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Health Tracking Physician Survey, 2008 [United States]

*Center for Studying Health System
Change*

Methodology Report

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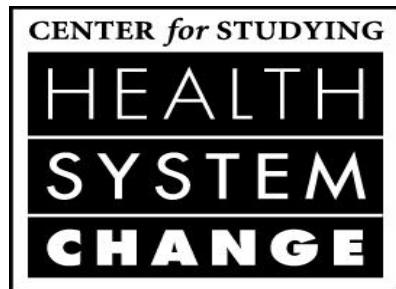
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HSC 2008 Health Tracking Physician Survey Methodology Report



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I. OVERVIEW

A. OBJECTIVES OF THE COMMUNITY TRACKING STUDY AND THE HSC HEALTH TRACKING SURVEYS

The Community Tracking Study (CTS) has been the core research effort of the Center for Studying Health System Change (HSC), a nonpartisan policy research organization in Washington, DC, that is funded in part by the Robert Wood Johnson Foundation (RWJF) and is affiliated with Mathematica Policy Research, Inc. HSC's mission is to inform health care decision makers about changes in the health care system at the local and national levels, as well as how such changes will affect people. Since 1995, HSC has conducted five rounds of household and physician surveys; an employer survey was conducted for the first round but discontinued for subsequent rounds.

The first four rounds of CTS surveys were focused on 60 nationally representative communities stratified by region, community size, and whether metropolitan or nonmetropolitan. In addition, the CTS examined 12 of the 60 communities in depth by conducting site visits and using survey samples large enough to draw conclusions about health system change in each community. The 12 communities make up a randomly selected subset of sites that are metropolitan areas with more than 200,000 people (as of July 1992). For budgetary reasons, the community-based design was replaced by a national sample design for the 2008 Health Tracking Household and Physician Surveys, although site visits continue to be focused on the 12 communities (6 rounds of site visits have been completed, with the latest occurring in 2007). Because the 2008 samples are no longer clustered in communities, the surveys have been renamed the HSC Health Tracking Household and Physician surveys. The name change

occurred after the field period commenced, so the survey documents contained in the Appendices still refer to the 2008 physician survey as the CTS physician survey.

The original plan for the 2008 survey was a dual-mode survey, using computer-assisted telephone interviewing (CATI) and self-administered mail questionnaire. This was motivated by the desire to transition to a self-administered mail survey and to maintain the ability to track changes from previous rounds of the CTS surveys. A 2006 pilot study conducted by HSC found that there were substantial mode effects between CATI and mail questionnaire responses. A dual-sample, dual-mode survey would allow tracking from previous rounds by using statistical adjustments. Data collection for the CATI portion of survey commenced prior to the mail portion. From the start, it became apparent that CATI response rates would be low and difficulties contacting physicians would unacceptably increase costs for CATI data collection, reducing funds available for the mail survey. Consequently, the CATI portion of the survey was abandoned and the survey became a single-sample, single-mode, self-administered mail survey. Discussion of the CATI portion of the survey is not included in this report.

B. THE 2008 HEALTH TRACKING PHYSICIAN SURVEY

For each round of the CTS physician surveys and the 2008 Health Tracking Physician survey, a sample of practicing physicians across the country offers perspective on how health care delivery is changing. For each of the first three rounds, more than 12,000 physicians were interviewed by telephone. The number of telephone interviews was reduced to approximately 6,600 physicians for Round Four. In 2008, the community-based sample design was replaced by a nationally-representative sample and the method of data collection was changed from telephone to mail. These changes reflected increased difficulty over time in persuading

physicians to participate in telephone-administered surveys, which raised the cost of conducting surveys and reduced survey response rates. Moreover, limited funding called for a more efficient national sample rather than one clustered in communities. The use of a national sample no longer allows for estimates at the individual community level, but national estimates can be made using smaller samples while maintaining precision.

A study conducted prior to the 2008 survey indicated that many of the variables tracked from earlier rounds were likely to be affected by the change in survey mode and that a shift from telephone to mail data collection with a pre-paid incentive was likely to increase the response rate.¹

In the 2008 survey, a total of 4,720 physicians replied to the mail survey and the weighted response rate was 61.9 percent. Physicians responded to questions on whether they can provide needed services for patients, how they are compensated, the impact of care management strategies on their practices, and their practice arrangements. For the first four CTS rounds, the Gallup Organization conducted the telephone interviewing for the physician survey while MPR was responsible for the sample design, sample weights, variance estimation, and, for rounds two through four, tracing of physicians who could not be located. For the 2008 survey, Westat conducted the mail survey and tracing activities and MPR was responsible for sample design and sampling weights. MPR and Social and Scientific Systems (SSS) collaborated with Westat and HSC to prepare the documentation for the public and restricted use files. Additional background on CTS is available at HSC's website (<http://www.hschange.org/>).

¹ See HSC Technical Publication No. 71- <http://www.hschange.com/CONTENT/889/>.

This report describes the survey design and data collection procedures used for the 2008 Health Tracking Physician Survey. We discuss the sample design in Chapter II, instrument design, cognitive interviewing, and survey preparation in Chapter III, data collection procedures in Chapter IV, and sample weighting in Chapter V. Cognitive interviewing protocols are included in Appendix A and the survey instrument and advance materials mailed to physicians in Appendix B. Reports describing the first four rounds of the CTS physician survey are included in Technical Publications #9, #32, #38, and #70.

II. INSTRUMENT DESIGN AND COGNITIVE INTERVIEWING

The survey instrument was designed by a team of HSC staff, in consultation with Robert Wood Johnson Foundation staff and other experts. In light of the original plan for a two-sample, dual-mode self-administered mail and CATI survey, a number of questions in the 2008 survey instrument were either copied or adapted from questions from previous rounds to allow for tracking. However, a substantial portion of the instrument consisted of new questions, both original and modified versions from other surveys. New topic areas included time spent communicating with patients via email or telephone, use of interpreter services, expanded questions regarding health information technologies, receipt of quality and other reports, care management, coordination of care, medical equipment and hospital ownership, malpractice, and receipt of honoraria and gifts from medically related companies.

New questions developed by HSC underwent cognitive testing, conducted by HSC consultant Carolyn Miller. The sample for the cognitive interviews was drawn from the Round Four CTS Physician Survey respondents, stratified by physician's practice type and specialty designation (PCP or specialist), as appearing in the Round Four data. Upon agreeing to participate in the interview, each respondent was sent a mail questionnaire with the new questions and room for comments on content, format, and layout. Questions covered practice organization and ownership, time allocation and reimbursement for communicating with patients, information technology, quality and coordination of patient care, sources of practice revenue and financial interest in medical equipment or hospitals, compensation method, and practice or hospital location information. After completing the survey, the respondent was

contracted by phone for a scheduled, follow-up telephone cognitive interview performed by the consultant.

Twenty-four interviews were completed, representing six solo- or two-physician practitioners, seven working in group practice, five in hospitals, three in HMOs, and one apiece in a community health center, medical school, and “other” setting. The interviewees consisted of 11 specialists, 10 PCPs, and three who identified themselves as both a PCP and a specialist. On average, interviews lasted for 36 minutes and respondents were offered \$100 honoraria for completing the cognitive interviews. The final reports on cognitive interviewing are included in Appendix A.

III. SAMPLE DESIGN

For the first three rounds of the CTS Physician Survey, interviews were administered by CATI to a stratified random sample of physicians in the 60 CTS sites, and to an independent, national sample of physicians, referred to as the “national supplement.” In Round Four (2004-2005), the national supplement was eliminated and the sample was re-allocated among the 60 sites to obtain a more efficient, proportional and national sample of physicians.²

For the 2008 Health Tracking Physician Survey, a stratified random sampling design (similar to the earlier national supplement sample) was used and the site-base sample was dropped. The survey was administered using a self-administered mail questionnaire instead of CATI.

In the following sections, we describe:

- The target population
- Design issues
- Sample size and precision
- Implementation of the sample design (including sample allocation, selection procedures and sample release procedures)

² In the first three rounds, target sample sizes were assigned to each CTS site to support site-level estimates (approximately 400 physicians in each of the twelve high-intensity sites and approximately 100 physicians in each of the other 48 sites). In round four, the target sample sizes for each site were assigned in approximate proportion to the weighted number of physicians in the site. The allocation of the target sample size is statistically more efficient (smaller sample size can obtain comparable standard errors for estimates by reducing the variation in the sampling weights) than the allocation for the prior rounds. The allocation in the 2008 survey was independent of the sites and was based on a proportional stratified sample to the 50 states.

A. TARGET POPULATION

The target population was based on information provided on the AMA Masterfile (which includes both AMA members and nonmembers). The AMA Masterfile includes licensed allopathic physicians and osteopathic physicians who obtained graduate training in allopathic medical schools or were identified on state licensing boards. The AMA Masterfile contains the majority of osteopathic physicians listed in the American Osteopathic Association (AOA) listing of osteopathic physicians. In the four prior rounds of the CTS surveys, the frame included physicians from both the AMA and AOA Masterfiles, ensuring coverage of all osteopathic physicians. However, only 0.5% of sampled physicians were listed in the AOA Masterfile while omitted from the AMA Masterfile. To reduce costs associated with acquiring and processing the AOA Masterfile in the 2008 survey, we sampled only from the AMA Masterfile; thus the survey coverage includes only osteopathic physicians who were in the AMA Masterfile.³

To meet the initial eligibility criteria for sampling, physicians in the frame must have 1) completed their medical training, 2) practiced within the 50 states and the District of Columbia, and 3) provided direct patient care for at least 20 hours per week. Residents, interns, and fellows were considered to be still in training and were excluded from the sample. The direct patient care criterion resulted in the exclusion of inactive or retired physicians and physicians who were not based in offices or hospitals (e.g. teachers, administrators, and researchers).

The following types of physicians were designated as ineligible for this survey and were removed from the frame:

³ Based on a comparison of the 2003 AOA Masterfile and the 2003 AMA Masterfile, approximately 85 percent of the osteopathic physicians in the AOA Masterfile were in the AMA Masterfile.

- Specialists in fields that do not focus primarily on direct patient care (see Table III.1);
- Federal employees;
- Graduates of foreign medical schools who are licensed to practice in the United States only temporarily.

Eligible physicians were then classified as either primary care physicians (PCPs) or specialists. PCPs were defined as physicians with a primary specialty of family practice, general practice, general internal medicine, internal medicine/pediatrics, or general pediatrics. All others with survey-eligible specialties were classified as specialists.

TABLE III.1
**SPECIALTIES EXCLUDED FROM THE SAMPLING FRAME,
BASED ON AMA MASTERFILE**

| | | |
|--|--|--|
| Allergy and Immunology/ Clinical Laboratory | Epidemiology | Pain Management |
| Aerospace | Forensic Pathology | Pathology |
| Anatomic/Clinical Pathology | Forensic Psychiatry | Pediatric Anesthesiology |
| Anesthesiology | Hematology/Pathology | Pediatric Radiology |
| Bloodbanking/Transfusion Medicine | Musculoskeletal Radiology | Public Health and General Preventive Medicine |
| Chemical Pathology | Medical Management | Radiology |
| Clinical Biochemical Gene | Medical Microbiology | Underseas Medicine |
| Clinical Pharmacology | Medical Toxicology | Vascular and Interventional Radiology |
| Cytopathology | Neuropathology Neuroradiology Nuclear Medicine | |

B. DESIGN ISSUES

The survey is based on a classical stratified design with proportional allocation. The 2008 survey design is simpler than those from prior rounds, and the key issue was to meet a cost constraint by reducing sample size while achieving the best possible precision for national estimates.

C. IMPLEMENTATION

1. Sampling Frame

The sampling frame was derived from physician records maintained by the AMA. This file contained the most current information available as of July 2007, just prior to the date of the

2008 Health Tracking Physician Survey sample selection. HSC requested the AMA Masterfile vendor to exclude physicians who resided outside of the 50 states and the District of Columbia, who were employed at a federal hospital (including military, US Public Service and Veterans Administration hospitals) or who were retired, inactive or deceased. The AMA Masterfile vendor was directed to include all physicians whose data record indicated “undeliverable” or “do not contact.” The AMA statistical Masterfile list provided to HSC contained information on 735,378 physicians. Data fields on the records in the statistical Masterfile included date of birth, specialty, and other information useful for sampling and weight computations. The statistical file did not contain the physician’s name, address or telephone number. After the sample was selected, contact information was obtained from the AMA Masterfile vendor only for physicians included in the sample.

The four steps used to construct the frame were:

1. Specify file content and format for ordering the files
2. Verify file content after receiving the AMA files
3. Exclude ineligible physicians
4. Classify records by the sampling stratum (physician classification and region).

After reviewing frequency counts for key items to ensure file accuracy and completeness, physicians who had an ineligible specialty and physicians for whom no information was available for the state of residence (either for office or preferred mailing address) were excluded from the sampling frame. The final sampling frame included 550,260 physicians. Each eligible physician was linked to the appropriate geographic stratum, based on the physician’s preferred mailing address from the AMA files. Finally, each physician was classified as either PCP or specialist according to specialty codes from the AMA data files.

2. Sampling Units and Stratification

Stratification, a feature of most large-scale surveys, performs several important functions. Using strata to define populations that are expected to have similar responses can increase survey precision. Another key function of stratification is to ensure an adequate sample size for important study populations. Stratification also helps to achieve optimum allocation for surveys in which some groups exhibit more variability in responses or are more costly to survey than others. The design for the 2008 physician survey used stratification to improve precision, to ensure adequate representation by region, and to control precision for survey estimates of PCPs and specialists.

The population for the sample included physicians in the 50 states and the District of Columbia. The states were divided into 10 geographic strata. The strata were defined to match those used in the four rounds of the CTS physician survey (with the addition of Alaska and Hawaii in one stratum), and were used in prior physician surveys conducted for the AMA. The geographic regions are defined as follows:

1. Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
2. New York
3. Delaware, New Jersey, Pennsylvania, West Virginia
4. District of Columbia, Georgia, Maryland, North Carolina, South Carolina, Virginia
5. Alabama, Florida, Kentucky, Mississippi, Tennessee
6. Arkansas, Louisiana, Missouri, Oklahoma, Texas
7. Indiana, Michigan, Ohio
8. Illinois, Iowa, Minnesota, Wisconsin
9. Arizona, Colorado, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Oregon, Utah, Wyoming, Washington
10. Alaska, California, Hawaii

The 20 sampling strata were formed by crossing the ten regions by whether the physician was classified as a PCP or a specialist. The resulting frame counts are listed in Table III.2.

3. Sample Allocation

For this survey, the goal of the sample allocation was to achieve the highest possible precision for national estimates. The design was based on a proportional allocation of the sample to PCPs and specialists and across regions.

TABLE III.2
FRAME COUNTS FOR THE 2008 HEALTH TRACKING PHYSICIAN SURVEY

| AMA Region | Total | PCP | Specialist |
|------------|---------|---------|------------|
| Total | 550,260 | 227,921 | 322,339 |
| 1 | 35,097 | 13,782 | 21,315 |
| 2 | 46,029 | 17,237 | 28,792 |
| 3 | 50,435 | 20,201 | 30,234 |
| 4 | 66,497 | 26,684 | 39,813 |
| 5 | 61,667 | 25,211 | 36,456 |
| 6 | 60,476 | 25,113 | 35,363 |
| 7 | 49,376 | 21,454 | 27,922 |
| 8 | 47,689 | 21,291 | 26,398 |
| 9 | 66,542 | 28,988 | 37,554 |
| 10 | 66,452 | 27,960 | 38,492 |

Source: MPR computation using AMA Masterfile.

4. Sample Selection and Sample Waves

The physician sample was selected in two phases: an initial screening sample and a mail survey questionnaire sample. In addition, a larger augmented sample was selected to provide a reserve for expanding the sample size in any stratum efficiently. The augmented sample included 20,316 physicians across the 20 sampling strata. In the sample selection, we imposed

implicit stratification within the explicit strata using gender, age, practice type (office-base, hospital-based or locum tenens) and zip code of the preferred address.⁴ This augmented sample was randomly partitioned into subsamples (called waves) within each stratum. The initial screening sample of 13,551 physicians was chosen by selecting a number of waves. This sample was sent to the AMA Masterfile vendor and the name and address information was returned for 13,135 physicians. We did not receive the name and address information for 426 physicians. The AMA Masterfile vendor does not release name and address information for physicians that specified a “do not contact” status to AMA.

⁴ Two forms of stratification were used in the physician survey: explicit and implicit stratification. For explicit stratification, separate subpopulations (strata) were formed and a specific sample size was assigned to each explicit stratum. The sample selection was performed independently in each explicit stratum. Implicit stratification was performed within each explicit stratum by sorting the sampling frame within the stratum by a set of characteristics of the physician (gender, age, practice type and zip code of the preferred address) and a sequential selection procedure was used to select the sample. This process can achieve a sample allocation that is approximately proportional across the variables used in the sorting step.

IV. SAMPLE FILE PREPARATION AND TRACING

A SAS file containing 13,135 records for the mail sample was delivered by MPR to Westat on October 2, 2007. A total of 150 records on this file were for doctors who had already been chosen by HSC for a telephone survey sample which was subsequently dropped from the study (see section I.A). These records were removed, leaving 12,985 records in the mail screening sample. Of these 12,985, 7.6 percent (991 physicians) were ineligible (based on Westat's initial screening contact). A first release of 8,367 physicians was selected from the remaining 11,994 cases and was sent to Westat for the mail questionnaire administration. In this first release, 5,554 records were used to conduct an initial experiment testing the optimal incentive level and follow-up procedure, (see chapter V for further discussion). For the second release, 108 of 150 physicians selected for the CATI survey were added back in, and 690 new eligible cases were added to the mail survey sample, resulting in the final mail sample worked by Westat of 9,165 physicians.

In addition, 306 physicians selected for the sample were designated as "do-not-contact" on the AMA Masterfile and were not included in screening or mail data collection, although they were included in the final sample as non-responses. Seven hundred and seventy nine cases were identified as ineligible based on the initial screening by Westat. The full mail survey sample included 10,250 physicians (9,165 physicians released to Westat, 799 physicians who were initially screened as ineligible by Westat and 306 physicians who were classified as "do not contact" cases by AMA). Ultimately, a total of 3,301 that were selected for the screening sample were never released for the mail survey. The total breakdown of the sample is shown in Table IV.1.

TABLE IV.1.
SAMPLE BREAKDOWN

| | Sample size |
|---|-------------|
| Release 1 - Experiment | 5,554 |
| Release 1 - Remainder | 2,813 |
| Release 2 | 798 |
| Subtotal: cases sent to Westat for mail survey | 9,165 |
| AMA No Contact Cases | 306 |
| Ineligible based on initial screening contact | 779 |
| Total Mail Survey Sample | 10,250 |
| Screening sample not released for the full study (includes 110 AMA no contact cases) | 3,301 |
| Full Screening Sample | 13,551 |

A. DATA PREPARATION AND TRACING

For some cases, the original file contained both the AMA mailing address and the office address. A new file with a single address was created for these cases: if the office address was different from the mailing address, the office address was used. Address data were reformatted to standardize address field placement and were reviewed by data management staff to check for missing values or formatting errors. Records without phone numbers were then put through a search (using a vendor's services) to obtain phone numbers.

Data were prepared in the format required by the Westat telephone research center (TRC) for conducting the screening calls. Two files were sent to the TRC: one for those with no phone number, which required tracing (1,980 cases), and another for those with a phone number that could be assigned to screening (11,113 cases). Information gathered during tracing included updated addresses and telephone numbers. Using the initial contact information (physician

name, last known office address, year of birth, year of graduation from medical school, and specialty), tracing was initiated on October 18, 2007.

The tracing protocol was based on the results from a previous physician study which indicated the most cost-effective and time-efficient tracing methods. The majority of cases were initially traced using the Internet (Google, Medicare Physician Directory, and Choice Trust), before relying on paid sources such as Directory Assistance and Lexus Nexus. Occasionally, physicians were located through name changes (usually females), medical centers, hospitals, group practices or HMO's.

If the address from the initial contact information matched the one provided by the tracing source, and the latter included a telephone number, the case was updated in the study management system (SMS). If conflicting contact information was identified, the case was screened to determine which information was correct before entering the information into the SMS. If no information was found, the case was coded as non-locatable.

The tracing of the 1,980 cases with initially missing phone numbers was largely successful. As shown in Table IV.2, approximately 68 percent of these cases were successfully traced. The cases that were not successfully traced were assigned a final status of non-locatable.

TABLE IV.2
CASES THAT HAD NO TELEPHONE NUMBER PRIOR TO SCREENING

| | Cases with no phone number | Cases for which phone number was obtained | Cases successfully screened or located* |
|------------------------|----------------------------|---|---|
| Release 1 - Experiment | 1,107 | 1,047 | 651 |
| Release 1 - Remainder | 172 | 169 | 172 |
| Release 2 | 99 | 95 | 65 |
| Not used | 602 | 565 | 464 |
| Total | 1,980 | 1,876 | 1,352 |

* These cases were finalized with a screener code of anything other than “non-locatable.”

B. SCREENING

Screening was conducted on all cases to determine whether the selected physician was eligible to participate in the study. Screening began on October 29, 2007, and was complete by February 4, 2008. Although screening calls were attempted for all 13,093 cases, not every case was successfully screened. The screener could not be completed in some cases due to:

- an inability to obtain cooperation from office staff within the maximum call limit of seven (Max Call);
- no answer by a live person at the telephone number, but the physician’s name was confirmed by the voicemail message (Name confirmed);
- office staff stating a refusal to participate in the study (Refusal by Office);
- the physician stating a refusal to participate in the study (Refusal by Physician); and

- an inability to find a valid telephone number for the case (Non-locatable).

Study eligibility was determined for cases where screening was successful by speaking directly with the physician or with a knowledgeable person in the physician's office.

Physicians who were deemed ineligible were marked as such in the SMS and did not receive any study mailings. Cases where the physician personally refused were also not included in any additional study activities. Cases with other screener codes progressed to the mailing stage of the study, including those designated as Max Call, Name Confirmed, Refusal by Office, and Non-locatable. Mailings were sent to all of these cases even though they did not have complete screeners.

All cases were given a final screening code prior to the end of tracing and screening procedures. Table IV.3 summarizes the final screener codes.

TABLE IV.3.
SCREENER RESULT CODES

| | | Screener result codes | | | | | | | Total sample size |
|---------------------------------|------------------|-----------------------|------------|---------------|----------------|-------------------|----------------------|---------------|-------------------|
| | | Eligible | Ineligible | Maximum calls | Name confirmed | Refusal by office | Refusal by physician | Non-locatable | |
| Release 1 - Experiment | Arm 1 | 1,527 | 92 | 38 | 69 | 23 | 22 | 283 | 2,054 |
| | Arm 2 | 642 | 48 | 0 | 0 | 0 | 12 | 0 | 702 |
| | Arm 3 | 610 | 45 | 0 | 0 | 0 | 15 | 0 | 670 |
| | Arm 2a | 788 | 50 | 23 | 35 | 9 | 12 | 157 | 1,074 |
| | Arm 3a | 773 | 50 | 18 | 32 | 13 | 23 | 145 | 1,054 |
| | Total experiment | 4,340 | 285 | 79 | 136 | 45 | 84 | 585 | 5,554 |
| Release 1 - Remainder | | 1,783 | 107 | 85 | 130 | 59 | 36 | 613 | 2,813 |
| Release 2 | | 584 | 35 | 18 | 24 | 10 | 12 | 115 | 798 |
| Remaining sample (not released) | | 2,202 | 1,126 | 49 | 84 | 29 | 30 | 408 | 3,928 |
| Total | | 8,909 | 1,553 | 231 | 374 | 143 | 162 | 1,721 | 13,093 |

V. CONDUCT OF THE MAIL SURVEY

A. IRB REVIEW

Prior to data collection, all materials (instrument, letters, fact sheets, etc.) were provided to the Westat IRB for review. In order to ensure informed consent, the IRB required the addition of several paragraphs to the survey cover describing the study and the use of the study data. On November 1, 2007, Westat's IRB approved the CTS survey data collection materials and procedures (see Appendix B, Attachment A). HSC also requested that the Westat IRB provide oversight for their work on the analysis and release of the database to a public website. On November 27, 2007, the Westat IRB agreed to serve as the approving body for HSC's work after the end of the official contract period (see Appendix B, Attachment B). HSC agreed to submit a checklist on Disclosure Potential of Proposed Data Releases as part of the IRB approval process.

