rate is the ratio of the weighted sample count for located physicians to the weighted sample count for all attempted cases. The weighted percentage of completed interviews, *among located physicians*, is the weighted sum of physicians who completed the interview or were screened out as ineligible divided by the weighted sample count of located physicians. The overall response rate (the weighted percentage completed among all physicians for whom an interview was attempted) is the weighted sum of physicians who completed the interview or were screened out as ineligible divided by the weighted sample count of all attempted cases. We used the weighted sum of eligible and ineligible physicians because both represented successful interviewing end points.

Since reinterviewed physicians had participated in Round Three of the survey, nearly all were located. The location rate for the reinterview stratum was 97.9. The location rates for Round Three noninterviews and new sample are similar, approximately 87 percent.

[5]Based on specialty codes in the 2003 AMA or AOA Masterfile, General and Family Practice included codes FP and GP; Internal Medicine included code IM; Pediatrics included codes PD and MPD; and all other codes were listed as Specialties.

[6]The disposition code for Round Three of the noninterview physicians: ineligible, refusals, and unknown location.

TABLE C.1

WEIGHTED LOCATION, COMPLETION, AND RESPONSE RATES BY SUBGROUP

Subgroups[a]	Total Sample (Unweighted)	Weighted Total	Weighted Located	Weighted Completes[b]	Weighted Percent Located	Weighted Percent Complete Among Located	Weighted Percent Complete
Totals	15,063	559,967	508,640	293,293	90.8	57.7	52.4
Reinterviews	6,504	208,115	203.660	159,956	97.9	78.5	76.9
Noninterviews	3,884	203,980	176,341	65,723	86.5	37.3	32.2
New	4,675	147,872	128,640	67,614	87.0	52.6	45.7

[a]The three subgroups are based on their Round Three interview status: "reinterviews" are the physicians who completed the Round Three interview; "noninterviews" are the physicians who were selected for the Round Three sample but who did not complete the interview (refusals, unlocated physicians, or ineligible physicians); "new" are the physicians in the Round Four frame who were not selected for the Round Three sample.

[b]Completed cases include completed interviews and physicians identified as ineligible for the survey.

The completion rates vary among strata more than location rates. The completion rate for located reinterview physicians is 78.5 percent, while the completion rate for located new physicians is 52.6 percent; and completion rate for the located noninterview physicians is only 37.3 (the noninterview sample included a sample of physicians who refused or could not be located in Round Three).

Tables C.2 – C.5 provide location and completion rates by stratum, and for the physician characteristics available for the entire sample.

3. Locating Physicians

The following discussion focuses on the three strata (reinterviews, noninterviews, and new sample members) (Tables C.3 through C.5). Across all three strata, we located 90.8 percent (weighted) of the released sample. The characteristics with substantial differences are candidates for use in the model to adjust for the inability to locate a physician. Differences in location rates for the reinterview sample were minimal and are not discussed (Table C.3). Differences for the other two (Tables C.4 and C.5) were generally small, as well, but the ones that exhibit variation between the characteristic levels are described below:

- **Region:** Location rates in the northeast (85 percent for noninterview and 86 percent for new) and west for the noninterview (84 percent) were slightly lower than in other regions, which varied from 87 to 88 percent.
- **MSA:** A physician in the nonmetropolitan areas (location rates from 88 to 89 percent) is slightly easier to locate than in the MSAs (about 86 percent).
- **Age:** Young physicians (less than 40 years old), who generally are more mobile than older physicians, were more difficult to locate (81 percent for the noninterview and 84 for the new). Location rates increase with age and doctors 50 and older were the easiest to locate at around 90 percent.

