



1. Which of the following statements comes closest to expressing your overall view of the health care system in your country? Select one.

- 1 On the whole the health care system works pretty well and only minor changes are necessary to make it work better.
2 There are some good things in our health system, but fundamental changes are needed to make it work better.
3 Our health care system has so much wrong with it that we need to completely rebuild it.

2. Overall, how satisfied are you with practicing medicine?

- 1 Very satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Very dissatisfied

3. In general, do you think the quality of medical care your patients receive throughout the health care system has improved, has become worse, or is it about the same as it was three years ago?

- 1 Improved 2 Worse 3 About the same

ACCESS TO CARE AND CARING FOR PATIENTS

4. How often do you think your patients experience the following?

Table with 4 columns: Often, Sometimes, Rarely, Never. Rows include: a. Have difficulty paying for medications or other out-of-pocket costs, b. Have difficulty getting specialized diagnostic tests, c. Experience long waiting times to see a specialist, d. Experience long waiting times to receive treatment after diagnosis.

5. What proportion of your patients who request a same- or next-day appointment can get one?

- 1 Almost all (>80%) 2 Most (60-80%) 3 About half (~50%) 4 Some (20-40%) 5 Few (<20%) 6 Don't know

6. Does your practice have an arrangement where patients can see a doctor or nurse if needed when the practice is closed (after-hours) without going to the hospital emergency room or department?

- 1 Yes 2 No

7. Does your practice routinely use written evidence-based treatment guidelines to treat these conditions?

Table with 4 columns: Yes, Routinely Use Guidelines, No, Do Not Routinely Use Guidelines, No Guidelines Available, Not Applicable, Do Not See These Patients. Rows include: a. Diabetes, b. Depression, c. Asthma or COPD, d. Hypertension, e. ADHD.

8. Do you provide patients with a written list of the medications they are currently taking?

- 1 Yes, routinely 2 Yes, occasionally 3 No

9. Do you give your patients with chronic diseases written instructions about how to manage their own care at home (e.g., instructions on what to do to control symptoms, prevent flare-ups, or monitor their condition at home)?

- 1 Yes, routinely 2 Yes, occasionally 3 No

**TEAMS AND CARE COORDINATION**

10. Other than doctors, does your practice include any other health care providers (e.g., nurses, nurse practitioners, physician assistants, medical assistants, or pharmacists) who share responsibility for managing patient care?

<sub>1</sub> Yes [ANSWER QUESTION #11]      <sub>2</sub> No [SKIP TO QUESTION #12]



| 11. IF YES: Do any of these other staff help manage patient care in the following ways?                      | Yes, Routinely                        | Yes, Occasionally                     | No                                    |
|--|---------------------------------------|---------------------------------------|---------------------------------------|
| a. Call patients to check on medications, symptoms, or help coordinate care in-between visits                | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| b. Execute standing orders for medication refills, ordering tests, or delivering routine preventive services | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| c. Educate patients about managing their own care  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| d. Counsel patients on exercise, nutrition and how to stay healthy   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |

12. Is your practice part of a network of other practices who share resources for managing patient care? This could include a network of nurses. <sub>1</sub> Yes <sub>2</sub> No

13. When your patient has been seen by a specialist, how often does the following occur?

|  | Always                                | Often                                 | Sometimes                             | Rarely                                | Never                                 |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| a. You receive a report back from the specialist with <i>all relevant</i> health information | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |
| b. The information you receive is timely, that is available when needed                      | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

14. After your patient has been discharged from the hospital, on average, how long does it take before you receive the information you need to continue managing the patient, including recommended follow-up care?

<sub>1</sub> Less than 48 hours    <sub>2</sub> 2-4 days    <sub>3</sub> 5-14 days    <sub>4</sub> 15-30 days    <sub>5</sub> More than 30 days    <sub>6</sub> Rarely or never receive adequate report

15. If received: How do you usually receive this information? <sub>1</sub> Fax    <sub>2</sub> Mail    <sub>3</sub> Email    <sub>4</sub> Remote access    <sub>5</sub> Other

**OFFICE SYSTEMS AND INFORMATION TECHNOLOGY**

16. Do you use electronic patient medical records in your practice (not including billing systems)? <sub>1</sub> Yes <sub>2</sub> No

17. Do you use any of the following technologies in your practice?

|  | Yes, Used Routinely                   | Yes, Used Occasionally                | No                                    |
|--|---------------------------------------|---------------------------------------|---------------------------------------|
| a. Electronic ordering of laboratory tests   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| b. Electronic access to your patients' laboratory test results                               | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| c. Electronic alerts or prompts about a potential problem with drug dose or drug interaction | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| d. Electronic entry of clinical notes, including medical history and follow-up notes         | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| e. Electronic prescribing of medication  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |

18. IF YES TO Q17(e): Are you able to electronically transfer prescriptions to a pharmacy? <sub>1</sub> Yes <sub>2</sub> No

19. How often does your practice communicate with patients *by email* for clinical or administrative purposes?

<sub>1</sub> Often    <sub>2</sub> Sometimes    <sub>3</sub> Rarely    <sub>4</sub> Never

20. With the patient medical records system you *currently* have, how easy would it be for you (or staff in your practice) to generate the following information about your patients? Is this process computerized?

|   | Ease/Difficulty                       |                                       |                                       |                                       | Is Process Computerized?              |                                       |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
|   | Easy                                  | Somewhat Difficult                    | Difficult                             | Cannot Generate                       | Yes, Computerized                     | No                                    |
| a. List of patients by diagnosis (e.g., diabetes or hypertension)   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| b. List of patients by lab result (e.g., HbA1C>9.0)   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| c. List of patients who are due or overdue for tests or preventive care (e.g., flu vaccine due)                     | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| d. List of all medications taken by an individual patient (including those that may be prescribed by other doctors) | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |

21. Are the following tasks *routinely* performed in your office practice?

|   | Yes, Using a Computerized System      | Yes, Using a Manual System            | No                                    |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| a. Patients are sent reminder notices when it is time for regular preventive or follow-up care (e.g., flu vaccine or HbA1C for diabetic patients) | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| b. All laboratory tests ordered are tracked until results reach clinicians  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| c. You receive an alert or prompt to provide patients with test results   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| d. You receive a reminder for guideline-based intervention and/or screening tests   | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |

22. Does your practice have a process for identifying adverse events *and* taking follow-up action?

<sub>1</sub> Yes, and process works well      <sub>2</sub> Yes, but process could use improvement      <sub>3</sub> No process

### MEASURING PRACTICE IMPROVEMENT

23. Does the place where you practice *routinely* receive and review data on the following aspects of your patients' care?

|   | Yes                                   | No                                    |
|---|---------------------------------------|---------------------------------------|
| a. Clinical outcomes (e.g., percent of diabetics or asthmatics with good control) | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| b. Surveys of patient satisfaction and experiences with care                      | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |

24. Are any areas of your own clinical performance reviewed against targets at least annually? <sub>1</sub> Yes <sub>2</sub> No

25. Do you receive information on how the clinical performance of your practice compares to other practices?

<sub>1</sub> Yes, routinely      <sub>2</sub> Yes, occasionally      <sub>3</sub> No      <sub>4</sub> Not sure

26. Do you have the potential to receive or do you receive extra financial support or incentives based on any of the following? (This includes bonuses, special payments, higher fees, or reimbursements.)

|   | Yes                                   | No                                    |
|---|---------------------------------------|---------------------------------------|
| a. High patient satisfaction ratings  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| b. Achieving certain clinical care targets  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| c. Managing patients with chronic disease or complex needs  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| d. Enhanced preventive care activities, including patient counseling or group visits                  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| e. Adding non-physician clinicians to your practice team (e.g., nurse for chronic disease management) | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| f. Non-face-to-face interactions with patients (e.g., email or telephone contacts)                    | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |

**27. How much of a problem, if any, are the following?**

|  | Major Problem                         | Minor Problem                         | Not a Problem                         | Not Applicable                        |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| a. Shortage of primary care physicians where you practice  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |
| b. Amount of time you or your staff spend on administrative issues related to insurance or claiming payments                 | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |
| c. Amount of time you or your staff spend on reporting clinical information or meeting regulatory requirements               | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |
| d. Amount of time you or your staff spend getting patients needed medications or treatments because of coverage restrictions | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |
| e. Amount of time you spend coordinating care for your patients  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> |

**PRACTICE PROFILE AND DEMOGRAPHIC DATA**

**28. How many full time equivalent (FTE) doctors, including yourself, are in your practice?** Insert # \_\_\_\_\_

**29. How many non-physician FTE health care providers (nurses, therapists or other clinicians) are in your practice?** Insert # \_\_\_\_\_

**30. Thinking about your medical practice, about how many hours a week do you typically work? *Your best estimate will do.*** Insert # \_\_\_\_\_

**31. About how many patients do you see in a typical week of practice? *Your best estimate will do.*** Insert # \_\_\_\_\_

**32. In a given week, about what percentage of your work time do you spend on face-to-face contacts with patients?** Insert % \_\_\_\_\_

**33. What percent of all your face-to-face patient visits during the past week do you think *could* have been handled over the phone or by email?**  
<sub>1</sub> None      <sub>2</sub> 1-9%      <sub>3</sub> 10-19%      <sub>4</sub> 20-29%      <sub>5</sub> 30% or more

**34. Do you plan to leave your medical practice within the next 5 years?**  
<sub>1</sub> Yes, retiring      <sub>2</sub> Yes, leaving for other reasons      <sub>3</sub> No      <sub>4</sub> Not sure

**35. Where is your practice located?**    <sub>1</sub> City      <sub>2</sub> Suburban      <sub>3</sub> Small town      <sub>4</sub> Rural

**36. How old are you?**      <sub>1</sub> Under 35      <sub>2</sub> 35-49      <sub>3</sub> 50-64      <sub>4</sub> 65 or older

**37. Are you...?**      <sub>1</sub> Male      <sub>2</sub> Female

**38. What is the *primary* setting of your practice site? *Select one.***  
<sub>1</sub> A private solo or physician group practice  
<sub>2</sub> Community clinic or community health center (serving low income areas)  
<sub>3</sub> Ambulatory center or clinic affiliated with hospital  
<sub>4</sub> On site at hospital, medical-center  
<sub>5</sub> Walk-in care center – sometimes called retail clinic  
<sub>6</sub> Other (*Please specify*) \_\_\_\_\_

**39. Is your practice part of a larger integrated provider system (e.g., Kaiser, VA, etc.)?**    <sub>1</sub> Yes      <sub>2</sub> No

**40. About what percentage of your patients are in each of the following categories?** Total can add to more than 100%.  
 \_\_\_\_\_ % Medicare  
 \_\_\_\_\_ % Medicaid or low income program for children or adults  
 \_\_\_\_\_ % Private or other insurance  
 \_\_\_\_\_ % Uninsured

**If you would like to receive a summary of findings, please provide your email address:** \_\_\_\_\_

**WHAT COMPLETES THE SURVEY. PLEASE RETURN IN THE ENCLOSED ENVELOPE. THANK YOU SINCERELY FOR YOUR TIME.**