Appendix B includes the final instrument (attachment C), cover letters for the first mailing (attachment D), cover letters for the second mailing (attachment E), cover letters for the third mailing (attachment F), fact sheets that accompanied the cover letters (attachment G), and a letter of support from the Agency for Healthcare Research and Quality (AHRQ, attachment H). The cover letters for the first mailing varied in the amount of incentive included as part of an experiment discussed in the next chapter (\$50 versus \$75), and the cover letters to the third mailing varied by incentive amount and by whether or not the physician had earlier cashed a check without responding.⁵

⁵ Note that these documents all refer to the survey as the Community Tracking Study Physician Survey rather than the HSC Health Tracking Physician Survey as decisions regarding the name change had not as yet been made.

B. SAMPLE RELEASE

The preliminary results from the screening portion of the survey, conducted by Westat, were provided to MPR and an initial release was developed based on these results. The first release contained 9,478 physicians. This sample of 9,478 physicians included physicians who were screened as eligible for the mail survey as well as physicians who were determined by the screening as ineligible and physicians who had informed AMA not to include them in any survey. The working sample consisted of 8,367 physicians. The working sample excluded physicians who traced as ineligible or who were designated as “do not contact” by AMA, or who had been part of another sample.⁶ Based on a preliminary assessment of expected response eligibility rates by strata and target numbers of completed interviews, we prepared a second sample release that included 772 physicians. The working sample released for data collection included 798 physicians (excluding 77 physicians who were classified as ineligible during the initial screening or who were designated as “do not contact” by AMA from among the 772 physicians and reintroducing the 103 physicians who were previously not released because they were deemed as potentially in the CATI sample). The final sample size for the mail survey was 10,250 (9,478 in the first release and 772 in the second sample release). The sample allocation is shown in Table V.1.

⁶ We had originally planned on a telephone component for the 2008 survey to directly measure mode effects, but dropped this component after a pilot study indicated that the response rate from a telephone survey would be unacceptably low.

TABLE V.1
FINAL SAMPLE COUNTS FOR THE 2008 HEALTH TRACKING PHYSICIAN SURVEY

| AMA Region | Final Sample Count | | |
|------------|--------------------|-------|------------|
| | Total | PCP | Specialist |
| Total | 10,250 | 4,271 | 5,979 |
| 1 | 732 | 287 | 445 |
| 2 | 945 | 357 | 588 |
| 3 | 834 | 349 | 485 |
| 4 | 1,133 | 468 | 665 |
| 5 | 1,282 | 475 | 807 |
| 6 | 1,225 | 497 | 728 |
| 7 | 886 | 399 | 487 |
| 8 | 864 | 359 | 505 |
| 9 | 1,095 | 496 | 599 |
| 10 | 1,254 | 584 | 670 |

Source: MPR computation.

C. EXPERIMENT TO TEST AMOUNT OF INCENTIVE AND FOLLOW-UP PROTOCOL

Because of the abandonment of the CATI portion of the survey due to low response rates, along with evidence of declining response rates on recent physician surveys conducted by HSC and other organizations, we conducted an embedded experiment to test the impact of differing levels of monetary incentive and follow-up efforts on response rates and survey costs. The experimental sample was “embedded” in the survey sample because the experimental cases comprised a significant part of the total sample. The results were then used to adopt an optimal incentive and follow-up protocol for the remainder of the survey.

A sample of 5,554 was used to test the amount of incentive (\$50 vs. \$75) and use of follow-up calls to respondents (received telephone calls vs. did not receive calls) on response and yield

rates. The response rate, which was the same as for the full study, was defined as completes plus ineligibles divided by the total sample, and the yield rate (which excludes ineligibles) was defined as complete eligible physicians divided by the total sample. The original design of the experiment was for 3,465 cases to be released in three arms: 1) \$50 incentive with telephone follow-up, 2) \$75 incentive with telephone follow-up, and 3) \$75 incentive with no telephone follow-up. Because an early draft of the advance letter was erroneously sent to physicians in the last two experimental groups, and because this error had the potential of confounding the results of the experiment, two additional arms (2a and 3a) were added to the experiment. The size and original treatment of each group are shown in Table V.2 below. The experimental sample included cases that were deemed ineligible during screening and final refusals; these cases, which were not mailed questionnaires, were included in order to compute response rates based on the full sample. The experiment was conducted during the early stages of the field period, from February 5, 2008 through April 16, 2008.

TABLE V.2
EXPERIMENT SAMPLE BREAKDOWN

| | Initial treatment | Sample size |
|------------------|--------------------|-------------|
| Arm 1 | \$50, follow-up | 2,054 |
| Arm 2 | \$75, follow-up | 702 |
| Arm 3 | \$75, no follow-up | 670 |
| Arm 2a | \$75, follow-up | 1,074 |
| Arm 3a | \$75, no follow-up | 1,054 |
| Total Experiment | | 5,554 |

The experimental results were analyzed based on survey dispositions on May 2, 2008 (see Table V.3). Arms 2 and 3 were not used in the analysis because of the error in the advance letter, although the results were similar to arms 2a and 3a. A review of survey outcomes indicated that the mix of the \$75 incentive and the follow-up calls (arm 2a) yielded significantly higher response and yield rates than the \$75 incentive without follow-up or the \$50 incentive with follow-up. An additional factor in assessing the three arms was the cost of the follow-up protocol, which was considered acceptable in order to achieve a higher response rate. The cost of the follow-up effort was modest as the protocol typically resulted in interviewers having brief calls with office staff or leaving messages, rather than speaking directly with physicians. Consequently, we decided to use the \$75 incentive with follow-up calls for the remainder of the sample. A follow-up protocol was subsequently incorporated into additional mailings for arms 3 and 3a.

TABLE V.3
RESULTS OF EMBEDDED EXPERIMENT (MAY 2, 2008)

| | Arm 1 \$50FU | Arm 2a \$75FU | Arm 3a \$75noFU |
|--|-----------------|------------------|--------------------|
| Mailed Questionnaire | | | |
| No Response | 618 | 292 | 436 |
| Survey Complete | 866 | 498 | 438 |
| Case Review - Interim ⁷ | | | |
| Re-mailed M1 | 60 | 27 | 1 |
| Re-mailed M2 | 7 | 6 | |
| Refused - Final | 194 | 75 | 5 |
| Deceased | 2 | | |
| Ineligible - Invalid Specialty | | 1 | |
| Ineligible - Federal Employee | 8 | 2 | 5 |
| Ineligible - Resident or Fellow | 5 | | 2 |
| Ineligible - Less than 20 hours care | 41 | 33 | 25 |
| Ineligible, Other | | 1 | |
| Ineligible - Not Practicing | 3 | 1 | |
| Ineligible - Retired | 5 | 3 | |
| Ineligible - Unavailable during Field period | | 2 | |
| Address Unknown | 84 | 46 | 36 |
| Unable to Locate | 45 | 27 | 33 |
| Sub-Total | 1940 | 1012 | 981 |
| Final Disposition at Screening (No mailing) | | | |
| Scrn Inelig Fed Empl | 4 | 3 | 3 |
| Scrn Inelig Res/Fellow | 7 | | 1 |
| Scrn Inelig No Direct Care | 17 | 7 | 9 |
| Scrn Inelig Specialty | 2 | 1 | |
| Scrn Inelig Retired | 48 | 17 | 25 |
| Scrn Inelig Not Avlb Fld Period | 4 | 2 | 2 |
| Scrn Inelig Institutionalized | 4 | 11 | 3 |
| Scrn Inelig Not in Prac | 2 | 6 | 6 |
| Scrn Inelig Other | | | |
| Scrn Deceased | 4 | 3 | 1 |
| Scrn Refusal | 22 | 12 | 23 |
| Sub-Total | 114 | 62 | 73 |

⁷ During follow-up calls, some respondents for physicians' offices requested that questionnaires be re-mailed. At the close of the experiment, 88 questionnaires had been re-mailed once and 13 had been re-mailed twice but had not yet been returned, to close out as final non-responses.

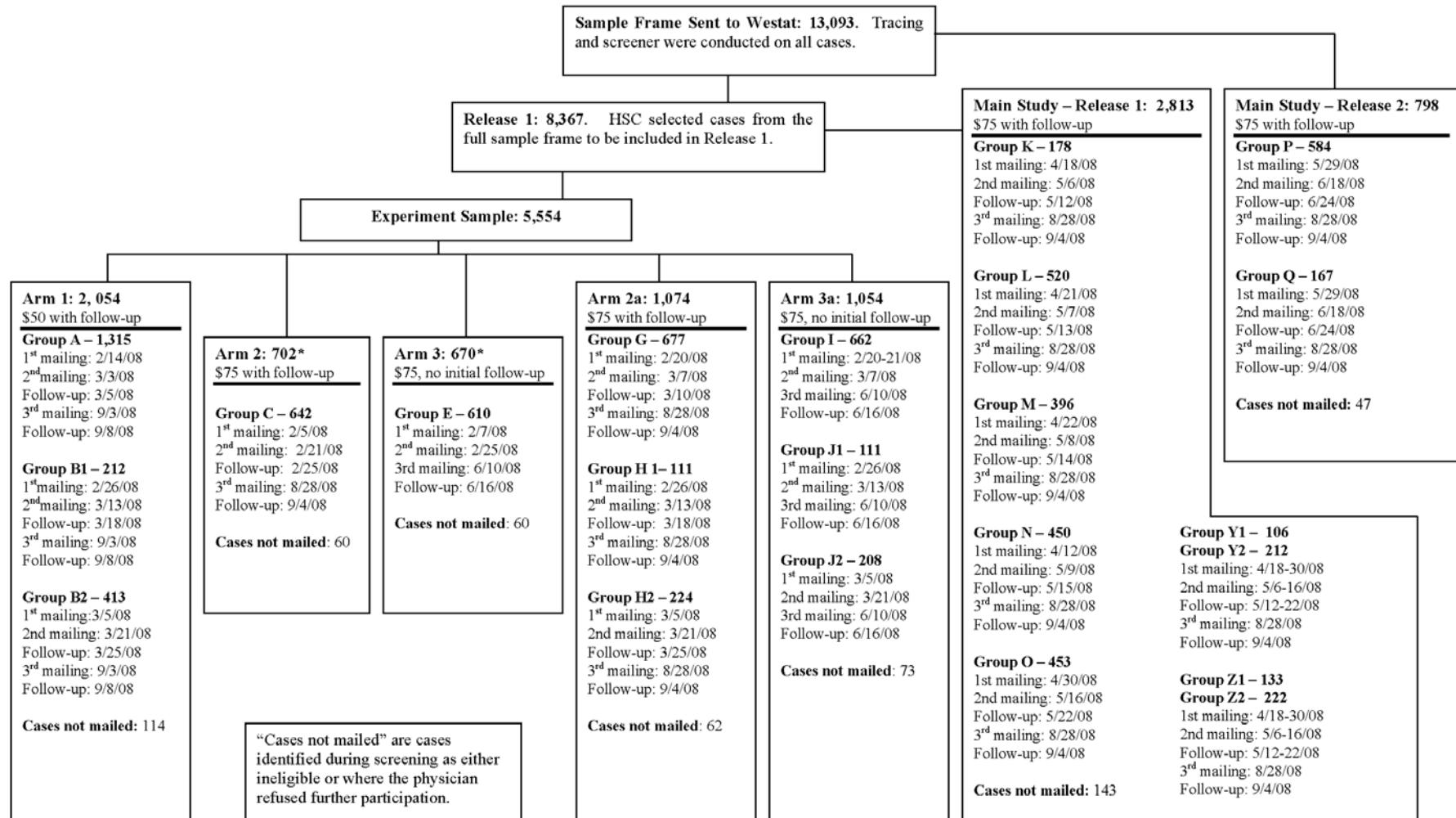
| | | | |
|----------------------------------|--------|--------|--------|
| Total Sample | 2054 | 1074 | 1054 |
| Response Rate (C+I)/Total sample | 49.85% | 54.84% | 49.34% |
| Yield Rate (C/Total sample) | 42.16% | 46.37% | 41.56% |

D. MAIL SURVEY DATA COLLECTION

The field period for the study started on February 5, 2008, and continued through October 31, 2008. This section outlines the procedures for the mailings, including package contents, calls from study respondents, and sending additional questionnaires by mail, fax and email. For exact dates of all mailings and follow-up calls see Exhibit V.1.

EXHIBIT V.1

STUDY DESIGN CHART



*These Arms originally included Groups Y and Z, which were moved to the Main Study-Release 1.

1. Mailing Protocol

Initial mailings to physicians were made in groups according to a schedule based on Westat corporate capabilities (i.e., check request requirements) and staff availability. Experimental groups received initial mailings in February 2008 and March 2008 while groups in the remainder of Release 1 received initial mailings in late April 2008. Groups in Release 2 received initial mailings in late May 2008. Second mailings were sent to physicians who had not responded within two weeks of the initial mailing. Physicians who sent back the first questionnaire did not have any further contact with the study. Physicians in the two experimental groups that did not initially receive follow-up treatment (arms 3 and 3a) received a third mailing that included follow-up calls in early June 2008. As a result of the success of this third mailing, the rest of the experimental groups (arms 1, 2 and 2a) and cases in the rest of Release 1 and Release 2 received a third mailing in September 2008. The number of cases to receive specific mailings is outlined in Table V.4 below.

TABLE V.4
NUMBER OF CASES PER MAILING

| | | First mailing | | Second mailing | Follow-up call to second mailing | Third mailing | | Follow-up call to third mailing |
|------------|--------|---------------|------------|----------------|----------------------------------|---------------|------------|---------------------------------|
| | | \$50 check | \$75 check | | | No check | \$75 check | |
| Experiment | Arm 1 | 1,940 | 0 | 1,328 | Yes | 59 | 347 | Yes |
| | Arm 2 | 0 | 642 | 421 | Yes | 54 | 297 | Yes |
| | Arm 2a | 0 | 1,012 | 682 | Yes | | | Yes |
| | Arm 3 | 0 | 610 | 397 | No | 12 | 682 | Yes |
| | Arm 3a | 0 | 981 | 661 | No | | | Yes |
| Release 1 | | 0 | 2,670 | 1,839 | Yes | 77 | 679 | Yes |
| Release 2 | | 0 | 751 | 489 | Yes | 30 | 170 | Yes |
| Total | | 1,940 | 6,666 | 5,817 | | 232 | 2,175 | |

2. Mailing Methods

For the experimental groups, two mailing methods were used. Cases that were coded as complete at the screener level were sent packages using two-day Federal Express delivery. Cases that were not coded as complete at the screener were sent packages using the US Postal Service's (USPS) Priority Mail system, which takes four days for delivery. USPS Priority Mail was used for screener non-completes because this delivery method obtained address corrections if the screener address was incorrect. Due to escalating costs for Federal Express delivery, all remaining cases in Release 1 and Release 2, as well as all third mailings, were sent using Priority Mail. Beginning April 18, 2008, all re-mails (requests from physicians to receive an additional questionnaire package) were also made by Priority Mail.

3. Package Contents

Table V.5 below summarizes the contents of each mailing. Initial mailings to respondents included:

- a questionnaire labeled with respondent and form IDs;
- a personalized cover letter (on Robert Wood Johnson Foundation letterhead);
- a fact sheet;
- a letter of support from the Agency for Healthcare Research and Quality;
- an incentive check of either \$50 or \$75 depending on group assignment; and
- a postage-paid return envelope.

TABLE V.5
CONTENT OF MAILINGS

| | First mailing | Second mailing | Third mailing | | Re-mails | |
|-------------------|---------------|----------------|---------------|---------|--------------|------------|
| | | | Non-cashers | Cashers | Full package | Check only |
| Questionnaire | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Cover Letter | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Fact Sheet | ✓ | ✓ | ✓ | | ✓ | |
| Letter of Support | ✓ | ✓ | ✓ | | ✓ | |
| Incentive Check | ✓ | | ✓ | | | ✓ |
| Return Envelope | ✓ | ✓ | ✓ | ✓ | ✓ | |

Each package was assembled with the return envelope folded in half and inserted into the front cover of the questionnaire with the incentive check, cover letter, letter of support and fact sheet cradled inside the fold of the return envelope. This arrangement was designed to ensure that incentive checks did not get separated from the rest of the materials. Second mailings and re-mails included all of the materials in the first mailing with the exception of the incentive check; the cover letter for the second mailing also was altered to reflect the absence of the check. Third mailings were divided between non-respondent physicians who had not cashed their incentive check and those that had. Physicians who had not cashed their check were sent a completely new package in the third mailing, including a new incentive check. Physicians in this group that had previously received a \$50 incentive check were sent a \$75 check. Physicians who had cashed their earlier incentive check but had not responded to the survey were sent a new

package without a new check. These cases also received a different cover letter. All versions of cover letters, fact sheets, and letters of support can be found in Appendix B.

4. Undeliverables

Two types of packages were returned to Westat as undeliverable: those with and those without a forwarding address. If new or forwarding address information was provided by the mailing service, this new address information was entered into the SMS and the package was resent to the new address. If no forwarding address was provided, the case was marked in the SMS as “address unknown” and sent to the TRC for tracing. If no new address could be located during telephone tracing, the case was finalized as “non-locatable.” A total of 917 cases were finalized as non-locatable.

5. In-Bound Calls

Materials sent to respondents referenced a toll-free number that respondents could call for additional information. At the beginning of the field period, calls went directly to The Robert Wood Johnson Foundation (RWJF). However, it became clear that most calls could be more easily answered by a staff member from Westat. Therefore, a toll-free number connecting to Westat was established. However, if the nature of the call indicated that the physician wanted to discuss the study rationale or had questions about the use of the data, the call was referred to the RWJF.

A total of 113 calls were received on the Westat toll-free line during the course of the study. Each call was logged into a tracking system and appropriately handled by a study staff person. The reasons for the calls and the protocol response are outlined in Table V.6 below. It should be

noted that some calls covered more than one topic and have therefore been included in the table more than once. This table only includes calls received directly by Westat; it does not include calls made to the RWJF.

TABLE V.6
DESCRIPTION OF INCOMING CALLS TO THE WESTAT TOLL-FREE NUMBER

| Number of Calls | Reason for call | Protocol response |
|-----------------|---|--|
| 30 | Physician cannot find honorarium and requests that a new check be sent | A new check was mailed to the physician. |
| 16 | Report that the physician is not eligible for the study. | The physician was asked to complete the screener portion of the instrument and send it in. |
| 7 | Refusal to participate; request no additional mailings or calls. | The case was marked as a hard refusal and received no additional mailings or calls. |
| 10 | Physician has moved. | If a new address was provided, a new package was mailed. If no new address was provided, the case was marked as "non-locatable." |
| 7 | Questionnaire already sent in, but received another in the mail and wants to know whether to fill it out again. | Physicians were assured that they did not need to complete the survey a second time. |
| 11 | Want to confirm that the mailed questionnaire has been received. | The case was checked in the SMS and receipt confirmed. |
| 34 | Other question or request. | Response varied according to need. |

6. Re-mails

A report was run daily to indicate which cases required a re-mail, fax or email. The majority of these requests originated in the TRC, although they could also be initiated by either the in-

bound toll-free number or through an undeliverable package with a corrected address. Re-mail requests were assigned a status in the management system that indicated whether the physician needed a repeat of either the first or second package. Physicians requesting the first package were sent the full initial package including a new check. Physicians requesting the second mailing received a complete data collection package except for a new check. An additional type of re-mail was for a check only. Physicians who reported that they had misplaced their incentive check were sent a new check. Table V.7 below outlines the number of re-mails by type in each of the sample groups.

TABLE V.7
TYPES OF RE-MAILS

| | | First package re-mails | Second package re-mails | Check-only re-mails |
|------------------------|--------|---------------------------|----------------------------|---------------------|
| Release 1 - Experiment | Arm 1 | 144 | 27 | 24 |
| | Arm 2 | 38 | 15 | 8 |
| | Arm 3 | 33 | 3 | 5 |
| | Arm 2a | 77 | 15 | 9 |
| | Arm 3a | 68 | 4 | 5 |
| Release 1 - Remainder | | 219 | 20 | 31 |
| Release 2 | | 84 | 1 | 6 |
| Total | | 663 | 85 | 88 |

7. Fax and Email Requests

Physicians could request to have the survey either faxed or emailed to them. These requests came through either the TRC or the in-bound toll-free number. Physicians requesting a fax received a set of materials including a questionnaire with ID number, a cover letter, and a customized fax cover sheet. They were asked to either mail the questionnaire back to the

provided address or fax it back to the provided number. Physicians requesting an email received the same set of materials in electronic (PDF) format. Physicians were asked to print the questionnaire before completing it and either mail it or fax it back. The number of fax and email requests is outlined in Table V.8. Some physician offices requested both a fax and an email or requested a fax on more than one occasion; therefore, Table V.6 reports the number of requests rather than the number of cases.

TABLE V.8
NUMBER OF FAX AND EMAIL REQUESTS

| | | Fax requests | Email requests |
|------------------------|--------|--------------|----------------|
| Release 1 - Experiment | Arm 1 | 99 | 30 |
| | Arm 2 | 15 | 1 |
| | Arm 3 | 21 | 3 |
| | Arm 2a | 67 | 18 |
| | Arm 3a | 80 | 0 |
| Release 1 - Remainder | | 219 | 13 |
| Release 2 | | 62 | 5 |
| Total | | 563 | 70 |

8. Mail Refusals

Packets returned with blank questionnaires and the original mailing contents (with or without the check) were deemed final refusals and were marked in the SMS as “final refusal” along with other comments that indicated the doctor was unwilling to complete the survey.

E. TELEPHONE FOLLOW-UP

Except for experimental arms 3 and 3a, follow-up telephone calls were made to the physician's office following the second and third mailings in order to encourage survey completion. (Based on analysis of experimental results, arms 3 and 3a received follow-up calls after the third mailing). Calls were made to physicians' offices between February 25 and October 31, 2008. The protocol for the follow-up calls is outlined in this section.

1. Training Interviewers

Fifteen interviewers, selected based on prior experience with physician studies that used similar methods, were trained on February 25, 2008. The training included an overview of the web-based Study Management System (SMS) used for tracking cases in the TRC. During the training, a total of six interactive practice sessions were conducted and a debriefing was held after the first hour of production to address any questions or issues.

2. Telephone Follow-up Protocol for Cases that were Complete at Screening

Cases coded as screener completes that did not respond to the initial mailings were assigned to the full telephone follow-up protocol outlined in this section. If a completed questionnaire was received at any time during the follow-up period, calls were halted and the case was coded as complete. Calls were scheduled as follows:

| | |
|-----------------------------------|-------------------------------------|
| If the last mailing date was..... | Then follow-up began the following: |
| Monday | Friday |
| Tuesday | Monday |
| Wednesday | Tuesday |
| Thursday | Wednesday |
| Friday | Thursday |

Interviewers were instructed to avoid calling offices between the hours of noon and 1:00 pm in the respondent's time zone to avoid the lunch hour. Later, it was discovered that these times varied from office to office. Therefore, those rules were modified according to notes provided for those offices that were considered outside the norm.

The SMS used to track cases in the TRC provided interviewers with a special section to note any unique instructions related to that particular office or case. These notes were routinely reviewed by the TRC manager to ensure that any particular or irregular circumstance for each case was addressed appropriately.

Follow-up calls were broken down into 3 tasks:

- **Task 1:** The goal of Task 1 was to verify that the package was received at the physician's office and to ask that it be physically handed to the doctor. In the case of small practices, this call was used to remind the physician to fill out the questionnaire. Up to five calls were made in trying to complete Task 1. If Task 1 was not completed in five calls, the TRC supervisor determined whether to move the case to Task 2 or to continue trying to complete Task 1.
- **Task 2:** Calls to complete Task 2 were made 7-10 days after the completion of Task 1. The goal of Task 2 was to leave a reminder message for the physician and to ascertain whether an additional survey needed to be sent. Two calls were made in an attempt to

complete Task 2. If Task 2 was not complete in two calls, the TRC supervisor determined whether to move the case to Task 3 or to continue trying to complete Task 2.

- **Task 3:** Task 3 calls started 10 days after the previous call. The goal of Task 3 was to speak with the physician directly. If this was not possible, Task 3 enlisted the help of the administrative assistant or office manager to encourage the physician to complete the survey. The interviewer also determined whether an additional survey needed to be mailed or faxed. A total of three calls were made in an attempt to complete Task 3. If Task 3 was not complete in three calls, the TRC manager reviewed the case to decide if additional calls would be helpful or if the case had been completely worked.

No more calls were made to the physician's office once the case was finalized or Task 3 was completed.

3. Telephone Follow-up Protocol for Cases other than Complete at Screening

Cases that were coded as "non-locatable" during the screener were not sent to the TRC for follow-up calls. Cases that had screener codes of maximum calls, no contact, or refusal were sent to the TRC for a single follow-up call. If this call was successful (e.g., reached a human being), then that case entered the full telephone follow-up protocol. If the single call was not productive, no further follow-up was attempted.