TABLE C.2

WEIGHTED LOCATION, COMPLETION, AND RESPONSE RATES BY PHYSICIAN CHARACTERISTICS
ROUND FOUR PHYSICIAN SURVEY

Characteristic	Unweighted Count	Weighted Sample Count	Unweighted Completes[a]	Weighted Completes	Unweighted Located Physicians	Weighted Located Physicians	Weighted Percentage Located	Weighted Percentage Complete/ Located	Weighted Percentage Complete
Total	**15,063**	**559,967**	**8,311**	**293,293**	**13,650**	**508,640**	**90.8**	**57.7**	**52.4**
Gender									
Female	4,315	144,575	2,311	73,344	3,738	125,578	86.9	58.4	50.7
Male	10,748	415,392	6,000	219,948	9,912	383,062	92.2	57.4	52.9
Age Category									
20-44	6,631	196,587	3,369	95,595	5,763	170,464	86.7	56.1	48.6
45-64	7,033	287,913	4,006	149,641	6,569	267,214	92.8	56.0	52.0
65+	1,399	75,467	936	48,057	1,318	70,962	94.0	67.7	63.7
Medical School									
Foreign	3,542	131,342	1,713	59,647	3,105	114,702	87.3	52.0	45.4
US	11,521	428,625	6,598	233,646	10,545	393,939	91.9	59.3	54.5
Board Certified									
Board Certified	11,183	421,913	6,368	226,445	10,460	396,107	93.9	57.2	53.7
Not Board Certified	3,880	138,054	1,943	66,848	3,190	112,533	81.5	59.4	48.4
Specialty									
Gen/Family Practice	3,315	100,433	1,868	52,889	2,983	89,751	89.4	58.9	52.7
Internal Medicine	3,242	96,517	1,668	47,028	2,869	85,514	88.6	55.0	48.7
Pediatrics	1,807	50,702	1,104	29,082	1,650	46,047	90.8	63.2	57.4
Specialist	6,699	312,314	3,671	164,292	6,148	287,326	92.0	57.2	52.6
Region									
North East	3,547	137,567	2,028	74,185	3,202	124,111	90.2	59.8	53.9
North Central	2,988	105,821	1,624	55,395	2,715	96,596	91.3	57.3	52.3
South	5,394	200,725	2,931	101,957	4,909	183,572	91.5	55.5	50.8
West	3,134	115,854	1,728	61,755	2,824	104,361	90.1	59.2	53.3
MSA									
MSA	13,581	498,551	7,451	259,651	12,262	451,652	90.6	57.5	52.1
Nonmetropolitan	1,482	61,416	860	33,641	1,388	56,987	92.8	59.0	54.8
Present Employment									
Office - Group	3,496	135,035	2,128	76,794	3,372	129,710	96.1	59.2	56.9
Solo or 2 practice	3,380	145,640	1,926	76,702	3,223	137,908	94.7	55.6	52.7
Other	8,187	279,292	4,257	139,798	7,055	241,022	86.3	58.0	50.1

[a]Completed cases include completed interviews and physicians identified as ineligible for the survey.

TABLE C.3

WEIGHTED LOCATION, COMPLETION, AND RESPONSE RATES FOR THE REINTERVIEW SAMPLE
BY PHYSICIAN CHARACTERISTICS
ROUND FOUR PHYSICIAN SURVEY

Characteristic	Unweighted Count	Weighted Sample Count	Unweighted Completes[a]	Weighted Completes	Unweighted Located Physicians	Weighted Percentage Located	Weighted Percentage Located	Weighted Percentage Complete/ Located	Weighted Percentage Complete
Total	**6,504**	**208,115**	**4,955**	**159,956**	**6,357**	**203,660**	**97.9**	**78.5**	**76.9**
Gender									
Female	1,617	47,520	1,230	36,408	1,554	45,777	96.3	79.5	76.6
Male	4,887	160,595	3,725	123,548	4,803	157,883	98.3	78.3	76.9
Age Category									
20-44	2,030	54,283	1,477	39,673	1,963	52,493	96.7	75.6	73.1
45-64	3,819	126,700	2,929	97,447	3,747	124,380	98.2	78.3	76.9
65+	655	27,133	549	22,836	647	26,787	98.7	85.3	84.2
Medical School									
Foreign	1,296	39,137	909	27,651	1,267	38,258	97.8	72.3	70.7
US	5,208	168,978	4,046	132,305	5,090	165,402	97.9	80.0	78.3
Board Certified									
Board Certified	5,310	172,201	4,084	133,681	5,205	168,882	98.1	79.2	77.6
Not Board Certified	1,194	35,915	871	26,276	1,152	34,779	96.8	75.6	73.2
Specialty									
Gen/Family Practice	1,617	40,754	1,240	31,464	1,575	39,841	97.8	79.0	77.2
Internal Medicine	1,417	35,364	1,035	25,955	1,387	34,623	97.9	75.0	73.4
Pediatrics	936	22,652	727	17,651	910	22,006	97.1	80.2	77.9
Specialist	2,534	109,346	1,953	84,887	2,485	107,191	98.0	79.2	77.6
Region									
North East	1,489	50,079	1,184	39,709	1,463	49,229	98.3	80.7	79.3
North Central	1,238	38,568	956	30,399	1,210	37,743	97.9	80.5	78.8
South	2,374	75,705	1,762	56,381	2,312	73,887	97.6	76.3	74.5
West	1,403	43,763	1,053	33,467	1,372	42,800	97.8	78.2	76.5
MSA									
MSA	5,741	180,504	4,387	139,170	5,608	176,533	97.8	78.8	77.1
Nonmetropolitan	763	27,611	568	20,787	749	27,128	98.3	76.6	75.3
Present Employment									
Office - Group	1,958	62,576	1,541	49,380	1,934	61,836	98.8	79.9	78.9
Solo or 2 practice	1,794	61,102	1,353	46,298	1,767	60,178	98.5	76.9	75.8
Other	2,752	84,436	2,061	64,278	2,656	81,646	96.7	78.7	76.1
Income (at R3)									
Less than 100,000	1,199	34,890	896	26,823	1,148	33,526	96.1	80.0	76.9
100,000-149,999	2,074	60,194	1,619	47,266	2,022	58,686	97.5	80.5	78.5
More than 150,000	3,231	113,031	2,440	85,867	3,187	111,447	98.6	77.0	76.0