4. Telephone Follow-up to Re-mail, Fax, and Email Requests

Physicians who received re-mails were returned to the TRC for follow-up once the additional materials were sent. These physicians received a follow-up call the fourth day after the package was re-mailed. Respondents requesting a check received a follow-up call seven days after the check was mailed. No follow-up calls were made if the completed questionnaire was received before the follow-up was scheduled to begin.

5. Calls Following the Third Mailing

Following the third mailing, a limited follow-up telephone protocol was used to encourage survey participation and to verify the mailing had been received. Each case was called only enough times to either talk to a person to confirm package receipt or to leave a message on an answering machine. Cases received no more than four total follow-up call attempts after the third mailing. The only exceptions were cases where a person who was reached requested that the package be re-mailed (either by Priority Mail, fax or email). Each of these cases received another follow-up call to confirm that the additional package was received.

6. Refusals by Telephone

Physicians who spoke to data collectors or called the toll-free number and stated they did not want to complete the survey were coded as final refusals and no additional follow-up calls were made to them. If someone other than the sampled physician called on behalf of the physician and stated that the physician did not want to complete the survey, the call history was reviewed by a supervisor. If the supervisor determined that a return call would be unproductive, the case was entered as a final refusal. Otherwise, the case received additional efforts according to the telephone follow-up protocol.

F. DATA MANAGEMENT AND PROCESSING

1. Receipt of Questionnaires

Completed questionnaires were processed and entered into the SMS on the same day or the next morning after arrival. Because each respondent could receive more than one mailing,

questionnaires were entered into the system by both the respondent ID and the form ID. This ensured that any duplicate questionnaires from the same respondent were noted and one could be discarded during cleaning. Questionnaires returned as undeliverable were also entered into the SMS as “Address Unknown” for the first two returned-as-undeliverable mailings. Upon receipt of the third returned mailing, the case status was changed to a final status of “Unable to Locate.”

All returned questionnaires were grouped and filed according to a status code (complete, ineligible, address unknown, etc). Completed questionnaires were coded, verified, batched and sent to data entry.

2. Coding and Keying

Completed questionnaires were coded according to decisions made jointly by HSC and Westat staff. Comments written in the margins were flagged and then reviewed by a supervisor to determine relevance to questionnaire responses. Problematic responses were also flagged and reviewed by a supervisor. All decisions regarding how to code responses were documented in a decision log and resultant new codes and consistency checks were incorporated into the codebook.

The supervisor reviewed the first 25 questionnaires completed by each coder. If there were no coding issues identified, the supervisor reviewed 10 percent of all subsequent coding work.

Following coding, questionnaires were batched and sent to data entry where they were double keyed. Once questionnaires were returned from data entry, iterative editing resumed, during which frequencies and cross tabs were generated and reviewed regularly. Comments written by physicians concerning the survey or health issues that they would like to see

addressed in future surveys were also captured in a separate Excel file. Completed questionnaire data was reconciled with the disposition codes recorded in the management system.

In accordance with IRB requirements, identifying information located on the last page of the questionnaire was keyed into a file kept separate from the rest of the data.

3. File Layout and Development

A SAS file of cleaned questionnaire data was created for delivery to HSC. This file contained SAS special missing values to indicate “Don’t know” (D), “Not Ascertained” (M), and “Not Applicable” (.) values.

4. Data Delivery

An interim data file was delivered to HSC in August 2008 and final data files were delivered in November 2008. The interim delivery consisted of 3,637 eligible records from the physician mail survey. The final data file produced by Westat consisted of 4,723 eligible physician records; subsequent editing reduced this number to 4,720. Both data deliveries consisted of SAS records and were accompanied by the following: files for format linking, formats, and frequencies; a status file related to the screening, mailing and follow up processes; an Excel file of physicians statements from the comment section at the end of the questionnaire; an Excel file containing the name and address for each physician’s main medical practice and the hospital name where he or she admits the most patients; and a codebook of the mail questionnaire.

5. Final Dispositions and Response Rate

The final dispositions of the sample and response rate are shown in Table V.9. The unweighted response rate, which is defined as the sum of completed eligible and ineligible cases divided by the total sample size, is 61.8 percent; the weighted response rate, shown in Table VI.1 of Chapter VI below, is 61.9 percent. This definition of the response rate assumes that the eligibility rate for non-responding and non-locatable physicians is the same as for responding physicians. Since the eligibility rate for non-locatable physicians is likely to be lower than for locatable physicians, this definition is conservative.

TABLE V.9
FINAL DISPOSITIONS AND RESPONSE RATE

| Mail Survey Final Dispositions | Total Sample |
|---|---------------------|
| No Response | 1,460 |
| Survey Complete | 4,720 |
| Refused - Final | 1,104 |
| Ineligible-Deceased | 10 |
| Ineligible - Invalid Specialty | 4 |
| Ineligible - Federal Employee | 45 |
| Ineligible - Resident or Fellow | 17 |
| Ineligible - Less than 20 hours care | 257 |
| Ineligible - Not Practicing | 36 |
| Ineligible - Retired | 29 |
| Ineligible - Unavailable during Field period | 7 |
| Ineligible, Other | 0 |
| Address Unknown | 0 |
| Unable to Locate | 917 |
| Total Mail Release | 8,606 |
| Screening and Tracing Final Dispositions | |
| Ineligible- Fed Employee | 98 |
| Ineligible- Resident/Fellow | 138 |
| Ineligible-Less than 20 hours care | 238 |
| Ineligible- Specialty | 24 |
| Ineligible- Retired | 400 |

| | |
|--|-------------------|
| Ineligible- Not Avlb Fld Period | 51 |
| Ineligible- Institutionalized | 81 |
| Ineligible- Not in Practice | 107 |
| Ineligible- Other | 1 |
| Final Refusal | 132 |
| Ineligible-Deceased | 59 |
| Ineligible (from CATI sample) | 9 |
| Screening Final | 1,338 |
| AMA Refusals (not attempted) | 306 |
| Total | 10,250 |
| Complete | 4,720 |
| Ineligible | 1,611 |
| Refusal (Eligibility Unknown) | 1,236 |
| No Response (Eligibility Unknown) | 2,683 |
| Total Sample | 10,250 |
| % Eligible | 74.55% |
| Eligible / (Eligible + Ineligible) | |
| Estimated Eligibles | 2,922 |
| Total Eligibles | 7,642 |
| AAPOR Response Rate (equivalent to (completes+ineligibles)/total sample | 61.8% |

VI. SAMPLING AND ANALYSIS WEIGHTS

A. OVERVIEW

The weights for the 2008 Health Tracking Physician Survey adjust for differences in probabilities of selection and response (that is, the propensity for a physician to be located and the propensity for a located physician to respond). The initial weights, also called sampling weights, were calculated as the reciprocals of the probabilities of selection. The initial weights were adjusted to account for locatability and non-response because some sampled physicians could not be located and others that were located did not participate.⁸ After these non-response adjustments, the weights were post-stratified. In this section we describe the initial weights, non-response patterns that motivate adjustments, and the adjustments themselves.

1. Analysis Weights

Unbiased estimates are the goal of any serious survey. Differences in probabilities of selection or response propensities across various population subgroups can result in the responding sample being distributed differently than the study population. Such inconsistent distributions, if not corrected by proper weighting, can produce biased survey estimates. Thus, our analysis weights adjust for differences in selection probabilities and the two components of response: 1) locatability and 2) participation among physicians that could be located. To calculate the adjustments for locatability and non-response, we employed logistic regression

⁸ For the purposes of both the examination of non-response and the weighting adjustments, “participation” and “response” include those determined in the course of the survey to be ineligible (such as those that had retired or whose practice included fewer than 20 hours per week of patient contact), as well as those that completed the questionnaire.

models using data from the AMA Masterfile (the sampling frame). Separate models were developed for each of the two adjustments.

B. INITIAL WEIGHTS

The initial sampling weight was calculated as the reciprocal of the probability of selection of each physician. The sample was selected and released for contact as described in Chapter III, and the probabilities of selection reflected each of the steps in selecting and releasing the sample. Probabilities of selection varied only slightly across strata. Thus, the sampling weights were roughly equal for all sample members.

C. RESPONSE PATTERNS

Response patterns were examined to assess the potential for non-response bias, gauge whether adjustment should be made in one or more steps, and inform the selection of variables to include in non-response adjustment models. We used data available from the AMA Masterfile to evaluate the response patterns. First, we concluded that response rates differed across groups of sampled physicians defined by characteristics that could be related to study variables; these differences, if not incorporated into weighting adjustments, could produce biased survey estimates. Second, patterns for the two components of non-response, locatability and propensity to respond once located, were sufficiently different to warrant separate adjustments.

On a weighted basis, 61.9 percent of the sample responded (i.e., completed the survey or were determined to be ineligible). The (net) percent responding is the product of the weighted percent located (88.1) and the weighted percent of those located who responded (70.3). We

found variation in all three measures across subgroups of the population that were defined based on frame information. We examined response patterns for subgroups based on:

- Classification (whether PCP or specialist)
- Region
- Gender
- Age
- Country of birth (United States or Canada; all others)
- Medical school location (United States or Canada; all others)
- Specialty among the PCPs (General/Family Practice, Internal Medicine, Pediatrics)
- Practice arrangement (solo- or two-physician practice; office, group, or HMO; all others)
- Percent of time practicing in hospitals
- Survey incentive

We examine each of these in turn. Results are presented in Table VI.1.

Classification and Region. A slightly higher net percentage of PCPs responded (62.6) than did specialists (61.4), but the patterns differed and there was more variation in the two components than in the net response. PCPs had a lower percentage located (86.7 versus 89.1) but a higher percentage responding among those located (72.2 versus 69.0). Across regions, the net percent responding fell between 57.9 and 67.4. The percent located ranged from 84.9 to 90.6 while the percent responding among those located ranged from 66.7 to 76.3.

When classification and region are crossed, they define the sampling strata. We find somewhat larger differences across strata, with the net percent responding ranging from 56.2 to 69.2, the percent located from 82.6 to 92.0, and the percent responding among those located from 63.7 to 78.1.

TABLE VI.1
RESPONSE PATTERNS FOR THE 2008 HEALTH TRACKING PHYSICIAN SURVEY

| Sample Classification | Total Sample | Unweighted Located Sample | Weighted Percent Located | Unweighted Sample Completes and Ineligible | Unweighted Sample Completes | Weighted Response Among Located | Weighted Percent Response |
|--|---------------|---------------------------|--------------------------|--|-----------------------------|---------------------------------|---------------------------|
| TOTAL | 10,250 | 9,027 | 88.1 | 6,331 | 4,720 | 70.3 | 61.9 |
| Physician Classification | | | | | | | |
| PCP | 4,271 | 3,699 | 86.7 | 2,665 | 1,959 | 72.2 | 62.6 |
| Specialist | 5,979 | 5,328 | 89.1 | 3,666 | 2,761 | 69.0 | 61.4 |
| Region | | | | | | | |
| 1 | 732 | 630 | 86.1 | 434 | 309 | 68.9 | 59.3 |
| 2 | 945 | 802 | 84.9 | 547 | 410 | 68.2 | 57.9 |
| 3 | 834 | 729 | 87.5 | 526 | 395 | 72.1 | 63.1 |
| 4 | 1,133 | 1,004 | 88.7 | 714 | 518 | 71.1 | 63.0 |
| 5 | 1,282 | 1,160 | 90.3 | 816 | 605 | 70.4 | 63.6 |
| 6 | 1,225 | 1,110 | 90.6 | 741 | 560 | 66.7 | 60.5 |
| 7 | 886 | 799 | 90.2 | 557 | 420 | 69.6 | 62.8 |
| 8 | 864 | 762 | 88.2 | 514 | 403 | 67.7 | 59.7 |
| 9 | 1,095 | 968 | 88.4 | 739 | 565 | 76.3 | 67.4 |
| 10 | 1,254 | 1,063 | 84.9 | 743 | 535 | 70.0 | 59.4 |
| Sampling Strata (Classification and Region) | | | | | | | |
| 101 | 287 | 246 | 85.7 | 179 | 135 | 72.8 | 62.4 |
| 102 | 357 | 295 | 82.6 | 210 | 153 | 71.3 | 58.8 |
| 103 | 349 | 300 | 86.0 | 221 | 164 | 73.7 | 63.3 |

| Sample Classification | Total Sample | Unweighted Located Sample | Weighted Percent Located | Unweighted Sample Completes and Ineligible | Unweighted Sample Completes | Weighted Response Among Located | Weighted Percent Response |
|-----------------------|--------------|---------------------------|--------------------------|--|-----------------------------|---------------------------------|---------------------------|
| 104 | 468 | 403 | 86.1 | 294 | 207 | 73.0 | 62.8 |
| 105 | 475 | 418 | 88.0 | 301 | 217 | 72.0 | 63.4 |
| 106 | 497 | 446 | 89.7 | 290 | 215 | 65.0 | 58.4 |
| 107 | 399 | 351 | 88.0 | 261 | 190 | 74.4 | 65.4 |
| 108 | 359 | 316 | 88.0 | 230 | 188 | 72.8 | 64.1 |
| 109 | 496 | 439 | 88.5 | 343 | 259 | 78.1 | 69.1 |
| 110 | 584 | 485 | 83.0 | 336 | 231 | 69.3 | 57.5 |
| 201 | 445 | 384 | 86.3 | 255 | 174 | 66.4 | 57.3 |
| 202 | 588 | 507 | 86.2 | 337 | 257 | 66.5 | 57.3 |
| 203 | 485 | 429 | 88.5 | 305 | 231 | 71.1 | 62.9 |
| 204 | 665 | 601 | 90.4 | 420 | 311 | 69.9 | 63.2 |
| 205 | 807 | 742 | 91.9 | 515 | 388 | 69.4 | 63.8 |
| 206 | 728 | 664 | 91.2 | 451 | 345 | 67.9 | 62.0 |
| 207 | 487 | 448 | 92.0 | 296 | 230 | 66.1 | 60.8 |
| 208 | 505 | 446 | 88.3 | 284 | 215 | 63.7 | 56.2 |
| 209 | 599 | 529 | 88.3 | 396 | 306 | 74.9 | 66.1 |
| 210 | 670 | 578 | 86.3 | 407 | 304 | 70.4 | 60.7 |

| Sample Classification | Total Sample | Unweighted Located Sample | Weighted Percent Located | Unweighted Sample Completes and Ineligible | Unweighted Sample Completes | Weighted Response Among Located | Weighted Percent Response |
|--------------------------------|--------------|---------------------------|--------------------------|--|-----------------------------|---------------------------------|---------------------------|
| Gender | | | | | | | |
| Male | 7,363 | 6,585 | 89.5 | 4,618 | 3,470 | 70.3 | 62.9 |
| Female | 2,887 | 2,442 | 84.6 | 1,713 | 1,250 | 70.4 | 59.6 |
| Age | | | | | | | |
| 20-44 years | 3,301 | 2,841 | 86.1 | 1,994 | 1,600 | 70.3 | 60.5 |
| 45-54 years | 3,301 | 2,945 | 89.2 | 1,957 | 1,591 | 66.6 | 59.3 |
| 55-64 years | 2,359 | 2,097 | 88.9 | 1,443 | 1,113 | 69.1 | 61.5 |
| 65 years or older | 1,289 | 1,144 | 88.9 | 937 | 416 | 82.1 | 73.0 |
| Gender and Age | | | | | | | |
| Male, 20-44 years | 1,932 | 1,683 | 87.1 | 1,191 | 987 | 70.9 | 61.8 |
| Male, 45-54 years | 2,334 | 2,127 | 91.2 | 1,388 | 1,172 | 65.3 | 59.5 |
| Male, 55-64 years | 1,944 | 1,741 | 89.6 | 1,197 | 931 | 69.0 | 61.8 |
| Male, 65 years or older | 1,153 | 1,034 | 89.8 | 842 | 380 | 81.6 | 73.3 |
| Female, 20-44 years | 1,369 | 1,158 | 84.7 | 803 | 613 | 69.5 | 58.8 |
| Female, 45-54 years | 967 | 818 | 84.3 | 569 | 419 | 69.9 | 59.0 |
| Female, 55-64 years | 415 | 356 | 85.8 | 246 | 182 | 69.8 | 59.9 |
| Female, 65 years or older | 136 | 110 | 81.6 | 95 | 36 | 86.4 | 70.5 |
| Birth Country | | | | | | | |
| U.S. | 7,190 | 6,397 | 89.0 | 4,580 | 3,448 | 71.8 | 63.9 |
| Other | 3,060 | 2,630 | 86.0 | 1,751 | 1,272 | 66.7 | 57.4 |
| Medical School Location | | | | | | | |
| U.S./Canada | 7,882 | 6,987 | 88.6 | 4,966 | 3,740 | 71.2 | 63.2 |

| Sample Classification | Total Sample | Unweighted Located Sample | Weighted Percent Located | Unweighted Sample Completes and Ineligible | Unweighted Sample Completes | Weighted Response Among Located | Weighted Percent Response |
|---------------------------|--------------|---------------------------|--------------------------|--|-----------------------------|---------------------------------|---------------------------|
| Other | 2,368 | 2,040 | 86.2 | 1,365 | 980 | 67.1 | 57.8 |
| Specialty | | | | | | | |
| General/family practice | 1,715 | 1,495 | 87.2 | 1,073 | 790 | 71.9 | 62.7 |
| Internal medicine | 1,624 | 1,395 | 86.0 | 939 | 679 | 67.5 | 58.1 |
| Pediatrics | 932 | 809 | 86.9 | 653 | 490 | 80.9 | 70.3 |
| Specialist | 5,979 | 5,328 | 89.1 | 3,666 | 2,761 | 69.0 | 61.4 |
| Present Employment | | | | | | | |
| Solo or 2 practice | 2,487 | 2,275 | 91.5 | 1,607 | 1,171 | 70.8 | 64.8 |
| Office-group-HMO' | 4,389 | 3,985 | 90.8 | 2,778 | 2,242 | 69.9 | 63.4 |
| Other | 3,374 | 2,767 | 82.0 | 1,946 | 1,307 | 70.6 | 57.9 |

| Sample Classification | Total Sample | Unweighted Located Sample | Weighted Percent Located | Unweighted Sample Completes and Ineligible | Unweighted Sample Completes | Weighted Response Among Located | Weighted Percent Response |
|--|--------------|---------------------------|--------------------------|--|-----------------------------|---------------------------------|---------------------------|
| Percent of Practice Hours Spent at Hospital | | | | | | | |
| 0 percent or unknown | 6,044 | 5,181 | 85.7 | 3,546 | 2,541 | 68.6 | 58.8 |
| 1-20 percent | 1,075 | 1,017 | 94.6 | 789 | 656 | 77.7 | 73.6 |
| 25-45 percent | 1,036 | 952 | 92.0 | 668 | 522 | 70.5 | 64.9 |
| 50-85 percent | 1,001 | 910 | 91.0 | 618 | 479 | 68.2 | 62.0 |
| 86-100 percent | 1,094 | 967 | 88.4 | 710 | 522 | 73.5 | 64.9 |
| Incentive Experiment⁹ | | | | | | | |
| \$50, full protocol | 2,325 | 2,030 | 87.3 | 1,385 | 1,031 | 68.4 | 59.8 |
| \$75, full protocol, old letter | 1,164 | 1,028 | 88.3 | 730 | 535 | 71.2 | 62.9 |
| \$75, no follow-up, old letter | 1,164 | 1,010 | 86.7 | 714 | 543 | 70.9 | 61.4 |
| \$75, full protocol, new letter | 1,214 | 1,071 | 88.2 | 779 | 585 | 73.1 | 64.5 |
| \$75, no follow-up, new letter | 1,201 | 1,081 | 90.1 | 759 | 574 | 70.3 | 63.3 |
| Not in the experiment | 3,182 | 2,807 | 88.2 | 1,964 | 1,452 | 70.1 | 61.9 |

Source: MPR computations

⁹ Note that the experimental protocols were standardized following analysis of the experimental data (discussed above in Chapter V). The \$75 protocols with no follow-up received follow-up calls for the third mailing and physicians who had not responded to the \$50 protocol after the second mailing were mailed \$75 for the third mailing. Physicians who were not part of the experiment all received the \$75 follow-up protocol. The incorrect (old) letter was replaced with a corrected letter for the second and third mailings.

Age and Gender. The net percent responding was higher for male (62.9) than for female physicians (59.6). Male physicians were also more likely to be located (89.5 versus 84.6 percent), possibly because of name changes, while the percent responding among those located was nearly identical for the two groups.

Response rates varied by age, with the percent responding being substantially higher for those 65 and older (73.0) compared with younger cohorts (59.3 to 61.5 percent). The percent located did not vary greatly, but was lower for the youngest group (86.1 compared to approximately 89 for the other three). There was more variation in percent responding among those located, which ranged from 66.6 (age 45-54) to 82.1 (age 65+).

When age and gender are crossed, the net response rates range from 58.8 percent (female physicians age 20-44) to 73.3 percent (male physicians, age 65+). Compared to female physicians, the net response for males is two to three percentage points higher in all age groups except 45 to 54 year olds. The percent located varies from 81.6 to 91.2, while the percent responding among those located has an even larger range (65.3 to 86.4).

Birth Country and Medical School Location. Compared to physicians born outside the U.S., overall response was higher for native-born physicians (63.9 versus 57.4 percent). Similarly, the net response was higher for those who attended medical school in the U.S. or Canada than for others (63.2 percent compared to 57.8 percent). In both cases the gap was larger for response among those located than it was for the percent located.

Medical Practices. In addition to distinguishing broadly between PCPs and specialists, we examined response patterns across three specialties within primary care, practice arrangement, and percentage of hours spent practicing in a hospital setting, and noted differences in response patterns along all dimensions.

While a slightly higher percentage of PCPs than specialists responded, there was considerable variation among the three subgroups of PCPs. The net percent responding ranged from 58.1 (internal medicine) to 62.7 (general and family practice) to 70.3 (pediatrics). There was little variation among groups with respect to percent located, but a large spread (13.4 percentage points) in the percent responding among those located.

We find a smaller difference in net percent responding by practice arrangement than across specialties. Net rates vary from 57.9 (other) to 64.8 percent (solo practice/two-physician practice). Unlike the difference across specialties, the difference across practice type is mostly attributable to locatability, where there is a 9.5 percentage point spread, compared to response, where there are almost no differences among the three types.

Examination of percent of hours practicing at a hospital shows a spread of roughly 15 percentage points in net response. This variable was derived from another survey conducted by the AMA, results from which were included on the Masterfile. The highest net response corresponded to those spending 1-20 percent of their time in a hospital, and the lowest to those with zero percent or missing data. The 1-20 percent group had the highest percent located and highest percent responding among those located. The zero (or unknown) percent group had the lowest percent located and was nearly the lowest in percent responding once located.¹⁰ Since the Masterfile did not differentiate between those values, it is possible that many of these cases did not respond to the AMA survey from which these data were derived, which could explain their lower response rates for the HSC survey.

¹⁰ Fifty nine percent of the sample had a value of zero or unknown hours.

Survey Incentive. The variation in net response among incentive groups was less than that for groups defined on other criteria, ranging from 59.8 to 64.5 percent.¹¹ The spread was similar for percent responding once located, and a bit smaller (86.7 to 90.1) for percent located.

The differences in net response led us to conclude that using frame variables including those discussed above was appropriate when developing a model or models to adjust for non-response. Since different patterns were observed for percent located and percent responding once located, we developed separate models for locatability and for response propensity among those located.

D. WEIGHT ADJUSTMENTS

The purpose of non-response adjustment to sampling weights is to reduce the potential for bias associated with non-response. If non-response to a survey is completely random, then estimates of means weighted by the sampling weights would be unbiased and no adjustment would be necessary. For estimating totals, however, a single adjustment still would be needed to inflate a weighted total to account for the proportion of physicians who did not respond.

However, non-responses are rarely completely random, and examination of response patterns suggests it was not for the CTS Physician Survey. Our approach to non-response adjustments (consistent with the patterns noted above) was to develop two logistic regression models designed to predict (1) the likelihood of locating a physician (location propensity score) and (2) the likelihood that located physicians complete the interview (response propensity score). Then, we computed an adjustment value for each physician who completed the interview. The

¹¹ Note that the differences in experimental groups underestimate the effect of the higher incentive and follow-up interventions because all non-responding physicians who were selected for the experiment were given the preferred approach (\$75 incentive with follow-up) in subsequent mailings.

weight as adjusted for non-response is the product of the inverse of the location propensity score, the inverse of the response propensity score, and the sampling weight.

A key factor in determining the usefulness of logistic regression models is the availability of information for respondents and non-respondents. In many surveys, information is limited beyond that used for creating sampling strata. However, 2008 Health Tracking Physician Survey has information for nearly all sampled physicians that can be used to enrich the models; the AMA file that was used as the sample frame contains many demographic and practice characteristics for physicians.

Logistic propensity modeling has been used for several surveys where information on the characteristics of both respondents and non-respondents is available. For example, this approach was used for the National Survey of Family Growth (Potter et al., 1998), and has been tested for use with the Survey of Income and Program Participation (Folsom and Witt, 1994). The procedure also has been employed in surveys of military personnel (Iannacchione et al., 1991) and in surveys of Medicare and Medicaid populations for which demographic and economic data are available from federal or state administrative files (CyBulski et al., 1999).

The modeling approach can result in a few sample members being assigned an extremely large adjustment factor (Little, 1986). However, the possibility of large adjustment factors can be reduced by using a restricted logistic regression model¹² or by trimming to compensate for adjustment factors from an unrestricted logistic regression model via a sample alignment or a post-stratification adjustment process. We used the latter approach. As discussed below, we examined the weights for outliers and concluded that trimming was not needed.

¹²The coefficients of the model are estimated based on restrictions on the size of the adjustment factor.

The model-based non-response adjustments are predicted values (based on maximum likelihood) and are estimators that are consistent, asymptotically efficient, asymptotically normal, and therefore, asymptotically unbiased.

After computing adjustment factors for the inability to locate a physician and for non-response among located physicians, these non-response adjusted weights were then checked for consistency with known (or estimated) population counts of eligible physicians and were post-stratified.

We prepared two sets of weighted logistic regression models to adjust the survey weights for our ability to locate physicians and to obtain a response (either a completed survey or ineligible disposition) among the located cases. Each model was used to predict locatability or response among located cases as a function of physician characteristics, represented by a series of indicator variables. The sampling weights were used in the location regression models and the sampling weights adjusted for non-location were used in the response regression models.

The variables used in the logistic regression models, chosen based upon the abovementioned non-response pattern analysis, were age, country of medical school, country of birth, gender, specialty, present employment, percentage of hours the physician worked in a hospital, year licensed, type of incentive offered, AMA region, and whether located in an MSA. We began by including all of them in the models (referred to as the full model). Many of these variables were in the form of multi-level categorical responses, so we transformed them into a series of indicator variables. To identify interaction terms among the main effects variables that should be included in the model, we employed the method of Chi-Square Automatic Interaction Detection (CHAID). Second-, third-, and fourth-order interactions were included if indicated by the CHAID analysis.

Nested models were used so that all lower-order interactions within a significant higher order interaction were included in the model regardless of their significance.

The categories for the first-order variables were chosen based on the number of observations in each category and the different location or response rates in each one. For example, the categorization of specialty in the model takes four categories: General/Family Practice, Internal Medicine, Pediatrics, and Specialists.

To prepare the models, we used a weighted, forward stepwise variable selection logistic regression procedure from SAS, which identifies and adds the predictor that minimizes the deviance when a new predictor is introduced in the model. We obtained a full logistic regression model with this method. Then we used this full model in SUDAAN, which computes accurate variances for the estimates of the models, taking into account the sampling design of the survey, and eliminated predictors that were not significant.

Table VI.2 summarizes the logistic regression model that was used for the location adjustments and Table VI.3 presents results from the response model. For each model, we also present the pseudo R-squared values, noting that small pseudo R-squared values are the norm in logistic regression and cannot be interpreted in the same way as those from linear regression (Hosmer and Lemeshow, 2000).

The goodness-of-fit tests indicated that the models were a reasonable fit. The pseudo R-squared values were small for some models, with an average value of 0.06 for the location model and 0.04 for the response model.

1. Location Weight Adjustments

The location models estimate the probability of locating a physician (location propensity score). The weight adjusted for location is obtained by multiplying the sampling weight and the

inverse of the location propensity score. These adjustments inflate the weights of the located physicians to compensate for those physicians who were not located.

The final logistic regression model for location showed that the location rates were higher among the following categories of physicians:

- specialists;
- those in the experimental arm receiving a survey incentive of \$50 with the full follow-up protocol;
- those who did not respond/responded zero or who responded “85% or more” to an AMA survey question on the percent of hours spent in hospital care (odds ratio 6.5);
- those whose present employment was not in the “other” category (odds ratio 3.2); and
- those born in the USA or Canada and whose present employment was in the “other” category (odds ratio 1.4).

TABLE VI.2
RESULTS OF THE LOCATION MODELING PROCEDURES

Variables Included in the Final Model^a

| |
|---|
| Medical school location (in USA or Canada; other) |
| Specialty (General, Family Practice, Internal Medicine, Pediatrics, Specialist) |
| Percent hours spent in hospital |
| Age (20-44, 45-54, 55-64, 65+) |
| Survey incentive |
| Physician’s gender |
| Employment (solo or two-physician; larger practice, group or HMO; other) |
| Birth country (USA, Canada, or other) |
| Whether practice is in MSA (population \geq 250,000) or not |

^aAll variables were significant at $p \leq 0.3$ as main effects or within interactions.

TABLE VI.3

RESULTS OF THE RESPONSE MODELING PROCEDURES

| Variables Included in the Final Model ^a |
|---|
| Medical school location (in USA, Canada; other) |
| Specialty (General, Family Practice, Internal Medicine, Pediatrics, Specialist) |
| Percent hours spent in hospital |
| Age (20-44, 45-54, 55-64, 65+) |
| Survey incentive |
| Physician's gender |
| Employment (solo or two-physician; larger practice, group or HMO; other) |
| Birth country (USA, Canada, or other) |
| Whether practice is in MSA (population $\geq 250,000$) or not |
| Year of first license |
| Region |

^aAll variables were significant at $p \leq 0.3$ as main effects or within interactions.

2. Response Weight Adjustments

The response models predict the probability that a physician completes the interview (response propensity score). The final weight adjusted for non-response is obtained by multiplying the weight adjusted for location and the inverse of the response propensity score. These adjustments inflate the weights of the physicians who completed the interview to compensate for those physicians who did not complete the interview.

The final logistic regression model for response showed higher response among the following doctors:

- those who are age 65 or above, attended a U.S. or Canadian medical school and who are located in an MSA with a population of at least 250,000 (odds ratio 4.2);
- those who were born in the USA or Canada and whose percent of hours worked in a hospital is zero or unknown (odds ratio 3.6);
- those who are pediatricians (odds ratio 2.8); are specialists (odds ratio 1.2); received a survey incentive of \$75 with full protocol and were in the “remaining” (post-experiment) sample (odds ratio 1.2);
- and those whose present employment is “other” (odds ratio 1.1).

E. FINAL COMPUTATION OF THE WEIGHTS

The objectives when computing the national weights are (1) to minimize the risk of introducing bias on the sample estimates, and (2) to reduce the design effect of the sample estimates. Thus, after applying the non-response adjustments, post-stratification is necessary to match the adjusted weights to the population totals in the frame. The post-stratified weights are checked to see if trimming was needed to avoid extreme weight values.

After applying the adjustments to the weights for non-locatable physicians and for non-response among located physicians, the weighted counts for physicians who completed the

interviews or who were ineligible did not reproduce the frame totals for region and specialty.¹³ Therefore, we formed 40 cells (10 regions by four specialty groups) and computed a ratio-type adjustment so that the sum of the non-response adjusted weights matched the frame counts for those cells. These adjustments were the frame count for a group divided by the corresponding sum of the non-response adjusted weights for the completed and ineligible interviews in the group.

After the post-stratified weights were developed, we examined the distribution to see if trimming was needed to address the potential of extreme weights that inflate the sampling variance of survey estimates. We concluded that trimming was not necessary. The sum of weights was 411,784.

¹³ Specialists, plus the three subgroups of PCPs: general/family practice, internal medicine, and pediatrics.

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APPENDIX A

2008 HSC HEALTH TRACKING PHYSICIAN SURVEY REPORT ON COGNITIVE INTERVIEWING

FINAL

March 2007

Note: The following document refers to the survey as the Community Tracking Study Round Five Physician Survey rather than the HSC Health Tracking Physician Survey. Decisions regarding the name change were made after these materials were published.

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I. INTRODUCTION

The Center for Studying Health System Change (HSC) developed new questions for the fifth round of the Community Tracking Study's (CTS) Physician Survey. The Center hired a survey research consultant to conduct cognitive interviews to evaluate these new questions. Cognitive interviews were conducted during February and early March 2007.

This report describes the methodology used in the cognitive testing and summarizes the results. Section II describes the methodology used to conduct the interviews and provides demographic and other information on respondents. Section III provides some general comments on the interviews. Section IV of this report presents findings from the cognitive interviews. There is a separate sub-section for each part of the questionnaire (practice characteristics, hours worked, etc) and each sub-section includes the goals for the questions in that sub-section, the test questions, summary results from the interviews, results in detail (by sample group and respondent), and suggestions for revisions.

II. METHODS

The Center provided the survey research consultant with the survey questions for testing, guidance on the goals for each test question, and identified particular areas of concern or target phrases or words for testing.

The consultant prepared a mail survey questionnaire and a telephone interview protocol, both of which were reviewed and approved by HSC. The mail questionnaire was sent to the respondent to complete prior to the telephone cognitive interview and included all test questions laid out as they would be for a mail survey and space for the respondent to record comments on the question content, format and layout (See Appendix A). The telephone interview protocol was used by the consultant to conduct the cognitive interview. This protocol included all the test questions as well as question-specific probes for each test question. (See Appendix B)

HSC provided a personalized introductory letter that was faxed, emailed or mailed to the respondent. In most cases, these letters were sent after an initial telephone contact by the consultant to the physician's office or home. The letter was then followed by additional telephone contacts by the consultant to secure cooperation. When a physician agreed to participate, he or she was faxed, emailed or mailed the survey test questionnaire and a time was scheduled for the telephone interview. At the start of the telephone interview, the consultant confirmed that the respondent had the completed mail questionnaire.

The sample for the cognitive interviews was drawn by from the CTS Round Four respondent pool and was selected in the following 6 strata related to the respondent's type of practice at the time of that survey: 1) Solo or two physician practice; 2) Group practice of 3+ doctors; 3) Group or staff model HMO; 4) Hospital; 5) Community Health Center; 6) Medical school. Within each stratum, the sample was further divided between primary care physicians (PCP) and specialists. The sample was provided to the consultant in an excel spreadsheet and contained names, contact information, and information related to the sample strata definitions.

A total of 24 telephone cognitive interviews were conducted. The interviews were divided among the different type of practice strata as follows: 6 physicians in solo or two physician practice, 7 physicians in group practice, 5 physicians in a hospital setting; 3 in HMOs, and one each in a community health center, a medical school, and one ‘other’ setting. Effort was also made to split interviews among PCP and specialists. Eleven interviews were conducted with specialists, 10 with PCPs, and 3 with physicians who considered themselves to be both a PCP and a specialist.

Telephone interviews were conducted between February 6, 2007 and March 7, 2007. Calls were made during the day, evening and on weekends and all but three interviews were recorded with the respondent’s knowledge and permission. Three interviews were not recorded because of technical difficulties. The average length of interview was 36 minutes and respondents were offered \$100 honoraria as a thank you for participating in the interview.

Table One presents sample and demographic information for the 24 respondents and Table Two presents the number of respondents who made comments or had problems with each question and the number giving key responses to each question.

TABLE ONE
SAMPLE AND RESPONDENT CHARACTERISTICS

| Complete Number | Date of Interview | Length of Interview | Gender | Type of Practice | PCP or Specialist | Time to complete mail questions |
|-----------------|-------------------|---------------------|--------|------------------|-------------------|---------------------------------|
| 1 | Feb 6 | 40 | M | Solo | Specialist | 15-20 |
| 2 | Feb 9 | 40 | M | HMO | Specialist | 15 |
| 3 | Feb 11 | 40 | F | Hosp | PCP | 15 |
| 4 | Feb 13 | 40 | M | HMO | Specialist | 10 |
| 5 | Feb 14 | 30 | M | Group | PCP | 25 |
| 6 | Feb 14 | 35 | M | Group | Specialist | 5 |
| 7 | Feb 15 | 45 | M | HMO | Spec/PCP | 25 |
| 8 | Feb 15 | 30 | M | Group+ | PCP | 15 |
| 9 | Feb 15 | 45 | M | Med sch+ | Specialist | 20 |
| 10 | Feb 15 | 35 | F | Hosp | Specialist | 30 |
| 11 | Feb 16 | 45 | F | Group | PCP | 10 |
| 12 | Feb 16 | 35 | F | Group | PCP | 10 |
| 13 | Feb 17 | 35 | F | Group+ | PCP | 25 |
| 14 | Feb 18 | 30 | F | Group+ | PCP | 10 |
| 15 | Feb 18 | 60 | M | Hosp+ | Specialist | 60 |
| 16 | Feb 18 | 30 | M | Solo | Specialist | 10 |
| 17 | Feb 20 | 30 | M | Hosp | Specialist | 30 |
| 18 | Feb 21 | 20 | M | Other* | PCP/Spec | 30 |
| 19 | Feb 21 | 45 | M | Solo | PCP | 15 |
| 20 | Feb 26 | 40 | M | Hosp | PCP/Spec | 10 |
| 21 | March 5 | 35 | M | Solo | Specialist | 25 |
| 22 | March 6 | 40 | F | CHC | PCP | NA |
| 23 | March 7 | 20 | F | Solo | Specialist | 15 |
| 24 | March 7 | 30 | M | Solo | PCP | 20 |

+ Dr was in solo sample group but is now in Group practice with 3+ doctors

+ Dr was in hospital sample but has changed to medical school

+ Dr was in hospital sample but has changed to group practice with 3+ doctors

+ Dr was in solo sample but now in group with 3 doctors

+ Dr was in CHC sample but now in hospital setting

* Works in a hospital ER but employed by an ER group which contracts with the hospital to supply the ER doctors. He is trained and boarded as General Internist (PCP) but works in “specialty setting” – the ER.

TABLE TWO
NUMBER OF RESPONDENTS WITH COMMENTS/PROBLEMS
AND KEY RESPONSES TO EACH QUESTION
BY SAMPLE GROUP

| QUESTION | Total | Solo | Group 3+ | Hospital | HMO | Other |
|---|-------|------|----------|----------|-----|-------|
| (n) | (24) | (6) | (7) | (5) | (3) | (3) |
| PRACTICE CHARACTERISTICS | | | | | | |
| Q1 – Comment/problem | 5 | | 1 | 1 | 2 | 1 |
| Q1a – Comment/problem | 1 | | | 1 | | |
| Q2,Q2a – Comment/problem | 4 | | 3 | | | 1 |
| HOURS WORKED AND REIMBURSEMENT | | | | | | |
| Q3/Q4 – Comment/problem | 6 | 2 | 1 | 1 | 2 | |
| Q3 – E-mail w/ patient/clinicians | 7 | 2 | 1 | 1 | 2 | 1 |
| Q4 – Reimbursed for any | 1 | | | | 1 | |
| INFORMATION TECHNOLOGY IN MEDICINE | | | | | | |
| Q5 – Comment/problem | 12 | 3 | 5 | 2 | 1 | 1 |
| Q5 – Any valid Yes | 2 | 1 | 1 | | | |
| Q5 – Don't know | 6 | | 2 | 2 | 1 | 1 |
| QUALITY AND COORDINATION OF PATIENT CARE | | | | | | |
| Q6/Q7 – Comment/problem | 11 | 1 | 5 | 2 | 2 | 1 |
| Q6 – Any valid yes | 4 | 2 | 1 | | | 1 |
| Q7 - Yes | 6 | 2 | 2 | 1 | | 1 |
| Q8 – Comment/problem | 3 | 1 | 1 | 1 | | |
| Q8 – Any yes | 19 | 6 | 7 | 3 | 1 | 2 |
| Q9 – Comment/problem | 9 | 4 | 2 | 1 | 2 | |
| Q9 – No patients in DMP | 9 | 4 | 2 | 1 | | 2 |
| Q10 – Comment/problem | 7 | 2 | 1 | 2 | 2 | |
| Q10 – NA | 3 | | | 1 | 1 | 1 |

| QUESTION | Total | Solo | Group 3+ | Hospital | HMO | Other |
|------------------------------------|-------|------|----------|----------|-----|-------|
| (n) | (24) | (6) | (7) | (5) | (3) | (3) |
| SOURCES OF PRACTICE REVENUE | | | | | | |
| Q11 – Comment/problem | 7 | 3 | 2 | 1 | 1 | |
| Q11 – Don't know | 3 | | | | 1 | 2 |
| Q12 - Q15 – Comment/problem | 19 | 5 | 6 | 4 | 2 | 2 |
| Q12 – Anv yes | 10 | 2 | 4 | 2 | 1 | 1 |
| Q13 – Any yes | 1 | | | | 1 | |
| Q14 – Yes | 4 | | | 1 | 2 | 1 |
| Q15 – Yes | 1 | 1 | | | | |
| COMPENSATION | | | | | | |
| Q16 – Comment/problem | 9 | 5 | 3 | 1 | | |
| Q17/Q18 – Comment/problem | 12 | 2 | 4 | 2 | 2 | 2 |
| Q17 – Any yes other than a/b | 16 | 4 | 5 | 3 | 1 | 3 |
| Q18 - \$1001 or more | 6 | 1 | 2 | 2 | | 1 |
| PERSONAL BACKGROUND | | | | | | |
| Q19/Q20 – Comment/problem | 3 | 1 | 1 | | 1 | |

III. GENERAL COMMENTS

Some respondents made comments that were not directly related to specific questions but may be valuable. Below are some general comments about the interviews.

- One solo specialist mentioned at the beginning of the interview that he did go to the HSC website to check it out before he agreed to participate.
- One solo specialist did not have his completed questionnaire with him for the interview but he said he had looked it over and completed it. It was not possible to reschedule before the end of the field period so I went ahead and conducted the interview. This was the only respondent who did not have his completed questionnaire during the interview.
- The community health center respondent wondered if respondents would be sent any kind of report from this survey. I explained that this interview was just for the design phase of the CTS physician survey. She wanted to know if respondents would be sent any reports when the CTS survey is done. I referred her to the HSC website and emailed her the link.
- The staff model HMO respondent indicated (at the end of the interview) that he thought many of these questions were irrelevant, intrusive and none of our business. “There are serious problems in medicine and none of them are addressed by the questions in this questionnaire.” I tried to explain that this was just part of the full CTS survey and I tried to explain more about HSC. I also asked him to go back and go through each question and tell me which he felt were irrelevant and intrusive. His was very willing to do this. His responses were as follows: #3, 4, 6 (snooping), 11 (none of our business), 12-15 no reason to ask, 16-20 no reason to ask. He thought the questionnaire was clear, straightforward, well laid out and that the questions made sense and were easy to understand. He just found fault with why we were asking. He wasn’t mad or upset, just very matter of fact. He said especially for PCP and solo practitioners, he would never answer these questions in a survey. He would have tossed it. Only did this because of pilot test aspect and he was interested. I gave him the HSC website again.
- Community Health Center – she and her husband work together in the clinic (and both were respondents in the last round of the CTS). She was unsure of some answers in the questionnaire and asked her husband who was sitting in the room with her.

IV. RESULTS AND SUGGESTIONS

A. PRACTICE CHARACTERISTICS

1. GOALS

These practice characteristic questions were changed significantly from the Mode Effect Survey and are therefore included in cognitive testing to determine if question wording is clear and unambiguous, if response options are appropriate, complete, and understandable to respondents, and if question format and skip instructions are clearly understood by respondents.

2. TEST QUESTIONS

1. Please check the box that best describes your main practice setting. If you work in more than one practice, check the one where you work the most hours.

MARK (X) ONE ANSWER

- 1 A solo practice
 - 2 A two physician practice
 - 3 A group practice with three or more physicians
 - 4 A group or staff model HMO
 - 5 A community health center
- 6 A hospital run by state, county, or city government
- 7 A hospital run by a private for-profit or non-profit organization
- 8 A medical school or university (private or government)
- 9 Some other setting (Please describe)

→ GO TO Q2

→ GO TO Q2

- 1a. If your main practice is in a hospital, medical school, or university, in which of the following settings do you spend most of your time seeing patients?

- 1 Office practice owned by the hospital, medical school, or university
- 2 On hospital staff
- 3 In the emergency room
- 4 In a hospital or medical school clinic
- 5 Somewhere else (Describe)

2. In your main practice, are you a full owner, a part owner, an employee with no ownership, or an independent contractor?

- 1 Full owner → Go to 3
- 2 Part owner → Go to 2a
- 3 Employee (Not an owner) → Go to 2a
- 4 Independent contractor → Go to 3

- 2a. If you are a part owner or employee, do any of the following have an ownership interest in your main practice? Check all that apply:

- 1 Other physician(s) in the practice
- 2 Another physician practice

- 3 A hospital or hospital group
- 4 Insurance company, health plan or HMO
- 5 Medical school or university
- 6 Other (specify) _____

3. RESULTS

Summary

Solo and two physician group respondents had no problem with these questions, nor did the medical school respondent or the ‘other’ respondent. The remaining sample groups all had some difficulty with these questions for different reasons.

Two of the three HMO physicians had some difficulty with question one because they work for an HMO but are hospital based. Both doctors indicated some confusion between response option #4 and #7. They both indicated that they would answer #4 but there was some confusion. The other HMO physician did not have any difficulty with the questions.

A few of the group practice physicians (3) had a problem with the category ‘part owner’. This seemed to be an issue for those who split ownership among more than two people. The remaining doctors in this group did not have a problem with these questions. One group practice physician thought the skip instructions were confusing but no other respondent mentioned a problem with the skip instruction.

The respondent from the Community Health Center sample group had a bit of difficulty with these questions. She originally answered question one as a group practice with three or more physicians. When I pointed out category #5 “community health center” (because I had already screened her to find out that she was in a community health center) she said that would be a better answer but she had stopped reading the categories when she found one that fit her situation. In question 2a she wanted to say none of the above. She did not notice the ‘other’ category. She had to ask her husband the answer to this question and he said the center is a non-profit corporation run by a community board. It is a public entity.

Hospital based physicians didn’t have trouble with these questions although one physician was a bit confused about office practice versus clinic and one physician suggested that question one should include federal hospital or veterans’ hospital as an option.

Results in Detail

Solo Specialist

- 1) No problem with these questions.
- 2) No problem with these questions.
- 3) No problem with these questions.

4) No problem with these questions.

PCP

1) No problem with these questions

2) NO problem with these questions.

HMO

Specialist

Q1 -- Confused about #4 or #7. He works at Kaiser HMO clinic attached to a hospital. He would probably answer #4.

Q2 -Employee but after a number of years he becomes a shareholder in Kaiser.

Staff model HMO

Same problem as above, confused about #4 and #7 – he works for Staff model HMO. He is hospital based (not clinic) and the hospital is run by a non-profit group. He admits this is a very rare practice situation but he wants to indicate both #4 and #7. If he answered #7, he would answer #3 in Q1a. Employee and other physicians have ownership interest

PCP/Specialist

He works in urgent care – used to be board certified in ER but let that lapse. He works in urgent care center. In some ways he considers himself a PCP and in some ways a specialist. His practice is a huge HMO that includes 5 urgent care clinics, 10 primary or specialty clinics, a hospital, and a main office. He thought the first page looked somewhat busy and a little confusing with the arrows and skip instructions. “Busy set of questions”. No real problem answering the questions but he didn’t know the answer to Q2a – he thought a non-profit corporation but was not sure.

Hospital

PCP

1) Q1 – confused about category #6 and #7. She works in a state hospital but felt she could have answered either. After she read it again (best describes) and read the category again, she felt it was okay.

Q1a – confused about office practice versus clinic (#1 and #4). She is in a family care center. It used to be a clinic but now an office owned by state hospital. After 1a, she went to Q2 and Q2a.

Specialist

1) No problem with any of these questions.

2) No problem with any of these questions.

3) He moonlights in a VA hospital and suggested that we have a VA or Federal hospital category. He answered 2 and at 2a skipped because none applied (government)

PCP/Specialist

1) No problem with any of these questions.

Group

PCP

1) Q2 – a bit confused about ‘part owner’ but that was his response. Seven doctors own the practice so he is a part owner.

2) No problem with any of these questions

3) Q2 – a bit of a problem with part owner – there are four of them who are all part owners.

4) Q2 – confused about ‘part owner’ – there are four partners in the practice.

Q2a – confusing question – she had not answered the question then read it again while we were on the phone and understood it and answered “other physicians”

Didn’t like the questions with skip instructions – found them confusing.

5) Q2a – answered “other” and specified ‘private group practice of 3+ doctors owned by hospital that is owned by insurance company’. She is an employee.