[a]Completed cases include completed interviews and physicians identified as ineligible for the survey.

TABLE C.4

WEIGHTED LOCATION, COMPLETION, AND RESPONSE RATES FOR THE NONINTERVIEW SAMPLE BY PHYSICIAN CHARACTERISTICS
ROUND FOUR PHYSICIAN SURVEY

Characteristic	Unweighted Count	Weighted Sample Count	Unweighted Completes [a]	Weighted Completes	Unweighted Located Physicians	Weighted Sample Located Count	Weighted Percentage Located	Weighted Percentage Complete/ Located	Weighted Percentage Complete
Total	**3,884**	**203,980**	**1,213**	**65,723**	**3,286**	**176,341**	**86.5**	**37.3**	**32.2**
Gender									
Female	1,041	50,870	313	15,324	832	41,658	81.9	36.8	30.1
Male	2,843	153,110	900	50,399	2,454	134,682	88.0	37.4	32.9
Age Category									
20-44	1,364	59,389	399	17,532	1,078	47,884	80.6	36.6	29.5
45-64	2,072	113,227	596	32,566	1,799	99,579	87.9	32.7	28.8
65+	448	31,364	218	15,625	409	28,878	92.1	54.1	49.8
Medical School									
Foreign	1,024	51,764	288	15,148	842	43,014	83.1	35.2	29.3
US	2,860	152,216	925	50,574	2,444	133,326	87.6	37.9	33.2
Board Certified									
Board Certified	2,773	150,424	839	46,667	2,480	136,845	91.0	34.1	31.0
Not Board Certified	1,111	53,556	374	19,056	806	39,495	73.7	48.2	35.6
Specialty									
Gen/Family Practice	913	40,854	278	12,881	751	34,043	83.3	37.8	31.5
Internal Medicine	998	42,335	288	13,224	841	36,263	85.7	36.5	31.2
Pediatrics	439	18,845	148	6,534	366	15,985	84.8	40.9	34.7
Specialist	1,534	101,946	499	33,084	1,328	90,050	88.3	36.7	32.5
Region									
North East	877	46,599	274	15,047	732	39,774	85.4	37.8	32.3
North Central	752	37,879	220	11,482	639	33,024	87.2	34.8	30.3
South	1,355	74,174	430	23,829	1,174	65,465	88.3	36.4	32.1
West	900	45,328	289	15,365	741	38,079	84.0	40.4	33.9
MSA									
MSA	3,539	182,114	1,093	58,211	2,984	157,114	86.3	37.1	32.0
Nonmetropolitan	345	21,866	120	7,512	302	19,227	87.9	39.1	34.4
Present Employment									
Office - Group	897	48,941	284	16,132	828	45,413	92.8	35.5	33.0
Solo or 2 practice	1,011	57,846	315	18,877	919	52,845	91.4	35.7	32.6
Other	1,976	97,194	614	30,715	1,539	78,083	80.3	39.3	31.6
Round Three Status									
Ineligible	616	31,796	353	19,256	478	25,322	79.6	76.0	60.6
Located Non respondent	2,758	148,947	692	38,179	2,478	135,871	91.2	28.1	25.6
Not Located	510	23,237	168	8,287	330	15,147	65.2	54.7	35.7

[a]Completed cases include completed interviews and physicians identified as ineligible for the survey.

TABLE C.5

WEIGHTED LOCATION, COMPLETION, AND RESPONSE RATES FOR THE NEW SAMPLE BY PHYSICIAN CHARACTERISTICS

Characteristic	Unweighted Count	Weighted Sample Count	Unweighted Completes [a]	Weighted Completes	Unweighted Located Physicians	Weighted Located Physicians	Weighted Percentage Located	Weighted Percentage Complete/ Located	Weighted Percentage Complete
Total	**4,675**	**147,872**	**2,143**	**67,614**	**4,007**	**128,640**	**87.0**	**52.6**	**45.7**
Gender									
Female	1,657	46,185	768	21,612	1,352	38,142	82.6	56.7	46.8
Male	3,018	101,687	1,375	46,001	2,655	90,497	89.0	50.8	45.2
Age Category									
20-44	3,237	82,915	1,493	38,390	2,722	70,087	84.5	54.8	46.3
45-64	1,142	47,986	481	19,628	1,023	43,255	90.1	45.4	40.9
65+	296	16,970	169	9,596	262	15,297	90.1	62.7	56.5
Medical School									
Foreign	1,222	40,440	516	16,847	996	33,429	82.7	50.4	41.7
US	3,453	107,431	1,627	50,766	3,011	95,210	88.6	53.3	47.3
Board Certified									
Board Certified	3,100	99,288	1,445	46,097	2,775	90,380	91.0	51.0	46.4
Not Board Certified	1,575	48,584	698	21,516	1,232	38,259	78.7	56.2	44.3
Specialty									
General/Family Practice	785	18,826	350	8,545	657	15,868	84.3	53.9	45.4
Internal Medicine	827	18,818	345	7,850	641	14,629	77.7	53.7	41.7
Pediatrics	432	9,205	229	4,897	374	8,057	87.5	60.8	53.2
Specialist	2,631	101,022	1,219	46,322	2,335	90,086	89.2	51.4	45.9
Region									
North East	1,181	40,889	570	19,429	1,007	35,108	85.9	55.3	47.5
North Central	998	29,374	448	13,514	866	25,828	87.9	52.3	46.0
South	1,665	50,846	739	21,747	1,423	44,220	87.0	49.2	42.8
West	831	26,763	386	12,923	711	23,482	87.7	55.0	48.3
MSA									
MSA	4,301	135,933	1,971	62,271	3,670	118,006	86.8	52.8	45.8
Nonmetropolitan	374	11,938	172	5,343	337	10,634	89.1	50.2	44.8
Present Employment									
Office - Group	641	23,518	303	11,283	610	22,462	95.5	50.2	48.0
Solo or 2 practice	575	26,693	258	11,527	537	24,884	93.2	46.3	43.2
Other	3,459	97,661	1,582	44,804	2,860	81,292	83.2	55.1	45.9

[a]Completed cases include completed interviews and physicians, identified as ineligible for the survey.

- **Board certification in primary specialty**: Board certified physicians are easier to locate than the non certified physicians. For both strata, 91 percent of board certified physicians were located, compared to only 74 percent of noninterviews and 79 percent of new sample who were not board certified.

- **Country of medical school:** Graduates of U.S. and Canadian medical schools were somewhat easier to locate (about 88 percent compared to 83 percent for the graduates from other countries).

- **Gender:** Because name changes increase the difficulty of locating female physicians, men were easier to locate (approximately 88 percent) than women (82 percent).

- **Type of Practice:** This variable was classified in the "other" category in the AMA Masterfile for most physicians. Physicians classified in the "other" category are more difficult to locate. Only slightly more than 80 percent of physicians in the other category were located. While more than 90 percent of those with type of employment specified as group, solo, or two-physician practice, were located.