6) No problem with any of these questions (was in 2 physician private practice, now there are 3 doctors).

Specialist

1) No problem with these questions

Medical School Specialist

No problem with these questions.

Community Health Center

Q1 – answered #3 and didn’t read the rest of the categories because #3 fit. When she read #5 she indicated that this was a better choice.

Q2a – she said none of the above. The Center is a non-profit corporation owned and run by a community board. It is a public entity.

Other – ER Group

This doctor works for an ER group which contracts with a hospital. He works only in the hospital ER but is employed by this group. He did not want to say group or hospital in Q1 – he put “other setting” and described his situation. He is an employee (Q2) and the group is owned by other physicians in the practice. He didn’t have any problem with these questions he just wanted to use the ‘other’ category.

4. SUGGESTIONS

General

- Add skip instruction after Q1a to go to Q3 rather than to Q2 (?).

Question 1

- Emphasize ‘best describes’ in the question wording and add instruction to read all response options.
- Address the issue of hospital based HMO by adding more detail to ‘a group or staff model HMO’ such as “(include clinic, office, or hospital based)”.

Question 2

- Consider adding the parenthetical phrase ‘with one or more other physicians’ in the question wording after ‘part owner’.

B. HOURS WORKED

1. GOALS

These questions ask the respondent to allocate time across four activities during a typical day and indicate whether or not they are reimbursed for this time. Key issues explored with respondents included ease of time estimation, respondent comfort with ‘typical day’, respondent interpretation of ‘other clinicians’, comprehension of instructions, appropriateness of response options, and layout of the response table.

2. TEST QUESTIONS

3. During a TYPICAL WORK DAY, how much time do you spend on each of the following activities?
MARK (X) ONE ANSWER FOR EACH ITEM

| | None | Less than a half hour | 1/2 hour to less than 1 hour | 1-2 hours | More than 2 hours |
|--|----------------------------|----------------------------|------------------------------|----------------------------|----------------------------|
| a. E-mail communications with patients | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. Telephone conversations with patients | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| c. E-mail communications with other clinicians | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| d. Telephone conversations with other clinicians | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

4. Is your practice reimbursed by any health insurance plans for these activities?
If you are unsure of the reimbursement policy or don’t perform an activity, please check the appropriate boxes on the right.

| | Reimbursed | Not Reimbursed | Unsure if reimbursed | Don’t perform activity |
|--|----------------------------|----------------------------|----------------------------|----------------------------|
| a. E-mail communications with patients | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b. Telephone conversations with patients | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. E-mail communications with other clinicians | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d. Telephone conversations with other clinicians | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

3. RESULTS

Summary

Question three was fairly straightforward for most respondents, although a few problems were cited. Only two respondents indicated that they spend any time in email communication with patients in a typical day; one is an emergency room doctor who answered $\frac{1}{2}$ to less than 1 hour, the other is a solo PCP and answered 1-2 hours. Only six respondents indicated that they email with other clinicians. Several respondents indicated that they don't use email at all and one of these respondents suggested reordering the four items with the two email items together followed by the two telephone items so respondents who don't use email can easily mark none to both email items.

Three respondents (2 solo and 1 group) had a problem with the phrase 'typical day'. One suggested a typical week might be easier for him. The other just mentioned that her phone time varies quite a bit from day to day so she had to just ballpark but she did not suggest making a change. The third respondent who remarked on this issue said it was difficult for him to estimate for a typical day. He wondered, "does that mean a typical day seeing patients"? He's a solo practitioner and said that he sets aside a day a week to do administrative and other work and does not see patients. His phone and email time on these days is probably higher than on days when he sees patients and on these days, things vary a great deal. He suggested using 'on average' and/or including a specification of typical day 'seeing patients'. None of the other respondents had an issue with estimating time for a typical day.

Two respondents mentioned issues with the response options in question three: one thought the last response category was fairly large and wondered if anyone spends this much time on email or phone communication in a day; the other thought there was too much room between 'none' and 'less than $\frac{1}{2}$ hr' and wanted to say 'very occasionally'. The response options worked well for all other respondents.

Question four was also fairly straightforward and only caused difficulty for a few respondents. Only one physician (staff model HMO) answered 'reimbursed' for telephone communication with other clinicians (the only item he spent any time on from question three). However, he went on to say that because he is in a staff model HMO, this question doesn't really apply, "the HMO is not a fee for service reimbursement so I get paid for all of my time but not reimbursed by health insurance plan". One respondent (hospital specialist) answer unsure to all items and the remaining physicians indicated 'not reimbursed' and/or 'don't perform activity.'

There were a few problems with the items in these questions. Respondents interpreted the phrase 'other clinicians' (items b and d) in different ways. While most respondents thought 'other clinicians' referred only to other physicians, four physicians (in solo, group and hospital sample groups) included time spent communicating with non-physician clinicians (e.g. nurse practitioners, dieticians, social workers, psychologists, teachers, radiologists) in this category.

One respondent indicated that he communicates with the parents and/or guardians of his patients, not with his patients directly (pediatric psychiatry) and suggested adding this designation to the

two items about patients. No other physicians mentioned this (even though some other respondents are in pediatrics).

Question three is an individual question – how the respondent spends his/her time. However, question four is worded more generally about the practice situation. This led to several respondents marking both the ‘don’t perform activity’ and the ‘not reimbursed’ columns or they just marked ‘not reimbursed’ even though they indicated in question three that they don’t perform the activity. They seemed to want to give a substantive response to question four if they were able. Several respondents simply did not see the instruction to use the ‘don’t perform the activity’ response.

Results in Detail

Solo

Specialist

1) Q3 – group items with telephone together and email together since some doctors don’t use email. For ‘other clinicians’, he was thinking of PCPs who refer, as well as psychologists and social workers. It was easy to ballpark amount of time, especially since he doesn’t do email.

Q4 - Doesn’t know any insurance company that reimburses for this so reverse order of cols 1 and 2. Probably no need for column three as most doctors know whether or not they are reimbursed.

2) Q3 – He answered none to email items. He was thinking about physician clinicians because he doesn’t deal with non-physician clinicians. He thought the last category was pretty large and wondered if anyone spends this much time on email or phone in a typical day.

Q4 – he marked both “not reimbursed” and “Don’t perform activity” for items a and c.

3) Q3- no problem

Q4 – no problem

4) Q3 – no problem, doesn’t do email.

Q4 – no problem, no to all

PCP

1) Q3 – he thought that maybe a typical week might be better than a typical day because time in phone conversations can vary so much day to day. He was thinking about specialists when he read the term ‘other clinicians’. He was not thinking about non-physician clinicians.

Q4 – no problem

2) Q3 – difficulty with the term typical day. He wondered if that means days when he is seeing patients. His days vary a lot. He sets aside a day where he does not patients and just does administrative work. On these days his time for these activities would be higher than on patient days. “Solo doctors wear so many hats, typical day may be harder for them than others. The smaller the practice the more difficult to talk about typical day.” Was thinking just about physician clinicians for ‘other clinicians’.

Q4 – no problem. No to all

HMO

Specialist

No problem with these questions, estimating amount of time, using either of the response tables. He was thinking of all physicians within the HMO for other clinicians

Staff model

Q3 – No problem. He was thinking of consulting and admitting doctors.

Q4 – he gets reimbursed for item d but not in the typical way. Staff model HMO so he gets reimbursed for all of his time but not reimbursed by insurance plan.

PCP/Specialist

Q3 -- He felt there was a lot of space between none and Less than ½ hour – wanted to be able to say very occasionally. He answered 1t ½ for b-d.

Q4 – he knows that PCPs in his practice are reimbursed for this if they document their time but his time is not because he does it so infrequently and doesn't document time. They use EMR so patients can send email questions to PCPs in the practice. The PCPs can then charge their time for answering emails and phone calls and the practice does get reimbursed.

He answered not reimbursed for each item.

Hospital

PCP

Q3 – no problem

Q4 – none of these reimbursed. Surprised to hear if anyone gets reimbursed for this.

Specialist

1) Q3 – she was not including any non-physician clinicians but she does talk to social workers and dieticians.

Q4 – She said “I’m an employee of the hospital, I have no idea.” She answered Unsure for all items even though she had indicated that she doesn’t do email. She said because she sometimes asks others in her practice to email for her and she is unsure about reimbursement for this.

2) Q3 – no problem with this question – doesn’t do email at all. He included non-physician clinicians here social workers, teachers, etc.

Q4 – not reimbursed for all. He didn’t see the instruction about the last column. Not reimbursed for anything beyond a daily rate for inpatient hospital stay.

3) Q3 – he has ‘mentally retarded’ patients so we should add to items a and b ‘parent/guardians’. He said no to all but clinicians. He was only thinking of physician clinicians.

Q4 – he indicated not reimbursed to all even though he doesn’t perform a –c.

PCP/Specialist

Q3 – no problem. He was thinking of physician clinicians only.

Q4 – no problem. His practice is not reimbursed for any of these activities.

Group

PCP

1) Q4 – he did not notice the instruction about using the ‘don’t perform activity box’. He originally said ‘not reimbursed’ and then indicated that he doesn’t do email with patients or other clinicians (on his lawyer’s advice). He had said none to these two in Q3

2) Q3- He included specialists and other physicians both inside and outside of practice. He also included ancillary staff such as nurses, dieticians, etc. He wanted to add more time for telephone as we talked because he started thinking of all the people he would include as ‘clinicians’.

3) Q3 – she included non-physician clinicians (nurse practitioners, dieticians)

Q4 – she didn’t see instruction about don’t perform activity column. She said not reimbursed for all because she knows that is the situation even though she doesn’t do email.

4) Q4 – answered Not Reimbursed even though she doesn't do email. She knows they don't get reimbursed because they tried.

She liked the table formats – thought it was very clear and easy to use.

5) She found estimating phone time to be difficult because it varies so much day to day.

6) No problem with either of these questions. She was thinking only of physician clinicians.

Specialist

He does not do email at all – in Q4 he answered not reimbursed because he didn't see instruction to use last column. However, when I pointed this out he said that he could answer both because he knows that he will not be reimbursed for email which is part of the reason he doesn't do it.

Medical School Specialist

He first thought about email with other clinicians and included research and education related email communications but then thought that we probably mean clinic based or patient related so he put less than $\frac{1}{2}$ hour. For other clinicians he was thinking about mostly about physicians (specialists and consults that come to the ER) rather than other types of non-physician clinicians. He didn't really notice the 'don't perform' and 'unsure' columns. He answered not reimbursed and said he is 99% sure they are not reimbursed but not absolutely certain.

Community Health Center

She had no problem with these questions. She was thinking only of physician clinicians for the term 'other clinicians'.

Other – ER Group

No problem with these questions. He doesn't do email or telephone conversations with patients and only $\frac{1}{2}$ to 1 hr of phone conversations with other clinicians (only thinking of doctors).

4. SUGGESTIONS

Question 3

- Although one physician suggested reordering the items so the two email items are together and the two phone items are together, I would not suggest doing this. I think the more important categorization to emphasize is the patient versus other clinicians so I would leave the items ordered as they are. Additionally, only one physician mentioned this so I don't think it was a significant issue.
- Although three respondents had some trouble with the term 'typical day', the remaining respondents said this was easy for them and had no trouble estimating their time. All three of these respondents provided an estimate and said it was a ballpark figure which is probably the best that can be expected in any case. I would be a bit concerned about changing this to 'on average' or 'typical day seeing patients' because these might create more problems for other respondents.
- Consider including 'and/or parent/guardian' along with patient for items a and b
- Items c and d should specify physician clinicians only or provide examples of non-physicians that should be included.

Question 4

- Items should be revised in whatever way they are revised for question 3.
- Specify more clearly whether question is about practice policy or about the doctor's time specifically.
- Highlight instruction to use 'don't perform activity' or get rid of this column if you just want practice policy rather than individual doctor's time reimbursement.

NOTE:

The questions sometimes use 'your practice' (Q4, Q11, Q13, Q15) and sometimes use 'your main practice' (Q5, Q6, Q8, Q12, Q14). It would be better to be consistent throughout the questionnaire, or indicate to the respondent up front that all questions about your practice means the main practice identified in Q1.

C. INFORMATION TECHNOLOGY IN MEDICINE

1. GOALS

This question was intended to find out about incentives for ‘information technology systems’ in the practice. The cognitive interview probes focused on the respondents’ understanding of the phrase ‘information technology systems’ and the respondents’ ability to answer the question.

2. TEST QUESTION

5. Does your main practice receive any financial incentives tied to the types of information technology systems it adopts?

MARK (X) ONE ANSWER

1 Yes

0 No

8 Don’t Know

3. RESULTS

Summary

This question was difficult for several respondents for two main reasons – uncertainty about the meaning of ‘information technology systems’ and about the source of the incentive. Additionally, several respondents just did not know the answer.

Several respondents were unclear about the meaning of ‘information technology systems’ and wondered if it includes just electronic medical records/charts/prescribing or if it also includes computerized scheduling and billing, phone systems, and other computer systems. Many of these respondents suggested we provide a definition or examples of IT systems. One respondent was unclear where the incentives would come from – government or insurance plans.

Six respondents answered ‘don’t know’, 15 respondents answered ‘no’, and three respondents answered ‘yes’. However, three respondents changed their original answers after talking about the question. Among the three respondents who answered yes, two were confused by the question and upon further discussion of the question, decided their answer should have been no and one respondent who originally answered No (group PCP) changed his answer to yes after discussion.

One respondent who answered yes was clearly confused by the question and said that they have IT systems but no one gives them anything for that. He realized as we talked about the question that he should have answered no. The other yes response that turned out to be a no was from a PCP in group practice who indicated yes to the question but then realized that we were asking about the current situation and changed her answer to no. She answered yes originally because

she knows that if they do adopt IT they will get incentives but they have not done it yet. "If we use EMR, certain insurance companies will give us incentives."

One respondent (group PCP) who originally marked no asked who would give the incentives. He thought the question was asking about government incentives. I asked about incentives from insurance plans and then he said that they do get incentives from insurance plans for their IT systems and changed his answer to yes.

One solo PCP physician, who uses electronic prescribing and gets incentives from BXBS for doing this, answered yes. He indicated that he would also get an incentive if he used electronic medical records but he doesn't do that yet.

Results in Detail

Solo

Specialist

- 1) Don't use any IT systems so easy to answer. He guessed that it means if you have EMR or other equipment, you get a deal or get incentives.
- 2) He answered No – he wasn't really clear about what we meant by IT systems but they don't get any incentives so he said no. They don't have EMR but they have computerized scheduling and billing systems.
- 3) He answered no but was not clear 'what kind of IT you're talking about'.
- 4) She answered no but said "information technology systems implies what?"

PCP

- 1) He answered 'yes'. He uses electronic prescribing and BXBS gives him an incentive for that. He would get incentive for electronic medical records as well but he does not have that. He felt that we should be more specific about the IT systems we are talking about.
- 2) No problem with this question. He said no. They have full IT system (paperless office) but don't get any incentives.

HMO

Specialist

He thought we meant things like new computer systems and such. A little trouble with definition of IT, he suggested that we include examples or definition. The Kaiser system just started using electronic charts. He doesn't purchase anything so he is not certain but he's pretty sure there is no incentive for using the system. He answered no.

Staff model HMO

His group has 'monumental IT system' but no incentive. Hospital system is run by a non-profit group. Medical group contracts with the hospital system. Doctors (like him) in medical group have little say or knowledge about incentives or anything to do with IT systems. It is possible that the larger hospital system gets some kind of incentive for EMR or something like that but he would not know. He answered no rather than DK because his medical group doesn't get any kind of incentive.

PCP/Specialist

He is unsure – they have IT systems (EMR) but not sure about incentives. He thought this would be a very difficult question for many doctors. He answered don't know.

Hospital

PCP

She answered Dk. She wasn't sure what we meant by ITS but thought we meant EMR. She thinks there is no incentive because if there was, she thinks her practice would use it. She wasn't sure. She thought we should include some examples.

Specialist

- 1) No IT systems.
- 2) He answered 'yes' but then went on to say that he thinks there would be incentives for that kind of thing but he isn't really sure. He seemed unclear about this and ended up saying 'I guess don't know would be a better response'. They don't have EMR yet – some parts of the hospital do but not his part (pediatric psychiatry). They have computer systems and charts on computer but he isn't really sure about incentives for this.
- 3) He answered dk but he's pretty sure it's no. They have computerized records and prescribing but no incentive he's pretty sure.

PCP/Specialist

No problem with this question. They have EMR and fairly extensive IT systems and he is sure they do not get any kind of incentive.

Group

PCP

- 1) He originally said no. They are just getting into IT. He wanted to know who the incentive would come from – government? I asked about insurance plans and then he said, yes they get incentives for IT from insurance plans.
- 2) He initially thought no but then realized he really didn't know so he put unsure.
- 3) She said that she wrote "What" on the questionnaire and answered Don't know. She was more confused about 'information technology systems' than about financial incentives. After we talked about it for a while she said she thought that some HMOs would reimburse her practice \$1 for each referral they sent in electronically and wondered if that would count. However, she did not think of this at first.
- 4) She answered No – her practice does not get incentives for IT systems (no EMR but they have computer systems and such). However, they have a management company and purchase their IT systems from them and she doesn't know if the management company gets some kind of incentive for the IT systems.

- 5) She answered the question about what would happen if they adopted IT. She said yes because she knows that they will get an incentive from insurance company if they adopt EMR but they have not done that yet. She did not understand the question to be asking about current situation.
- 6) She wasn't really sure what we meant by IT systems or by financial incentives but she is sure they aren't getting anything. They don't have EMR just simple computer systems and they don't get any kind of incentive for that. She would have liked examples or definition of IT.

Specialist

Said no – all they have in the office is internet access (which they hardly ever use). Does this even count as IT system?

Medical School Specialist

‘Sincerely doubt it but don’t know’ – he answered ‘don’t know’.

Community Health Center

She was not sure exactly what is meant by IT systems but she answered no because they don’t get any financial incentives for any thing like this. She wondered if IT just meant EMR and electronic prescribing or if it included other types of systems.

Other – ER Group

No problem with this question – no incentives for the little IT they have.

4. SUGGESTIONS

Question 5

- Provide more specific information about the source of incentives – insurance companies, government?
- Provide definition and/or examples of IT – just EMR or other things as well (computer systems, phone systems)
- Consider rewording the question to something like “Does your main practice currently receive incentives from _____ that are tied to the types of IT systems it has? By IT systems, we mean things like _____”

D. QUALITY AND COORDINATION OF PATIENT CARE

1. GOALS

The questions on quality and coordination of care focused on different types of performance reports the respondent might receive from the practice and programs in which he/she might participate that are outside of the practice. Respondents were also asked about specific services and programs for their patients with chronic conditions and their efforts to coordinate patient care.

The goal of the cognitive interview was to determine if respondents understood the types of performance reports, programs and services being asked about, if they are familiar with the terms used in the questions and if they are able to respond easily using the response options and the response tables.

2. TEST QUESTIONS

6. Please indicate whether you receive any of the following types of performance reports from your main practice.

If you receive the types of reports listed in a or b, do they describe individual physician performance, the practice's performance, or both individual and practice performance?

| TYPE OF REPORT | RECEIVE REPORTS? | | IF YES, WHOSE PERFORMANCE DO THE REPORTS DESCRIBE? | | |
|--|----------------------------|------------------------------|--|----------------------------|--|
| | No | Yes | Individual Performance | Practice Performance | Both Individual and Practice Performance |
| a. Delivery of preventive care to eligible patients | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> ➔ | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| b. Delivery of care to patients with chronic conditions | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> ➔ | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| c. Delivery of care to patients of different races or ethnic backgrounds | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | | | |
| d. Patient lists or registries (e.g., lists of patients with specific clinical conditions, medications, or laboratory results) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | | | |

7. Do you personally participate in quality reporting programs sponsored by organizations outside of your practice (e.g., Bridges to Excellence, or the Centers for Medicare & Medicaid Services)?

1 Yes

0 No

8. Does your main practice provide the following services to patients with chronic conditions (such as asthma, diabetes, depression, or congestive heart failure)?

If your practice does not treat patients with chronic conditions check “Not Applicable” for each item.

| TYPES OF SERVICES FOR PATIENTS WITH CHRONIC CONDITIONS | Yes | No | Not Applicable |
|---|----------------------------|----------------------------|----------------------------|
| a. Written materials that explain guidelines for recommended care in English..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| b. Written materials that explain guidelines for recommended care in languages other than English (Check Not Applicable if your practice treats few or no non-English speaking patients.) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| c. Nurse care managers to monitor and coordinate the care of patients with chronic diseases..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| d. Non-physician staff to educate patients in managing their chronic illnesses..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| e. Group visits in which patients with similar conditions meet with staff who provide routine medical care or address educational or personal concerns | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 3 <input type="checkbox"/> |

9. Disease management programs are intended to reduce costs and improve quality of life for patients with chronic diseases by integrating delivery of care and involving the patient in self-care.

Please indicate your level of agreement or disagreement with the following statements about disease management programs *sponsored by health plans or employers*.

If none of your patients are in disease management programs sponsored by health plans or employers, check the box on the right.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Agree Strongly | Agree Somewhat | Disagree Somewhat | Disagree Strongly | Neither Agree nor Disagree | No Patients in Disease Management Programs |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|--|
| a. Disease management programs improve the overall quality of care for my patients with chronic conditions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| b. Disease management programs improve my ability to provide high quality care to my patients with chronic conditions. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |

10. This question concerns your experiences coordinating patient care with other physicians.

- If you are a primary care physician (general and family practitioners, and internists and pediatricians who provide general care), answer items (a-d).
- If you are a specialist answer items (a) and (e-g).
- Check “not applicable” If you rarely or never coordinate patient care.

| | Always or Most of the Time | Sometimes | Seldom or Never | Not Applicable |
|---|---|----------------------------|----------------------------|----------------------------|
| <i>ALL PHYSICIANS</i> | | | | |
| a. How often do you think you know about all the visits that your patients make to other physicians? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>PRIMARY CARE PHYSICIANS ONLY</i> | | | | |
| b. When you refer a patient to a specialist, how often do you send the specialist notification of the patient's history and reason for the consultation? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. How often do you receive useful information from specialists about your referred patients? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d. After your patient has seen a specialist, how often do you talk with the patient about the results of the visit(s) with the specialist? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>SPECIALISTS ONLY</i> | | | | |
| e. When you see a patient referred to you by a primary care physician (PCP), how often do you receive notification about the patient's medical history and reason for consultation? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| f. For the patients that were referred to you by a PCP, how often do you send the PCP notification of the results of your consultation and advice to the patient? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| g. How often are new patients you see self-referred? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

3. RESULTS

Summary

Question six posed some difficulty for some respondents. The difficulty arose from confusion about the source of the reports. Respondents seemed to miss the phrase ‘from your main practice’ in the text of the question and answered this question about reports they receive from insurance companies.

Seven respondents answered yes to at least one of these types of reports and 17 respondents answered no to all items. However, among the yes responses, three were not valid yes responses – one respondent indicated that he doesn’t get these reports but the chief of his department gets them from the hospital (he answered yes to items a and b). The other two respondents indicated yes to and a, b, and d but then indicated that they come from HMOs or insurance plans not from the main practice. Neither of these respondents noticed the phrase ‘from your main practice’ in the question text.

The valid yes responses are described below.

- Solo PCP who answered yes for items a and b and answered individual performance to the follow-up question. He indicated that he gets these reports generated from his practice data but his IPA uses Medventive to generate the reports. There is an incentive tied to these reports and the data in the reports is from certain HMO patients not his full patient population.
- Solo PCP answered yes to items a, b, and d. He indicated that for items a and b, the reports describe both individual and practice performance. He did not have any problem with this question although he said it seems a bit weird to ask solo practitioners if they give themselves reports on their performance.
- Group PCP (owned by a hospital system). He answered yes to items b and d. He found the question difficult to answer because the reports used to come from insurance plans but now they come from the hospital system.
- Community health center respondent initially answered yes to items a, b, and d but then indicated that a and d are reports from insurance companies. Item b reports come both from her main practice and from insurance companies. She answered both individual and practice performance for the follow-up question.

Respondents did not seem to have any difficulty with the follow-up question or with the layout of the response table. Only one respondent said the table was ‘too busy’ – other respondents thought the table was easy to understand and use.

One respondent was confused by item d and wondered if this meant lists of patients on certain drugs in case of recall.

Question seven was slightly difficult for a few respondents who were not familiar with the term ‘quality reporting programs’ or with the two examples provided in the question. In some cases, respondents said that they answered no because this didn’t sound like anything they were doing.

Six respondents answered yes, 17 respondents answered no and one respondent did not answer the question.

Respondents who answered yes to this question gave the following explanation for their responses:

- One said he was unclear about the meaning of ‘quality reporting programs’ but he sits on a physician advisory board for a local insurance company and he wasn’t sure if this would count or not. This work is outside of his practice, the Board is a group of consultants who are paid for their time and meet to discuss issues related to quality of care, medical coverage and procedures.
- One respondent gets reports from BXBS about his patients covered under that plan. There is an incentive tied to these reports.
- One respondent said he is on the QA committee of local medical helicopter group and on the regional emergency medicine advisory committee.
- One respondent said she is familiar with Bridges to Excellence but not sure exactly what it is. She said yes to the question because she fills out lots of surveys on her patient practice and how she practices and she thinks these are quality reporting programs. She just doesn’t know exactly who sponsors the programs but knows that it is outside of her practice.
- Two respondents indicated that they had not signed up for the program. One said ‘yes but not by choice’. She explained that she gets reports from insurance companies about which of her patients have had mammograms and which haven’t, which kids are up to date on immunizations and which are not and things like that. She gets these reports because she participates with the insurance company. “If you participate in certain insurance companies you are automatically in the program and get the reports.”

Among respondents who answered no, a few are familiar with Bridges to Excellence but even among those not familiar with this program, most indicated that they understood the question. One respondent who answered no said he is looking into Pay for Performance but none of his insurance companies have this. One respondent said he thought Bridges to Excellence was “some kind of coalition of people trying to quantify quality” something in the category of the Leap Frog group. Five of the respondents who answered no, indicated that they were not really clear what these programs are but they are pretty sure they do not participate in anything like this so they said no. One respondent who said no said that he is not familiar with the term quality reporting programs or Bridges to Excellence but said “it is called Pay for Performance here” (Washington state).

One respondent who answered no said he does not do preventive care or deal much with patients with chronic conditions so he felt the questions did not apply to him. He wanted to be able to indicate NA rather than no. Another respondent also indicated that he was probably not eligible for such a program but he just answered no.

The respondent who did not answer the question was confused by the question. He is not familiar with the specific terms in the question (quality reporting programs or Bridges to Excellence). He talked about Performance Appraisals he gets from the hospital once a year but then realized that this is from within practice and is probably just a job review and would not

count. He also talked about the Joint Commission on the Accreditation of Health Organizations which gives the hospital a report for each group in the hospital and how they are doing but it is not specific to individual doctor. He ended up deciding the answer was probably no to the question but he was definitely confused by the question.

Question eight was straightforward and easy for most respondents. Most respondents were able to answer the question easily, found the items to be clear and easy to understand, and had no difficulty with the response table.

There were just a few comments about the question.

- One respondent felt these questions were more appropriate for PCPs than for specialists but he answered the question (yes to a, no to the remaining items).
- One respondent said the answer to items a and d would be yes if we added the phrase ‘or parent/guardian’ – otherwise the answer is no to all items.
- One respondent said ‘sometimes’ for item b – “when available”.

Question nine was interpreted differently by different doctors. Some respondents answered this question very specifically from experience with patients in disease management programs (either patients they enrolled in these programs or patients they see who they know are in DMP but enrolled by someone else). Other respondents answered the question very generally and not based on personal experience with DMP. Most respondents were familiar with these types of programs and had an opinion about them but this opinion was not always based on actual personal experience with patients in these programs. The personalization of the two statements ('my patients'/'my ability') did not always stand out to respondents nor did the instruction to use the last response column. Additionally, the phrase "programs sponsored by health plans or employers" was missed by several respondents.

Eight respondents answered the question based on general impression of disease management programs rather than on personal experience with patients in these programs.

Most respondents understood what was meant by disease management programs and thought the first sentence of the question was accurate and useful. Only one physician said he thought we should not use the term disease management program because he thought it was not very common language. He was familiar with the term but didn't think other physicians would be.

Some of the comments made by respondents:

- One respondent who answered generally and said he did not see the instruction about the last column or notice the 'my' in the two statements, suggested we put the "No patients in DMP" column first rather than last, highlight the instruction and bold and/or cap the word 'my' in the two statements.
- One respondent answered strongly agree and no patients in DMP to both items. He suggested skipping people out of the question altogether if we don't want general responses.
- One respondent answered strongly agree to item a but wanted to answer NA to item b because he doesn't think DMP affect his ability to provide care. "People I see on an

episodic basis are in these programs and I'm sure they are helped by that but that does not affect my ability to provide quality care."

- One respondent thought the question was only asking about her enrolling patients in these programs.
- One respondent said it was a good thing the question emphasized 'programs sponsored by health plans or employers' because he has patients in hospital DMP and they are very different and his answers to this question would be different (less positive).
- One respondent thought the 'neither agree nor disagree' column should be in the middle.

Question ten was fairly straightforward and easy for most respondents. For the most part respondents found this question clear, easy to understand and answer and the response table clear and easy to use.

There was one issue with the separate items for PCP and specialists. While respondents were clear about the instructions and knew which items they were supposed to answer and which they were supposed to skip, three respondents did not follow the instructions. Two respondents who are specialists felt the PCP items were more relevant for them and answered those instead of the specialist items. One of these was in an HMO (urgent care clinic) and the other was in a hospital (emergency medicine). A third respondent answered both sets of items because he has some patients for whom he is a PCP and others for whom he is a consulting neurologist (state mental health hospital). A fourth respondent answered the PCP items because he was instructed to but he indicated that he also does obstetrics (although he is not board certified in ob) and could have answered both sets of items.

Some of the other comments respondents made about this question are listed below.

- Two respondents mentioned a problem with the scale and both wanted more choices – one wanted to answer something between 'sometimes' and 'seldom/never' for item e and the other one said he wanted five choices not three. There were no other comments about the scale.
- One respondent suggested that the item letters should be made to stand out more by bolding or capitalizing them. There were no other comments about the layout of the table.
- One respondent was slightly confused by item C and wondered if we want to know if she gets information or if the information she gets is useful. She thought the latter and answered that way.
- One respondent thought item a was "worded oddly" – the phrase 'you think you know' seemed odd to him.
- Two respondents answered NA for all items because they do not coordinate care. They both noticed the instruction and the response option and used it with no problem.

Results in Detail

Solo

Specialist

1) Q6 – Clear, easy to understand no problems. Doesn't receive any of these types of reports.

Q7 – Unclear what “quality reporting programs” means. He was unfamiliar with Bridges to Excellence and doesn't do Medicare or Medicaid. He answered yes because he is on a physician advisory board for a local insurance company but wasn't sure if this counts or not. This is outside of his practice but related to practice. The Board is a group of consultants that meet to discuss issues related to quality of care, medical coverage, and procedures. He gets paid for his time.

Q8 – Clear and easy to answer but he felt this question was more for PCPs. He said yes to A

Q9 – He is familiar with DMP for adults in his community so he answered the question very generally about these types of programs (answers strongly agree to both). He did not notice that the question was asking about HIS patients and he did not notice the instruction about using the last column. He felt we need to highlight more that we are talking about personal situation and not DMP in general. Suggested putting last column first, my in caps and instruction in bold.

Q10 – no problem with this question, skip instructions, items, or response table.

2) Q6 – he hasn't really heard of others who get these types of reports. He understands what we are asking here and he answered no to all.

Q7 – answered no – has not heard of quality reporting programs or Bridges to Excellence but he understands what we are talking about. He's looking into Pay for Performance (a Medicare thing, he thinks) but none of his insurance companies have this.

Q8 – no problem.

Q9 – He answered both ‘agree somewhat’ and ‘no patients in DMP’ to each item. He doesn't have patients in dmp but he was thinking generally about dmp and is imagining what it could be like and answered on that basis (agree somewhat). He suggested skipping people out of this question if they don't have patients in dmp if we want answers based on real experience with these programs

Q10 – item e, he wanted to say something between sometimes and seldom/never. He answered sometimes.

3) Q6 – he answered no to all and said “I get no performance reports from anyone.”

Q7 – he answered no and said he is familiar with Bridges to Excellence for hospitals.

Q8 – he indicated yes to a and no to all other items and said he sees very few patients with chronic conditions that he is responsible for caring for but he does see some do he did not want to answer NA.

Q9 – he answered no patients in disease management programs and had no problem with this question.

Q10 – no problem

4) Q6 – didn't understand the question so she did not answer it but then said all no. She wasn't sure what the reports are or who would provide them.

Q7 – not familiar with these terms but she is not participating in such a program. She thinks she was in a program like this three years ago but not now.

Q8 – she wondered if medical assistants are included in non-physician staff and assumed they are so she answered yes to item d and also to a and b.

Q9 – she was thinking generally about DMP and answered agree somewhat to both but then read it again and marked ‘no patients in DMP.’

Q10 – no problem

PCP

1) Q6- He felt that table was too busy and thought it would be better to have four separate questions for the four kinds of reports. He said yes to a and b and said the reports describe individual performance. He explained that these reports are generated for him by an Independent Physician Association (IPA) who uses Medventive to produce reports based on data from patients in his practice who are in certain HMOs. So the reports come from data in his practice but only for some patients and the reports are generated outside the practice. He gets information about his performance and is compared to other doctors in the IPA.

Q7 – He said yes here as well and felt that Q6 and Q7 are related. In Q7 he was talking about reports he gets from BXBS about his patients covered by that insurance company. He also explained that there is an incentive that is tied to these reports.

Q8 – No problem with this question

Q9 – He indicated agree somewhat to both. He enrolls patients and has patients he knows are in these types of programs through insurance companies. He has patients who get contacted by insurance companies based on his diagnosis. He understands what we mean by this but doesn’t think dmp is the phrase to use because he doesn’t think this is very common language.

Q10 – No problem with this question. He is a PCP in Family Medicine but he also does obstetrics (although not board certified in ob) so he could have answered specialist and PCP items but he just answered PCP.

2) Q6 – he thought it a little weird for solo practitioners to say they give themselves reports on their performance but this is what this is asking and he said yes to a, b, (both individual and practice performance described) and d.

Q7 – he said he understood the question and he answered no and said ‘it’s called pay for performance here (Washington state).

Q8 – they provide a, b, and d but they refer for c. He did answer no for c.

Q9 – good thing we emphasized programs sponsored by health plans or employers because he would have answered differently for programs sponsored by hospitals (less positively). He thought the neither column should be in the middle.

Q10 – He wanted more response options – 5 instead of 3.

HMO

Specialist

Q6 – He originally answered yes to a and b and indicated practice performance for the follow-up question. However, he then said that he does not personally get these kinds of reports but the chief of his department does and he knows this information is accessible it’s just not routinely provided in a report form. He thought maybe we should provide examples of reports and highlight ‘regularly receive’.

Q7 – He participates within the practice as department rep for quality management but not outside practice. He indicated ‘no’. He was not familiar with Bridges to Excellence or CMMS.

Q8 – item a is worded oddly – ‘you think you know’. He knows about all visits within HMO because his patients only go within HMO.

Q9 – he does not put patients in dmp but he has some who are in these programs and he thinks they are a good idea. He answered strongly agree to both a and b.

Staff model HMO

Q6 – no to all reports. Question and table were clear and easy to understand. No problem.

Q7 – has heard of Bridges to Excellence but not sure exactly what it is. Thinks it's 'coalition of people trying to quantify quality', in category of Leap Frog group. He answered no. NO problem with the question.

Q8 – no to all in Q8. No problem with the question or table.

Q9 – strongly agree for a but for b wants to say NA because DMP don't affect his ability to provide quality care. "People I see on an episodic basis are in these programs and I'm sure they are helped by that but that does not affect my ability to provide quality care."

Q10 – he doesn't coordinate care and he saw that instruction so he responded NA. Question and table were fine.

PCP/Specialist

Q6 – he doesn't do preventive care or deal much with patients with chronic conditions so he felt these questions didn't really apply to him. He wanted to be able to indicate NA rather than NO.

Q8 – he had no trouble answering this question for his practice even though he does not really deal with chronic conditions. He seemed very knowledgeable about what his practice has to offer.

Q9 – he feels that this question doesn't really apply to him because he does not put patients in DMP. He sees some patients who are in DMP but he doesn't enroll them. He did answer them agree strongly, and agree somewhat.

Q10 – He indicated that 'coordinating care' is a phrase used in billing so he felt there should be no problem for doctors to understand what it means. After reading the items in the question, he felt as though the PCP items were more appropriate for him than the specialist questions so he answered those. He said that in his practice he is listed under PCP heading. No other problems with the question

Hospital

PCP

Q6 – the practice doesn't give these reports but the HMO does. She first indicated Yes to a, b, and d but then when she re-read the question and saw 'from your main practice', she said no. The table is fine.

Q7 – She said yes, and is familiar with Bridges to Excellence but not sure who sponsors these programs. She thought we were talking about filling out surveys from drug companies and others who invite her to fill out surveys.

Q8 – no problem

Q9 – no problem

Q10 – no problem

Specialist

1) Q6 – no problem

Q7 – didn't seem to understand what quality reporting programs is – had not heard of Bridges to Excellence. Did not think she was in any kind of program so she said no.

Q8 – no problem

Q9 – she was not familiar with the term DMP but read the description and thought about hospital based programs for patients with HIV/AIDS or diabetes. Her hospital sponsors programs so she answered about those and answered strongly agree to both statements. She did not see the phrase in the question 'sponsored by...'.

Q10 – no problem

2) Q6 – he answered no to all of these and seemed very clear about it.

Q7 – he wasn't sure how to answer this. He was not familiar with any of the terms in the questions – quality reporting program or Bridges to Excellence, etc. He talked about Performance Appraisals he gets from the hospital once a year but this is from within practice and sounds like a job review. He also talked about the Joint Commission on the Accreditation of Health Organizations. This organization gives the hospital a report about his area of the hospital and how they are doing but it isn't specific to doctors. Sounds like the answer is no to this question.

Q8 – Q9 – he didn't have this page.

Q10 – no problem with this question

3) Q6 – he knows what we are talking about but he doesn't get any of these – answered no to all

Q7 – not familiar with these specific terms (Bridges to Excellence or quality reporting programs) but understands what we are asking about and said no.

Q8 – add ‘to family/guardians’ then the answer is yes for a and d. Otherwise no because doesn't give to patients.

Q9 – no problem. He answered no patients in dmp.

Q10 – he answered all items because he has some patients for whom he is PCP and others he's consulting neurologist. He considers himself a specialist but does act as PCP for some patients so he answered all items. Item d – add ‘family’

PCP/Specialist

Q6 – does not get any of these kinds of reports but had no problem with the question. He gets an Annual Performance review every 6 months but this is job performance review. He understood what we were asking about with these reports but he doesn't get any of them from his practice.

Q7 – no problem with this question. He was familiar with Bridges to Excellence and quality reporting programs because other physicians in his group participate but he does not.

Q8 – no problem with this question. He answered yes to a, b, and d but no to the other items. He found this question very straightforward and easy to answer.

Q9 – no problem with this question. He answered agree strongly for both items. He is very familiar with DMP – he enrolls patients and treats patients who have been enrolled by others. He felt the explanation of DMP provided was accurate and useful.

Q10 – he answered the items for PCP because he felt they were more appropriate for him. He did not want to use the NA column because he does coordinate care but more from the PCP perspective.

Group

PCP

1) No problem with any of these questions – all were clear and easy to understand.

2) No problem with any of these questions

3) Q6d – wasn't sure what this means. Does it mean lists of patients on certain medications in case of recall, for example?

Q7 – was not familiar with quality reporting programs or Bridges to Excellence. Her practice doesn't take Medicare or Medicaid so she didn't know but she is not aware of participating in anything that sounds like this so she said no.

Q8d – they have ‘advice nurses’ who answer patient questions over the telephone and help people manage their care and educate but this is not formal or structured thing and it’s not just for patients with chronic illness – it’s for all patients (parents). Pediatrics

Q9 – She thought this was only asking about her enrolling her patients in dmp so she answered No pt in dmp for a (she doesn’t enroll patients) and neither agree nor disagree for b (because she has no experience on which to base an answer). She missed the phrase ‘sponsored by health plans or employers’. She said she used to have insurance companies calling her to try to get her to enroll her patients in dmp but this hasn’t happened in five years or so.

Q10 – no problem

4) Q6 – she does not receive any of these types of reports from her main practice but she talked a lot about these kinds of reports from insurance companies and the state medical society. She had not answered the question because she was confused about this but she probably would have answered yes – she did not notice the phrase ‘from your main practice’. She talked about “Physicians for Performance incentive” which she gets from the state medical society. She didn’t think any private practice would provide these types of reports to their physicians because it would cost too much and take too much time. Because she couldn’t imagine private practices doing this, she was thinking about other sources of these types of reports (state medical society and insurance companies).

Q7 – she said “yes but not by choice”. She said that she get reports from insurance companies about which of her patients have had mammograms and which haven’t, which kids have gotten immunizations and which haven’t. She gets these because they participate with insurance companies. It is not by her choice. If you participate in certain insurance companies you automatically are in the program and get reports.

Q8 – she said ‘sometimes’ to item b (‘when we have it available’). Item e – they used to do this but they were not getting reimbursed so they stopped –she said no.

Q9 – she answered agree somewhat to both items but she really was not familiar with disease management programs. She was thinking about guidelines for her to follow to treat patients with chronic diseases. She does not enroll patients in any programs and is unaware of any formal structured programs for patients but she answered the questions thinking about guidelines she uses for treating patients with chronic diseases. She did not notice the phrase ‘sponsored by health plans or employers’, nor did she see the column ‘no patients in dmp’.

Q10 – no problem with this question

5) Q6 – found question confusing. She didn’t understand the question to be asking about reports from main practice. She wanted to know if we were talking about reports from insurance companies. From main practice, the answer is no to all.

Q7 – she was not familiar with the term quality reporting programs but answered yes to the question because she gets reports from insurance companies on her personal practice performance but she didn’t sign up for it – she just gets them because her practice participates with that company. The reports provide information such as the number of her patients who are up to date on immunizations, how often she prescribes generic drugs, etc. She had not heard of Bridges to Excellence.

Q8 – no problem

Q9 – she did not see the phrase ‘sponsored by health plans or employers’. They don’t have a lot of patients in dmp. She refers some but mostly they get signed up in other ways, such as through insurance. She answered agree somewhat but then went on to say she didn’t think much of dmp and didn’t think they helped much. When I asked why she agreed somewhat with the statements

she said she was thinking about an ideal world – ‘dmp should work they just don’t work very often because of patient issues such as other stressors and not being reliable about participating. She said she was also thinking about one patient who was signed up for a dmp and it helped her. Q10 – make item letters stand out more. Item C – she was confused – are we asking if she gets information or if information is useful. She thought we wanted to know how often it is useful and answered that way.

6) Q6 – she did not understand who the source of the report would be..."If you're the main practice than who would this be?" She didn't really understand performance report either. She answered No to everything because she doesn't get anything like this from anyone. After we talked about it she said they have access to this information but they don't generate any kind of report.

Q7 – she was not familiar with quality report programs and had not heard of Bridges to Excellence. She answered No.

She suggested that before Q6, we have a few sentences that set the stage for what we are asking about in Q6 and Q7, some kind of context or framework for these questions.

Q8 – no problem

Q9 – wasn't familiar with the term dmp. She doesn't enroll any patients and doesn't know this about her patients. Her practice is primarily Medicare. Does Medicare enroll patients in dmp?T The description of dmp was helpful to her and she saw the instruction about using the last column and she did.

Q10 – no problem

Specialist

Q6 – he said Yes but indicated that the reports came from insurance companies. He does not get any reports from his main practice. He didn't notice this phrase in the question.

Q7 – no but he is familiar with these programs. He thinks he is probably not eligible.

Q8 – no problem

Q9 – he doesn't put any patients in DMP but he has patients that are in such programs through insurance companies. He only knew about insurance company sponsored programs. He does not think much of them. He also disagreed with the definition of dmp in the question.

Q10 – no problem with this question or table.

Medical School Specialist

Q6 – Don't do preventive care so item a is NA. Otherwise no problem with this question

Q7 – He answered yes – he is on QA committee for local medical helicopter group and on the regional emergency medicine advisory committee. He wondered if we should add lines to allow doctor to list what he/she does in this area. He liked having comment lines throughout the questionnaire.

Q8 – no problem

Q9 – wanted to explain his answer (agree somewhat) otherwise no problem with the question

Q10 – No problem

Community Health Center

Q6 – she indicated yes to items a, b, and d but indicated that items a and d come from insurance companies not from her main practice. Item b reports come from both insurance companies and her main practice. She thought this question was asking about reports about patients in her main practice but generated by any anyone, she did not read this as reports generated by the main

practice. She had no trouble answering the follow-up questions (both individual and practice performance)

Q7 – she didn't have a problem with the question although she has not heard of quality reporting programs or Bridges to Excellence. She is not in any kind of program that sounds like this.

Q8 – no problem, she said yes to a, c, d, e.

Q9 – no problem, she said no patients in dmp for both items. She indicated that if she were talking generally about dmp she would answer agree strongly. She is familiar with these types of programs and very positive about them. Her practice is trying to building some of these programs themselves.

Q10 – no problem

Other – ER Group

Q6 – he does not get any of these types of reports. He only gets acute care reports from his group and from the hospital (e.g. length of time in ER, time from check in to being seen in ER, cardiac care guidelines followed, etc).

Q7 – he has heard of quality reporting programs but does not participate. Has not heard of Bridges to Excellence.

Q8 – No to all. While he is sure that some of the patients he sees have chronic conditions, he is not dealing with that when he sees them in the ER.

Q9 – No patients in DMP.

Q10 – NA to all. He does not follow up with patients, He does not refer to PCP and he doesn't get many referred patients so he felt these were all NA for him.

4. SUGGESTIONS

General

- Add a few introductory sentences before Q6 to provide context and framework for Q6 and Q7.

Question 6

- Emphasize the phrase ‘from main practice’ or reword to indicate ‘generated’ by main practice.
- Provide examples of reports or examples of the kind of information that would be in the reports.

Question 7

- Provide more of an explanation of what quality reporting programs are and/or what physicians would have to do if they were in these programs.

Question 8

- None

Question 9

- If the intent of the question is to focus on doctors who use DMP for their own patients and get opinions from doctors with actual personal experience with these programs, the

question needs revision. If the intent of the question is to get very general impressions and opinions about DMP in general, revision may be unnecessary.

- Highlight/emphasize ‘sponsored by health plans or employers’
- Consider skipping respondents out of question if they don’t have patients in DMP (specify who are enrolled by employers or insurance companies). Maybe a screener question first – do you have patients in DMP then use that to skip around opinion question about the programs.
- If not skipping doctors out of the question, may want to rewrite to something like...”Thinking just about your patients with chronic conditions who are enrolled in DMP, please indicate your level of agreement”
- Bold/italics for ‘my patients’ in Q9a and ‘my ability’ in Q9b

Question 10

- Make item letters stand out more.
- Think about rewriting to address useful issue (?)
- Item d – add ‘family’
- Address issue of PCP versus specialist (esp. for ER or urgent care doctors)

E. SOURCES OF PRACTIC REVENUE

1. GOALS

The practice revenue questions included in cognitive interviewing asked about managed care contracts and financial interests (both practice and personal) in medical equipment and hospitals.

The follow-up questions and probes for the question on managed care contracts focused on the respondents' understanding of what types of contracts to include, their willingness and ability to provide a response, whether or not they sought the information from someone else in the practice and their view of how good an estimate they were able to provide.

The goals for the cognitive interview for the questions on financial interest (Q12-Q15) were to determine if respondents understood the definition of financial interest provided, if they thought the definition was complete, if they were knowledgeable enough about their practice situation to be able to answer the questions and if they felt the response options and the response tables were clear and easy to use.

Additionally, a particular concern with the questions on financial interests was whether or not respondents would be willing to provide the information and if they would feel the questions were intrusive or too personal or make them unwilling to complete the questionnaire.

2. TEST QUESTIONS

11. With how many health plans does your practice have managed care contracts?

Managed care contracts are contracts with health plans, such as HMOs, PPOs, IPAs, and Point-Of-Service plans that use financial incentives or specific controls to encourage utilization of specific providers associated with the plan.

Your best estimate is fine.

1 None

2 1-4

3 5-9

4 10-19

5 20 or more

12. Physicians are relying on more diverse business models now than in the past. Does your main practice have a financial interest in the following types of medical equipment located in your main practice site, in a free standing facility other than a hospital, or both?

Financial interest includes full ownership, partnership, stock investment, or leasing arrangements.