- **Specialty:** Specialists were slightly easier to locate than PCPs (general and family practice, general internal medicine, and pediatrics) for both strata.

- **Disposition Code in Round Three for the noninterview physicians:** The eligible sample physicians who were located but not interviewed in Round Three were the easier ones to locate among the noninterview stratum with a location rate of 91 percent. The most difficult to locate in this stratum were the physicians that could not be located in Round Three, with a location rate of only 65 percent.

4. Response Rate

Overall, the *conditional* response rate (including completed interviews and ineligible physicians) for the located physicians was 58 percent, with substantial variation by sample group—79 percent for reinterviews, 37 percent for noninterviews, and 53 percent for the new sample (Table C.1). For the nonresponse analysis, we defined the conditional response rate as the ratio of the weighted number of physicians who were ineligible or completed an interview divided by the weighted number of physicians who were located. This rate is a weighted estimate of the conditional probability of obtaining a response, having first located the physician. For ease of exposition, we will refer to the conditional response rate as the response rate in this section.

Variation in response rates, by geographic differences, demographic and practice differences, and Round Three characteristics are discussed here (see Tables C.2, C.3, C.4, and C.5).

- **Region:** The amount of variation in response rates by region was fairly consistent across strata—five to six percentage points from highest to lowest region. Among reinterview physicians, response rates across regions ranged from 76 to 81 percent. The response rates for noninterview physicians ranged from 35 percent to 40 percent. The new physicians' response rates ranged from 49 percent to 55 percent. There aren't any clear regional response patterns across strata except that the response rate in the southern region was slightly lower for reinterview and new sample, but not for noninterview physicians.

- **MSA:** Differences in response rates were about two percentage points between MSAs and nonmetropolitan areas across all three samples.

- **Age:** Older physicians (65+) in all strata had substantially higher response rates and middle-age physicians (ages 45-64) had the lowest response rates in two of the samples. Overall, the response rate for the older group was 68 percent compared to 56 percent for each of the two younger age groups.

- **Board certification in primary specialty:** While physicians who are board certified are far easier to locate in all strata, in two of the three strata, the situation is reversed for response rates. For noninterview physicians who are board certified the response rate is only 34 percent compared to noncertified physicians at 48 percent. For new physicians who are board certified, the response rate is 51 percent compared to 56 percent for the noncertified physicians. It is easier to locate the board certified physicians but they are more difficult to interview. This reversal between location rates and response rates demonstrates the merit of using different propensity models for location and response.

- **Country of medical school:** Graduates of U.S. medical schools had somewhat higher response rates in all strata (3 to 5 points higher) than graduates from other countries.

- **Gender:** Response rates are virtually identical for located men and women in the reinterview and noninterview samples, differing by only about one percentage point. However, females in the new sample were more likely to respond (57 percent) than were males (51 percent). For surveys that are limited to new samples, this is another example of reversal of the rates between location and response.

- **Specialty:** Pediatricians have the highest response rates in all strata while internists have the lowest. Among pediatricians, the response rate is 80 percent for reinterview physicians, 41 percent for the noninterview physicians, and 61 percent for the new physicians. For physicians practicing in internal medicine, response rates are 75, 37, and 54 percent, respectively).

- **Income for reinterview physicians:**[7] While easier to locate, higher income physicians (150,000+) are slightly less likely to complete the interview. Their response rate is 77 percent compared to 80 percent for the two lower income groups.

- **Disposition Code in Round Three for the noninterview physicians:** Noninterview physicians who refused to be interviewed in Round Three were much easier to locate but more difficult to interview (response rate of only 29 percent). The highest interview rates in this sample were for physicians who were ineligible in Round Three, with a response rate of 70 percent. (Note, however, that the ineligibles are included as respondents.) This is a very important variable and another example of reversal in rates between location and response.

5. Summary

We were able to compare location and response rates for several variables: board certification in primary specialty, country of graduation from medical school, gender, type of practice, specialty, and income for reinterview physicians, and Round Three disposition for noninterviewed physicians. After controlling for stratification (reinterview, noninterview, and new sample), differences in these rates were generally small and sometimes balanced out (with lower location rates balanced by higher conditional response rates). Any differences in location and response rates for these variables were controlled for by nonresponse adjustments applied to sample weights.

[7] This variable was based on the Round Three interview and was not available for noninterview or new sample.