MARK (X) ONE ANSWER FOR EACH ITEM

| Medical equipment used for: | YES | | | NO | UNSURE |
|--|----------------------------|--------------------------------|--|----------------------------|----------------------------|
| | In practice site ONLY | In free standing facility ONLY | In BOTH practice site AND free standing facility | | |
| Laboratory testing | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| X-rays | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Other diagnostic imaging, such as CT or MRI scans | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Non-invasive testing besides EKGs (e.g., Echocardiograms, treadmill, nuclear testing, sleep testing) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Invasive procedures, such as endoscopy or cardiac catheterization | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |

13. Excluding any financial interests your practice might have, do you personally have a financial interest in a freestanding facility other than a hospital that has the following types of medical equipment?

MARK (X) ONE ANSWER FOR EACH ITEM

| Medical equipment used for: | Yes | No | Unsure |
|--|----------------------------|----------------------------|----------------------------|
| Laboratory testing | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| X-rays | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Other diagnostic imaging, such as CT or MRI scans | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Non-invasive testing besides EKGs (e.g., Echocardiograms, treadmill, nuclear testing, sleep testing) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Invasive procedures, such as endoscopy or cardiac catheterization | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> | 8 <input type="checkbox"/> |

14. Does your main practice have a financial interest in a hospital?

MARK (X) ONE ANSWER

- 1* Yes
0 No
8 Unsure

15. Excluding any financial interests your practice might have, do you personally have a financial interest in a hospital?

MARK (X) ONE ANSWER

- 1* Yes
0 No
8 Unsure

3. RESULTS

Summary

Question 11 was not a difficult question for respondents to understand but respondents admitted that they were guessing about the number of plans. Several respondents said they were glad to see the statement ‘your best estimate is fine’ because they really were estimating. Three respondents did not answer the question because they just didn’t know. Four respondents said none, 3 said 1-4 plans, 6 said 5-9 plans, and 8 said 10-19. No one answered 20 or more plans.

One respondent indicated that he had answered the question (10-19) but then asked someone in the office administration and changed his answer (5-9). Another respondent said that if she had been in the office when she was answering the question she would have asked someone. She said ‘who knows’ but answered 10-19 as a guess.

Respondents who used the larger category (10-19) said things like, ‘we accept everything’. Two of these respondents were very sure of their answers the others said it was more of an estimate.

Respondents did not seem to have any difficulty understanding what to include as managed care contracts but some respondents indicated they were unsure how to count products within larger health plans. For instance, one respondent indicated that they accept BXBS, Tufts and Harvard/Pilgrim. He answered 5 to 9 but then said it should probably have been 10-19 because of all the products within these plans that he may have missed. Another respondent answered 5 to 9 but noted that some large health plans (like HealthNet) have sub-plans and practices may accept some but not all of the sub-plans. She noted that the count could be very different if you count individual plans or just the larger plans. Her count was just of the larger plans – she counted HealthNet as one. One of the respondents who answered don’t know, subsequently asked her husband who said it would be 30 to 50 if all sub-plans were counted separately and 19-19 if the count was just of the larger plans.

One respondent (solo PCP) who answered 10-19 said that he contracts with an ‘umbrella contracting network – First Choice – that has 150 different insurance companies in it’. He counted this as one and wondered if we should ask about “health plans or health networks”.

The respondent in the staff model HMO said he had trouble deciding whether to answer none or one and said that the question assumes that the practice contracts at all. The health plan contracts with the medical group and the medical group contracts with the hospital. He answered none but felt he could have answered one.

One respondent thought the categories should include a larger range because he feels that most respondents will be guessing and won’t really know if it’s 4 or 5 plans, for instance. He suggested using none, less than 10, 10 to 19 and 20 or more. He was the only respondent who mentioned anything about the response options.

Question 12 was difficult for some respondents because of confusion about the definition of ‘free-standing clinic’ and ‘financial interest’. Overall, 10 respondents said yes to at least one item, 14 respondents answered no to all.

The confusion about the free-standing clinic seemed to result from respondents wondering if this means physically free-standing or free-standing as a business entity. One respondent (solo specialist) reported that he performs cataract surgery in a surgery center that is physically connected to his main practice (in the same building) but is a separate business entity. He answered ‘in practice only’ for this. He also marked ‘in practice only’ for items c and d – they do these things as part of the practice but they bill separately for them and they own the equipment.

Three respondents (one solo and two group respondents) wondered if small equipment for standard, small tests performed in the office (such as urine analysis or rapid strep tests) would count. This is equipment they have in their offices that did not involve a large capital investment and they are not sure if these tests are billed separately or not. The three situations are described below:

- One respondent (group PCP) has a small lab in her practice that does a few tests (rapid strep, blood counts, urine tests, hearing and vision screening). She thinks they are reimbursed for some of these and not for others. It is not a separate business or separate place. Would this count? She answered no but was wondering.
- Another group PCP said they have equipment for bone density scans in the office but it is not a separate business or space. She also answered no.
- The third respondent (solo PCP) also answered no to all but wondered about simple lab equipment for blood counts and urine analysis and about simple procedures such as ‘flexible sigmoidoscopy’.

The hospital specialist answered ‘in practice site’ to lab because they have a lab in their hospital clinic office and he answered no to everything else because it’s all in the hospital and they don’t have a financial interest.

There was also some confusion about the definition of financial interest. One respondent (HMO specialist) is a shareholder in the HMO and wondered if this counted. He didn’t invest personally in any of this and it doesn’t affect his income but he is a shareholder in the HMO. He answered no to all items.

One respondent (hospital specialist) had a confusing situation and was not sure how to answer. His hospital has a lab and x-rays and he answered “Yes, in practice site only” for these two items but he’s not sure this is really ‘financial interest’ because he’s in a state hospital. They own equipment for lab and x-rays but they don’t bill patients for it so they don’t make any money by having the equipment. They avoid losing money by having this equipment because if they had to send patients out for this, the other facility would bill the patients and his hospital would end up paying. He thinks the situation for government hospitals is different from private hospitals or practices who bill patients for the procedures. He answered no to all other items because they don’t have any of this in the hospital.

Four respondents (one solo practitioner, one group PCP, one HMO PCP/Specialist, and the Community Health Center respondent) had the following difficulties with specific items.

- 1) The solo practitioner wondered where to put equipment for diagnostic endoscopy of the nose and throat. He didn't think it fit well in item five (which gave endoscopy as an example) because it is non-invasive and a diagnostic tool rather than a procedure.
- 2) The group PCP respondent wondered if ultrasounds would be included in 'other diagnostic imaging' and, if so, she thought the question should specify. For this item she said "In free standing clinic only" but only if ultrasounds are included. She also felt that ultrasounds are very different from CT and MRI scans in terms of financial interest and equipment so she wasn't sure if she should include. Similarly, echocardiogram is very different from nuclear testing in terms of the sophistication of the equipment and the cost. She thought it odd that these would be combined in one item.
- 3) The HMO respondent had difficulty with the fifth item. He indicated that his answer would be yes for endoscopy 'in the practice site only' but no for catheterization because they only do that at the hospital and they don't have financial interest there.
- 4) The community health center respondent wondered where mammograms would fit and thought they would fit in the third item "other diagnostic imaging" but wasn't sure.

One respondent did not realize that question 12 was asking about the practice – he answered no to all items in question 12 and no to all in question 13. However, when we were talking about question 13, he realized that question 12 was about the practice, not his personal situation and he went back and changed his response for item A to 'yes'. The lab is in the same building with his practice but in a separate space – he wasn't sure if that should be column one or two.

Respondents did not express a great deal of concern about why these questions were being asked. Only three doctors mentioned this concern at all and two of these said it was not a concern for them (because they don't have any financial interests) but they thought it might be for others. One of these doctors said he would wonder why the personal questions were being asked and what the information would be used for. He thought maybe a confidentiality reminder or explanation of data use might help. The respondent from the staff model HMO was the only one who felt this was no one's business and couldn't see how any of this information would be useful for research purposes (although he did answer the questions). In contrast, a few doctors indicated that they have to provide this type of information when they renew their state license so they did not see it as a problem at all.

Question 13 was more straightforward for most respondents than question 12 because they were clear about their personal financial situation, with most saying no to all. Only one respondent answered yes to any item. This respondent (HMO PCP/Specialist) has financial interest in a clinic he started many years ago in a different state. It is totally unrelated to the main practice he was talking about in the survey. He first thought the answer would be no because the clinic is completely unrelated to his current practice situation but then decided the answer would be yes to items a, b, and d because he does have personal financial interest in this clinic.

The question was somewhat difficult for one solo practitioner because he said it is difficult for him to separate himself from the practice. To him, question 12 and 13 are the same and question

14 and 15 are the same. He said no to all of them. However, another solo practitioner said he has no problem at all separating his incorporated practice from his personal financial situation.

One respondent thought we should be asking about the personal situation of the respondent as well as his/her immediate family members. He felt that if his spouse had a lab and he was sending all his patients there, it would be his financial interest. He didn't feel that the question as worded includes that situation. One respondent expressed confusion about the phrase 'you personally'. She said "we have lab testing in our office, so I benefit from it but as an extra investment, no". She answered no.

Several respondents expressed some confusion about question 14 because their practice is owned by a hospital and they wondered if this would count as having a financial interest in a hospital. One respondent in this situation was unsure how to answer but answered yes. One hospital specialist was unsure because his hospital is part of a community health network that includes 5 hospitals and other facilities. Overall, four respondents answered yes (2 group HMO, 1 hospital, 1 medical school physician). Two respondents answered unsure (group and hospital) and the remaining 18 physicians answered no.

A few respondents were unclear about the definition of financial interest here and wanted another definition or at least reference to the definition given in question 12 if that applies. One respondent (Group PCP) said unsure but then said if the definition of financial interest from question 12 held for this question, the answer would be no. He was thinking of financial interest as "benefiting financially from the performance of a hospital". His practice is owned by a hospital system so "the hospital has financial interest in us."

The medical school specialist answered yes but then said if the definition of financial interest in Q12 holds here, the answer would be no. He's an employee of a hospital and his practice is part of the hospital.

Question 15 did not raise any issues other than those discussed above for question 14 and was easier for most respondents to answer than question 14. Only one of the respondents answered yes (solo practitioner).

Results in Detail

Solo

Specialist

1) Q11 – no problem

Q12-Q15 – no problem. He has no financial interest in any equip or hospital in practice or personally so it was easy for him. He did not have a problem answering these questions but thought some doctors might be concerned about why we are asking these questions. He suggested adding a confidentiality reminder before these questions and/or explanation of who is getting this info and how it will be used.

2) Q11 – answered none. No problem

Q12 – problem with ‘free standing’ do we mean physically free standing or business-wise free standing? He does cataract surgery in a surgery center that is physically connected (in same office building) but is separate business entity. He marked in practice for this.

He marked ‘in practice’ for items c and d – they do these things as part of the practice (imaging for the eye and tests of the eye) but they bill separately for them. They own the equipment.

Q13-Q15 – no problem. Said no to all.

3) Q11 – no problem.

Q12 – he owns X-ray equipment so he said yes in practice site only to this item and no to all others. He was not sure what to do about “diagnostic endoscopy of the nose and throat” which he performs in his practice site. He didn’t want to say yes to the last item because he says the diagnostic endoscopy is non-invasive and it is not a ‘procedure’ (which removes or fixes something), it is a diagnostic tool.

Q13- no problem, answered no to all. It is easy for him to separate himself from his practice in terms of financial interest. His practice is an incorporated separate entity.

Q14 – no problem, answered no.

Q15 – answered yes.

4) Q11 – she said her answer (10-19) was a rough estimate and wondered if Medicare and Medicaid HMO counted. She said ‘the whole HMO thing is pretty unclear to me’.

Q12 – Q15 – no to all and no real problem but thought we should provide another definition of financial interest in Q14 or refer back to Q12 definition.

PCP

1) Q11 - he answered #3 but as we talked he decided he really should have answered #4 when he thought about the different products within BXBS, Tufts and Harvard/Pilgrim which are the main ones he uses.

Q12, Q14 – he had no problem with these questions.

Q13, Q15 – he had a bit of trouble since he is solo practice. It is hard for him to separate what would be him personally from his main practice. To him, Q12 was the same thing as Q13 and Q15 was the same as Q14. He said no to all in Q12-Q15

2) Q11 – he has one health network which is an ‘umbrella contracting network with 150 different insurance companies under it. He counted this as one but wondered if we should say health plans or health networks. He understood this question to be asking about all non fee-for-service contracts.

Q12 – he answered no to all but was wondering if his small lab equipment in his office (that he owns) would count here. He does urine analysis and blood counts but the equipment is small and not a large capital investment. He thought it would not count. They also do flexible sigmoidoscopy in the office but he said it is a simple inexpensive procedure so he did not think it would count under item #5.

Q13-Q15 – no to all. No problem.

HMO

Specialist

Q11 – no problem. He answered 1-4.

Q12 – Q15 – he was confused by ‘financial interest’. If we fix the definition it should solve problems for all questions. He is a share holder, does this count. He didn’t invest personally in any of these things and it doesn’t affect his income but he is a share holder in the HMO. His gut

reaction would be no to all items in Q12 but he wasn't sure. Definitely no to Q13 For Q14 – his main practice is part of a hospital, does that count?

He was not bothered by us asking these questions – he said that he had to answer the same types of questions when he renewed his state license so it didn't bother him. He just wanted more clarity about what we meant by financial interest.

Staff model HMO

Q11 – either one or none. He's not sure which to answer but would probably go with none. The question assumes you have a practice that contracts. The health plan contracts with the medical group and the medical group contracts with the hospital. Could be either one or none.

Q12-Q15 – no to all. Questions are clear and make sense and he has no difficulty answering but he feels this is none of our business and can't possibly be useful for research purposes.

PCP/Specialist

Q11 – he has no idea. Would like to have a dk response. He thinks this will be a very difficult question for most doctors.

Q12 – He originally thought 12 was asking about him personally. Confused about what 'free standing clinic means' – does it mean not associated with a hospital? His practice has 5 urgent care centers, 10 other types of clinics (specialty and primary care) and a hospital. Some of this equipment is in these centers. Are these free standing clinics?

On the last item – endoscopy is at one of the clinics but the cardiac catheterization is only at the hospital so he wasn't sure how to answer. He answered BOTH for items a, b, and d, and NO for item c and unsure for item e.

Q13 – He has financial interest in another practice totally unrelated to the one we were talking about. It's in WA state and he hasn't practiced there in years but still has financial interest. Does this count here? He thought no because he thought this question was related to q12. He would have said no to all. If we wanted him to include the financial interest in the other practice, he would have said yes to items a, b, and d.

Hospital

PCP

1) Q11 – no problem HMO and PPO (all that I know of)

Q12 – no to all. She didn't read the definition of financial interest and didn't see the phrase 'other than a hospital'.

Q13 – no problem

Q14 – the practice is owned by the hospital. She said unsure than answered Yes

Q15 – no problem

Specialist

1) Q11 – her practice takes everything and she has seen a list so she was pretty sure about this answer – 10-19. She was thinking about HMO, PPO, etc.

Q12 – they have a lab in their hospital clinic office. Everything else is in the hospital but they don't have a financial interest in the equipment or in the hospital. She seemed very clear on this.

Q13- Q15 – no problems

2) Q11 – he first marked #4 (10-19) but then spoke to someone in administration who said it was #3 (5-9).

Q12 – He answered no to all of this – said the hospital has all of this as part of the hospital but not as a separate business entity.

Q13 – no to all. This was easy

Q14 – He answered ‘unsure’ – his hospital is part of a ‘community health network’ that includes 5 hospitals and other facilities.

Q15 – he answered no to this. This was easy.

3) Q11 – no problem. Answered no

Q12 – confusing. His hospital has lab and xrays and he answered “Yes, in practice site only” for these two items but he’s not sure this is really ‘financial interest’ because he’s in a state hospital. They own equipment for lab and x-rays but they don’t bill patients for it so they don’t make any money by having. They avoid losing money by having this equip because if they had to send patients out for this, the other facility would bill the patients and his hospital would end up paying. He thinks situation for government hospitals is different from private hospitals or practices who bill patients for the procedures. He answered no to all other items because they don’t have any of this in the hospital.

Q13 – he thinks we should add “do you or any family member” have financial interest. He suggested that if his wife owned a lab and he sent all his patients there, it would be to his financial benefit and his interest.

Q14 – Q15 – no problem

PCP/Specialist

Q11 – he answered 10-19 because his practice accepts ‘everything’.

Q12 – he didn’t have a problem with this question. He felt he understood the definition of financial interest and felt it was complete and appropriate. He answered no to all.

Q13 – no problem. He answered no to all. This was easy since it was personal.

Q14 – he was a little unclear about financial interest here and wondered if it meant the same thing as in Q12. He suggested that we define it again or reference the definition in Q12.

Q15 – no problem.

Group

PCP

1) No problem with Q11 – he included HMO and PPO contracts. It is an estimate but it pretty good one.

Q12-Q15 – his practice has financial interest in some of this equipment but not in a hospital. He has no personal financial interest in any of the equipment or hospital. He suggested that we order the questions to first ask about the practice (Q12 and Q14) and then ask about personal (Q13 and Q15). He said he thought that doctors who do have personal financial interest may be more unwilling to answer these questions honestly. He would have been wondering why we were asking about the personal situation and who was getting the information.

2) Q11 – he would have used larger categories (1 to 9, 10 to 19, 20 or more) because he thinks that no one will really know for sure – just guessing. He really guessed since he doesn’t have to know this sort of stuff.

Q12-Q15 – not getting that definition of financial interest given in Q12 should still hold for this question. He was wondering what we meant by financial interest. He originally said unsure but if definition from Q12 still holds for this question than he would say No. He thought of financial interest as benefiting financially from performance of the hospital.

Q14 –not sure what to answer. My practice is owned by a hospital system so the hospital has financial interest in us.

3) Q11 – she said “who knows” but had marked 10-19. She said if she had been in her office when she was completing the survey, she would have asked someone.

Q12 – her practice (pediatrics) has a small lab with equipment that does a few tests (rapid strep, urinalysis, blood counts, hearing and vision screenings. She thinks they are reimbursed for some of these and not for others. Would this count for item a or not? It is not a separate business or separate space.

Q13-Q15 very clear on the rest of these questions – all no.

4) Q11 – She answered 5-9 but noted that some large health plans (she gave HealthNet as an example) have sub plans and practices may take some but not others of these sub-plans. The count therefore could be very different depending how you count these. She counted Health Net as one main plan. She also said it was a good thing we included the phrase ‘your best estimate is fine’. Her answer is a ‘pretty good estimate but definitely an estimate.’

Q12 – they have equipment to do bone density scans in their main office but they don’t get paid as a separate business for that. Does that count here? Would that be a free standing clinic? Not sure what free-standing clinic means.

Q13-Q15 – no problem.

5) Q11 – no problem. She would count Health Net as one big one. She answered 5-9

Q12 – Q15 – seemed clear on this. No problem

6) Q11 – no problem. They have none and she was very clear about that.

Q12 – she had a few problems with this question. For the third item she wondered if ultrasounds would be included in ‘other diagnostic imaging’ and, if so, we should specify. For this item she said “In free standing clinic only” but only if ultrasounds are included. She also felt that ultrasounds are very different from CT and MRI scans in terms of financial interest and equipment so she wasn’t sure if she should include. Similarly, echocardiogram is very different from nuclear testing in terms of the sophistication of the equipment and the cost. She thought it odd that these would be combined in one item. She found the definition of financial interest clear, complete and helpful.

Q13 – she was a little confused by the ‘you personally’ she said “we have lab testing in our office, so I benefit from it but as an extra investment, no”.

Q14-Q15 – no problem

Specialist

He somehow did not realize that Q12 was asking about the practice – he answered Q12 all no and Q13 all no. Then when we were talking about Q13, he realized that Q12 was about the practice, not him personally and he went back and changed response for item a to Yes. The lab is in the same building with his practice but in a separate space – wasn’t sure if that should be column one or two.

No other problems with these questions

Medical School Specialist

Q11 – His answer is really a guess. He’s not in administration so he really doesn’t know.

Q12 – he didn’t seem to have any problem with this question

Q13 – easy because he has no financial interest

Q14 – he answered yes but if the definition of financial interest given in Q12 holds for this question as well, the answer would be NO. He’s employee of a hospital, his practice is part of the hospital

Q15 – easy because he has no financial interest

Community Health Center

Q11 – She answered don't know but then spoke to her husband and estimated that the number is 30-50 if all sub-plans are counted separately and 10-19 if they are not counted separately.

Q12 – She answered ‘in practice site only’ for the first four items and explained, “We rent space in our building for other entities to perform these tasks”. She also wondered where mammograms would fit. Would it fit in other diagnostic imaging?

Q13 – answered no to all. No problem with this question.

Q14 – no problem. Answered no.

Q15 – no problem. Answered no.

Other – ER Group

Q11 – no idea

Q12 - Q15 – no to all. He understood these questions and didn't have any comments about them, he and his practice don't have any financial interest in any of this.

4. SUGGESTIONS

Question 11

- Consider offering an ‘unsure’ category to pull out the real guesses.
- Clarify for respondents how to count large plans that include multiple products and health networks.
- Although one respondent suggested reordering questions Q12, Q14, Q13, Q15, I do not recommend doing this. The way the four questions are structured and worded makes more sense and is easy to follow if the question are ordered the way they are now. Only one doctor has an issue with the order of the question. I don't think it will make this series any easier to change the order of the question.

Question 12

- Emphasize *the practice* having financial interest.
- Emphasize ‘other than hospital’.
- Provide definition of free-standing clinic and expand/clarify definition of financial interest.
- Address issues raised by respondent comments on items four and five and specify where mammograms would fit.
- Consider (?) making the question just yes/no rather than practice, free standing, both.

Question 13

- Note to include all outside personal financial interest (in another practice other than main)
- Although one physician suggested including the personal financial interest of immediate family members, I would not recommend that – it would be difficult to define and explain and would probably be considered even more intrusive.

Question 14

- Provide guidance for respondents in practices that are part of or owned by hospitals and groups/hospitals that own other hospitals.
- Provide another definition of financial interest in Q14/Q15 or reference definition in Q12.

Question 15

- None

F. COMPENSATION

1. GOALS

Question 16 is intended to measure the respondent's method of basic compensation. The cognitive interview was to determine if the concept of 'basic compensation' was meaningful to respondents, if the response options are appropriate and cover the majority of compensation methods and if respondents have any trouble selecting an appropriate category.

Questions 17 and 18 are intended to categorize and estimate the amount of supplemental income physicians receive from drug, device and medically related companies.

The concern here was to determine if respondents are willing and able to answer these questions, if the items make sense to them, if they are able to recall the previous year and if they are willing and comfortable providing this information. In particular, the cognitive interview was to determine if these questions would cause any respondents to refuse to complete and return the questionnaire.

2. TEST QUESTIONS

16. Which of the following methods best describes your basic compensation? Do not include bonuses or incentives. **MARK (X) ONE ANSWER**
- 1 Fixed salary
 - 2 Salary adjusted for performance (e.g., own productivity, practice's financial performance, quality measures, practice profiling)
 - 3 Shift, hourly, or other time-based payment
 - 4 Share of practice billings
 - 5 Share of workload
 - 6 Other Method (Describe)
17. During the last year, have you personally received any of the following from drug, device, or other medically related companies? Include honoraria and payments from marketing and research firms working for medically related companies.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Yes | No |
|--|----------------------------|----------------------------|
| a. Food and/or beverages in your workplace? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| b. Free drug samples? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| c. Honoraria for speaking? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| d. Honoraria for participating in surveys on prescribing practices? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| e. Payment for consulting services? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| f. Payment in excess of costs for enrolling patients in clinical trials? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| g. Costs for travel for attending meetings? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h. Gifts that you receive as a result of prescribing practices? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| i. Complementary tickets to cultural or sporting events? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| j. Complementary or subsidized admission to meetings or conferences for which CME credits are awarded? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

18. Excluding any food, beverages, and drug samples you may have received in your workplace, please estimate the total value of all goods and services you received in the last year from drug, device, or other medically related companies? Include honoraria or payments from surveys conducted by marketing or research firms for medically related companies.

Your best estimate is fine.

MARK (X) ONE ANSWER

- 1 Less than \$1,000
- 2 \$1,001 to \$5,000
- 3 \$5,001 to \$10,000
- 4 More than \$10,000
- 5 None

3. RESULTS

Summary

Question 16 posed some difficulty for five of the solo practitioners and three of the group practice doctors but other respondents (those in HMO, hospital, other) did not seem to have difficulty with it. The confusion stemmed from the response options. The solo practitioners felt they could answer more than one category.

- Three answered salary adjusted for performance although they all thought they could have answered fixed salary. One of these mentioned that the adjustment is a bonus.
- One answered share of practice billings (100%) but said he could also have answered salary adjusted for performance.
- One said he could have answered share of practice billing and share of workload. He marked ‘other’ and wrote the following note, “Paid as total reimbursement from insurance companies minus expenses, done separately for the two doctors in the practice.”

One solo practitioner had no problem answering the question – he said salary adjusted for performance.

The group practice doctors who had trouble with the question reported two different situations. One doctor had trouble deciding between 4 and 5 – she indicated that they have five doctors in the practice, one who gets a fixed salary and then the workload and practice profits are split among the remaining four (she being one of them). The other group doctor said that she gets salary adjusted for productivity (#2) but the adjustment is considered a bonus and the question instructed her to exclude bonuses. She ended up answering fixed salary but could have answered salary adjusted for productivity. The third group practice physician was unclear about the meaning of ‘performance’ and asked, ‘does performance mean how good a job you’re doing taking care of patients or how much money you bring to the practice?’

One hospital specialist said he gets a fixed salary but he also gets paid for taking call which is voluntary. He wasn’t sure how or if to record this. He noted it on the questionnaire but only as we were talking about it, he had not noted it before the interview.

Question 17 was not particularly difficult for most respondents but there were a few issues with the question and the items. One respondent asked what exactly is meant by ‘medically

related companies' and wondered if the honorarium for this survey would count. This respondent also indicated that he does CME credits on line that are free so someone is subsidizing that but he doesn't know who. He said he sometimes isn't exactly clear who is paying for conferences or CME meetings. A few respondents did not seem to notice the phrase 'on prescribing practices' in item d and talked about this survey and other surveys not related to prescribing practices.

Additionally, there were a few isolated concerns about some of the items –

- Three respondents said that item H is not allowed by regulations of the AMA
- One respondent thought that item G costs for travel for attending meetings was only for CME conference and meetings and didn't include meetings he had with a drug company until we talked about it and then he thought it should be included here.
- One respondent was unclear if we meant last 12 months or last calendar year.
- One respondent said she has gone to dinners sponsored by drug companies where they have lectures by experts or specialists but no CME credits are given. Should this be included somewhere?
- One respondent was unclear if the question was asking about her as a person or about her as a doctor in her practice. She personally doesn't get drug samples but her practice does. Similarly for food – could be for person or practice. The other items were more clearly about her personally. She thinks of herself as the practice.

Question 18 was not particularly difficult for most respondents but there were a few isolated problems. The issue raised most often was that the first category could be much smaller – maybe less than \$500 or even less than \$100. The isolated concerns raised were:

- One respondent initially read it as taking money from drug companies. He did not include his work on the advisory board for an insurance company because he did not think of insurance as medically related company. One respondent did not notice the 'exclude food, beverage and drug samples phrase.'
- One respondent said it was very difficult for him to estimate and wanted a "don't know" category. He answered less than \$1000 but said the answer is really less than \$100 but difficult to estimate.
- One respondent said that she often doesn't know the sponsorship or purpose of the surveys she does so it's hard for her to know if she should include the honoraria or not.

There seems to be a bit of mismatch between item d in question 17 which asks about surveys on prescribing practices and the last sentence of question 18 which does not mention 'prescribing practices'. This confused a couple of respondents. It seems that question 18 is asking respondents to include any kind of survey conducted by marketing or research companies for medically related companies but question 17 only talked about surveys on prescribing practices.

There was not a great deal of concern among respondents about answering these questions. Only one respondent mentioned a concern without prompting. This respondent (group PCP) answered \$1800 and seemed uncomfortable about providing the information and wanted to be sure it was confidential first. He thought other doctors would have a problem with it, especially those who have made a lot of money from these things. However, for most respondents, even when the issue was raised, most did not have any problem answering these questions. One respondent

indicated that he has to provide a ‘disclosure’ statement for his job each year and it is very similar to this so he had no problem with it. No one indicated that they would not answer the survey because of these questions.

Results in Detail

Solo

Specialist

1) Q16 – confusing. What is difference between #2 and #4?

Q17 – He only answered yes to E – consulting services because of his work on Advisory Board for insurance company.

Q18 – He first read this question as ‘did you take any \$ from drug companies’. He did not think of insurance companies as being medically related so he did not include is work on the advisory board. He did not realize this question was related to Q17. He thought first category should be less than \$500 or less than \$100.

He was not at all bothered by these questions. Doesn’t think most doctors would have a problem with these questions.

2) Q16 – he answered #2 and said it is adjusted for productivity. When I asked about the second sentence and category #1 he said the bonus part was not confusing but then wondered if his adjustment could be considered an incentive.

Q17 – yes to a, b, d no problem

Q18 - #1 no problem

3) Q16 – no problem

Q17 – no problem

Q18 – no problem

4) Q16 – She answered salary adjusted for performance but said she gets a fixed salary which is adjusted each year for performance and she called this a bonus.

Q17 – she thought items g and j were similar

Q18 – no problem, answered less than \$1000

PCP

1) Q16 – he answered #2 but said he could have answered #1. He pays himself a fixed salary but it can be adjusted based on quality measure and IT incentives that he gets from various insurance plans.

Q17 – he answered yes to a-d and g. He went on to explain that he had travel costs reimbursed for some consulting he did. I pointed out that he had said no to consulting services – he had missed that.

Q18 – be answered #2. No problem with this question.

2) Q16 – he answered ‘other’ and said ‘paid as total reimbursement from insurance companies minus expenses, separately for the two doctors in the practice.’ He said he could have answered share of practice billings or share of workload.

Q17 – he said item h is a violation of AMA regulations

Q18 – no problem.

HMO

Specialist

Q16 – no problem, fixed salary

Q17 – no to all but drug samples and food/beverage.

Q18 – said LT \$1000 – didn't notice the exclude food and beverage. Thinks first category should be less than \$500 or less than \$100.

Staff model HMO – no problem with any of these.

PCP/Specialist

Q17 – What exactly does medically related company mean? He does CME credits on line that are free so someone is subsidizing that but he doesn't know who. Often can't be sure who is paying for conferences, CME credits etc.

Would this survey be included?

Q18 – very difficult to estimate. Should offer a dk response. His answer (lt \$100) is really a guess.

Hospital

PCP

Q16 – no problem. Good that we said to exclude bonuses and incentives or she would not known how to handle.

Q17 – yes to a, b, and d

Q18 – start with less than \$500

She did not seem at all uncomfortable or bothered by these questions.

Specialist

1) No problem with questions – missed the instruction to 'exclude food and beverage'.

2) Q16 - He answered 'fixed salary'.

Q17 – he felt that item h is no longer allowed. He said yes to a, b, c, d, g, j.

Q18 – Answered #3.

He didn't have any problem answering these questions.

3) Q16 - He answered fixed salary but said he gets paid for taking call which is voluntary and wasn't sure how or if he should include this. He noted it on the questionnaire but only as we were talking.

Q17 – no problem. Yes to a and b/

Q18 – no problem. Answered none.

PCP/Specialist

Q16 –no problem

Q17 – had a slight problem with item g. He originally said no because he thought this was just travel to meetings that involved CME. He did go to a meeting held by a pharmaceutical company and so he eventually said yes here. He said yes to items a and g and no to all other items.

Q18 – no problem. Answered #2 for the travel expenses he indicated in Q17.

He didn't have any problem answering these questions and didn't think other doctors should have a problem with it. He said that he has to complete a similar set of questions (a disclosure statement) every year for his job so he didn't think it was strange at all to have these questions.

Group

PCP

1) He had a questionnaire that did not have the examples for response option #2 in Q16 so he was confused about what type of performance we were talking about – quality care of patients or bringing money into the practice. When I read him the examples we added to this response option, he said that cleared it up for him.

Q17 – he said yes to food, drug and honoraria for surveys

Q18 – said \$1800 but he didn't have this question in front of him so difficult to determine answer. He seemed uncomfortable about giving this information – wanted to be sure it was confidential. He thought some doctors will have trouble answering these questions. Those who have gotten a lot of money will be more uncomfortable answering these questions, he thinks.

2) No problems with any of these questions.

3) Q16 – no problem with

Q17 – she has gone to dinners sponsored by drug companies where they have lectures by experts or specialists but no CME credit is given. Do we care about this? Do we want to capture this somewhere here? She didn't see 'prescribing practices' on D.

Q18 – smaller first category

4) Q16 – not sure about difference between #4 and #5 – there are four doctors who split the workload and the profits of the practice. They have one additional physician in the practice who gets a salary but the rest of them split the profits.

Q17 – She said yes to a and b and no to everything else. She said that item I is not allowed by regulations of the AMA.

Q18 – no problem

5) Q16 – She answered fixed salary but only because we said in the question not to include bonuses. She said she gets salary adjusted for her productivity but the adjustment is considered a bonus so she excluded it. Otherwise she would have said #2.

Q17 – was unclear about her as a person or as a doctor in her practice. For instance, she doesn't get drug samples but her practice does. Food could also be for practice or for person. Other items are for person. She thinks of herself as the practice.

Q18 – first category needs to be smaller.

6) Q16 – no problem with this question. She has salary adjusted for performance (productivity) and it is not a bonus so she was very clear about this.

Q17 – she did not see the 'on prescribing practices' part of the item, just say the surveys.

Q18 – no problem with this question

Specialist

No problem with any of these questions. He did not seem at all bothered by indicating that he had received a-d. He complained that he no longer gets some of the other items.

He was somewhat confused about during the last year – last 12 months or last calendar year

Medical School Specialist

No problem with any of these questions

Community Health Center

Q16 – no problem

Q17 – She sometimes doesn't know the sponsor or purpose of the surveys she does so it's hard for her to know what to count for item d.

Q18 – She answered #1. She indicated that it is hard for her to estimate the value of the honoraria for surveys because she is sometimes unclear of sponsorship and purpose of the surveys she completes. She indicated that she was a little uncomfortable answering this question and thinks that if she had made more money she would be more uncomfortable.

Other – ER Group

Q16 – shift, hourly, other time-based payment. No problem with this question.

Q17 – no problem with this question

Q18 – no problem with this question

4. SUGGESTIONS

Question 16

- Revise categories to address issues raised by solo and group doctors.
- Specify what to do about bonuses or incentives that are adjustments for performance.

Question 17

- Specify calendar year or last 12 months
- Emphasize the phrase ‘prescribing practices’ in item D or include all surveys conducted by marketing or research firms for medically related companies as question 18 indicates.
- Delete item h.

Question 18

- Make the first category smaller – start with less than \$500, then \$500 to less than \$1000
- Note that the last sentence of the question does not match up with item d in question 17. Question 18 says to include surveys conducted by marketing or research firms for medically related companies but it does not specify ‘surveys on prescribing practices’ as item d in Q17 says.

G. PERSONAL BACKGROUND

1. GOALS

These questions are intended to gather practice and hospital location information including name and address. The concern to be addressed in cognitive interviewing was if respondents would be willing to provide this information and if asking for this information would have any impact on their overall willingness to complete and return the survey. If respondents expressed concern, the goal was to determine the nature of their concern and the best way to address that concern.

2. TEST QUESTIONS

19. What are the name and address of the practice we have been talking about during this interview?

Your information is confidential and individuals or practices will not be identified. Your practice information will help us categorize types of physician practices and will be helpful if we select your practice for a follow-up study in future years.

20. What is the name of the hospital where you admit the largest number of patients?

This information is confidential and will be used solely for analytic purposes, for example, to define hospital referral regions. The hospital will not be contacted.

3. RESULTS

Summary

The majority of respondents was willing to provide the requested information and seemed to have no concerns about providing it. They did not seem at all surprised to be asked for this information and provided it without comment. When specifically asked if they had any reservations about these questions, most indicated they had none. A few said they wondered why it was needed but they didn't have a problem providing the information and a couple of respondents said they would fully expect to be asked this information at the end of a survey. Several respondents said they read the confidentiality reassurance statements after each question and appreciated that information and felt better after reading it.

Two respondents (staff model HMO and group PCP) refused to give the information and said they would never provide this information in a survey such as this. Neither of these respondents was reassured by the statements and they saw no reason for us to ask for the information and would not provide it. It did not prevent them from completing the survey, they just wouldn't answer these questions.

A couple of respondents who did provide the information suggested that we ask for city and state only and not name and street address of the practice.

Results in Detail

Solo

Specialist

- 1) No problem with these questions. Thinks maybe we should explain more about why we are asking – he did not notice the explanations. When he saw the statements and read them, he thought this was useful and thought we should highlight these statements more.
- 2) No problem with these questions but he did like having the confidentiality assurance statements.
- 3) No problem answering the question. He said that because he has done a survey for HSC before he feel comfortable that it is confidential but he did say he was a bit surprised that a confidential survey was asking for this information.
- 4) No problem answering the questions.

PCP

- 1) No problem answering these questions but he did wonder why we needed name and street for the practice. He thought we should just ask for city, state, and zip.
- 2) No problem answering the questions.

HMO

Specialist

No problem answering these questions. Didn't see why others would be bothered by them either.

Staff model HMO

He would not provide this information in a survey.

Specialist/PCP

No problem answering these questions.

Hospital

PCP

No problem answering these questions.

Specialist

- 1) No problem answering these questions.
- 2) No problem answering these questions.
- 3) No problem answering these questions.

PCP/Specialist

No problem answering these questions.

Group

PCP

- 1) No problem answering these questions.
- 2) No problem answering these questions
- 3) Would not answer questions – felt uncomfortable. Didn't understand why we wanted the information. Did read the reassurances but still wondered by we wanted it. She would have felt much better if we had only asked for practice name and city, state, zip. She was uncomfortable with street address. Didn't want to give hospital either.
- 4) No problem answering these questions.
- 5) No problem answering these questions.

6) No problem answering these questions.

Specialist

No problem answering these questions

Medical School Specialist

No problem answering these questions.

Community Health Center

No problem answering these questions but did read the confidentiality.

Other – ER Group

No problem answering these questions.

4. SUGGESTIONS

Question 19

- None

Question 20

- None

MEMORANDUM

TO: Mai Pham, Jim Reschovsky, Richard Strouse
FROM: Carolyn Miller
RE: Additional Cognitive Testing for CTS Round Five Physician Survey
DATE: April 26, 2007

I've completed six interviews with physicians from the first round of cognitive interviewing to test questions 25 and 54. The interview also included question 50a as a screen for Q54 and Q53 to provide context for Q54. Respondents were told they did not need to answer Q53. (The protocol I used is attached)

The respondents to this test included 3 physicians in group practice with 3 or more physicians, one physician from a hospital, one physician from a staff model HMO, and one physician from a community health center.

Among the six interviews, four respondents answered both test questions and two respondents (staff HMO, hospital physician) answered only Q25 because they screened out of Q54 at Q50a.

QUESTION 25

Five respondents answered question 25 with no difficulty. One respondent was unsure of the answer but didn't really have trouble with the question. Four respondents answered 'yes', one respondent answered 'No', and one respondent did not know the answer to this question. When I asked the follow-up questions, there were a few comments but none of the respondents changed their answer or described having any real difficulty answering the question. Five of the six respondents were familiar with the term 'intensivists' and said that the definition provided in the question matched their understanding of this term. One respondent (CHC) said she was only vaguely familiar with the term.

Comments that came up during follow-up questions:

- One respondent wondered if there is a separate board certification in critical care. His experience is that intensivists are pulmonologists and wondered if there is a separate board certification. He suggested that the question specify the type of board certification.
- One respondent wondered about the phrase 'always staffed'. He was not sure if the question meant 24 hours a day physically in the ICU or covering the ICU. In his hospital, there are 3 intensivists and one is always 'covering' the ICU but may not always be there physically.
- One respondent asked if the question 'really means *always* staffed'. He indicated that his hospital had some 'staffing issues' when an intensivist quit.
- One respondent said that the ICU at her hospital is staffed mostly by cardiologists but she wasn't sure. She then went on to say that she didn't really admit patients to the hospital. If she had been looking at the question she would have checked the box that said "I did not admit patients to the hospital in the last year".

QUESTION 54

Four respondents answered this question and had no problem with it. One respondent answered 1 to 10%, two respondents answered 76-100% and one answered 51% to 75%.

Two of the respondents had a bit of difficulty with Q50 but I think that was a context problem more than anything else. I had to read the question a couple of times but I think that in the context of the compensation section of the questionnaire with other items in Q50, it would be clear to respondents.

Once the respondents understood Q50a and heard question 53, they had no problem with Q54. One respondent answered 50% to 75% so I had to re-read the categories. If he had been looking at the categories he would not have had a problem.

One respondent said she wasn't completely sure if the answer was 1 to 10% or 11 to 25% but she could figure it out.

None of the respondents expressed any reluctance to answer the question.

*Questions for Second Round of Cognitive Testing of Physician CTS Survey
April 2007*

INTRODUCTION:

Hello Doctor ___, this is Carolyn Miller and I'm calling from the Center for Studying Health System Change. As you may recall, I did an interview with you this past FEB to test some questions for the next round of the Community Tracking Study's Physician Survey. We really appreciate your help with that and I hope that you received your check for \$100 as a thank you for participating.

I'm calling now because we've added two new questions to the survey. I was wondering if I could just read them to you over the phone and get your opinion about them. It should only take about 5 minutes. Would you be willing to give us your opinion about these new questions?

The first test question is....

25. *Intensivists are physicians who are board certified to care for critically ill patients in settings such as medical intensive care units. Does the hospital where you admit the greatest number of your patients have intensive care units that are always staffed with intensivists?*

IF YOU DID NOT ADMIT ANY PATIENTS TO A HOSPITAL IN THE LAST YEAR OR YOU ARE A PRACTICING INTENSIVIST, CHECK THE APPROPRIATE BOX FOR THAT RESPONSE.

1 Yes

o No

I did not admit patients to hospital in the last year

I am a practicing intensivist

Is there anything about this question that you find confusing or difficult to answer?

Have you heard the term 'intensivists' before?

Does the definition we provided in the question make sense to you?

The last test question is about factors that contribute to your net income. I have to read two questions to you first so you will understand the context in which the test question is asked.

50. Medical practices may take various factors into account in determining the compensation (salary, bonus, pay rate, etc.) paid to physicians in the practice. Please TELL ME IF FACTORS THAT REFLECT YOUR OWN PRODUCTIVITY ARE explicitly considered by the practice in determining your compensation.

- | | |
|---|-----|
| 1 | YES |
| 2 | NO |

This next question is about your own net income but you don't need to answer it. I just want to read it for you to provide some context and explanation for the last test question. You don't have to answer it.

53. During 2006, what was your own net income from the practice of medicine, after expenses but before taxes? *Please include earnings (salaries, fees, bonuses, retainers, etc.) from all practices, not just your main practice, as well as contributions to retirement plans made for you by your practice(s). Exclude investment income, defined as income from investments in medically related enterprises independent of your medical practice(s), such as medical labs or imaging centers.*

- 1 Less than \$100,000
- 2 \$100,001 to \$150,000
- 3 \$150,001 to \$200,000
- 4 \$200,001 to \$250,000
- 5 \$250,001 to \$300,000
- 6 More than \$300,000

This is the last test question.

54. What percent of your own net income from the practice of medicine is based on factors that reflect your own productivity?

- 1 None
- 2 1 to 10 percent
- 3 11 to 25 percent
- 4 26 to 50 percent
- 5 51 to 75 percent
- 6 76 to 100 percent

How easy or difficult is it for you to answer this question with the intervals I provided?

Any reluctance on the respondent's part?

Any other comments about this question?

APPENDIX B

2008 HSC HEALTH TRACKING PHYSICIAN SURVEY IRB APPROVAL, FINAL SURVEY INSTRUMENT, COVER LETTERS, FACT SHEETS, AND AHRQ LETTERS OF SUPPORT

FINAL

March 2007

Note: The following documents refer to the survey as the Community Tracking Study Physician Survey rather than the HSC Health Tracking Physician Survey. Decisions regarding the name change were made after these materials were published and used.

Attachment A

IRB Approval Dated November 1, 2007



MEMORANDUM

TO: Caroline McLeod
Project Director, Westat

November 1, 2007

FROM: Thomas W. McKenna
Chairman, Institutional Review Board

SUBJECT: IRB Review and Approval
Community Tracking Survey, Survey of Physicians
Contract 6008-07-09
Project 8455
FWA 5551

A handwritten signature in black ink that reads "Thomas W. McKenna".

As Chairman of the Westat IRB, I have reviewed the questionnaire submitted for the following: **Community Tracking Survey, Survey of Physicians**, Contract 6008-07-09, Project 8455. Westat's IRB reviews all studies involving human subjects research. This study is funded by Robert Wood Johnson Foundation and Westat's client is HSC a private organization which has contracted to Westat and other organizations to help with various parts of this research.

This review pertains only to the request for approval of the physician survey work performed by Westat. That is collection of the physician survey data by CATI interview and hard copy mail survey. Westat is not responsible for the data processing or analysis of physician survey data.

The regulations permit expedited review of certain activities involving minimal risk 45 CFR 46, part 110(b) (1). We understand this survey data collection will be carried out in accordance with established Westat confidentiality and data security procedures. I am therefore approving the data collection for this survey

You are required to submit the survey for an annual review on or before October 30, 2008. In the interim you are responsible for notifying the Office of Research Administration as soon as possible if there are any injuries to subjects, problems with the study, or changes in the study that relates to risk for human subjects.

cc: Institutional Review Board
Jeanne Rosenthal

Attachment B

IRB Approval Dated November 27, 2007



MEMORANDUM

TO: Caroline McLeod
Project Director

FROM: Thomas W. McKenna
Chairman, Institutional Review Board

SUBJECT: IRB Review and Approval to Proceed with Activities
Community Tracking Survey
Contract 6008-07-09
Project 8455
FWA


Thomas W. McKenna

November 27, 2007

On November 1, 2007, Westat's IRB issued an approval letter for the work performed by Westat. At that time it was understood that analysis of data and release of the database to a public use website would be done by Westat's client, Centers for Studying Health Systems Change (HSC).

HSC has asked Westat's IRB to serve as the IRB for their work also. That work includes using the data from the surveys to prepare reports that will be published in nationally recognized journals and they will prepare public use files of the data. Two versions of the data sets will be available: public use and restricted use versions. The public use and restricted use files both exclude respondent identifiers, but the files differ in the amount of information they contain, as well as the ease with which they can be obtained and used. The public use version in previous rounds contained no geographic identifiers and had greater variable masking and suppression, but is easily accessible in that they can be downloaded directly from the Inter-university Consortium for Political and Social Research (ICPSR) Web site. The purpose of excluding information from the public use files is to protect the confidentiality of survey participants, since individuals with an unusual configuration of responses on multiple variables might otherwise be identified. The restricted use version contains more information, including county in which the practice is located, but in order to obtain and use the restricted use files, researchers must apply or access to the data and agree to the strict terms and conditions contained in the data use agreement. The restricted use file is not available to private or corporate entities that are not legitimate noncommercial researchers.

The Westat IRB agrees to serve as the IRB for HSC with regard to this project. We have noted HSC's indication that a complete checklist on Disclosure Potential of Proposed Data Releases will be used as a tool to assist the projects designated Disclosure Review Board for review of individual disclosure-limited data products. The Westat IRB asks that HSC forward a completed copy of the "checklist" to the Westat IRB before release of the database outside HSC. Westat's IRB also asks that HSC indicate the name(s) of individuals serving as the HSC Disclosure Review Board for this project. While it is understood that Westat's IRB is not the project Disclosure Review Board, we want to expressly note that we have the right to review compliance with the completed checklist and/or for HSC Disclosure Review Board's approval of the disclosure protection reflecting the completed checklist. We further note that HSC agrees that by submitting the database to ICPSR, HSC will comply with all the human subjects standards of that institution.

I am approving the HSC work on this study under the conditions given above. You are required to submit the study for an annual review on or before November 27, 2008. In the interim, you are responsible for notifying the Office of Research Administration as soon as possible if there are any injuries to the subjects, problems with the study, or changes to the study design that relate to human subjects.

cc: Institutional Review Board
 Miriam Aiken
 Jeanne Rosenthal

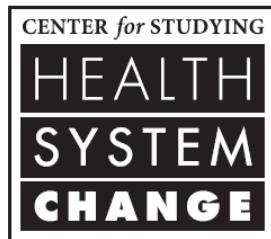
Attachment C

Survey Instrument

COMMUNITY TRACKING STUDY

SURVEY OF PHYSICIANS

CONDUCTED BY



Robert Wood Johnson Foundation

About this survey

The Community Tracking Study (CTS) Survey of Physicians is sponsored by The Robert Wood Johnson Foundation (RWJF). The Center for Studying Health System Change (HSC), an independent, nonpartisan research organization, is conducting the study on behalf of RWJF.

This survey asks about your practice and your views about the challenges facing physicians today. The questionnaire takes about 20 to 30 minutes to complete. Information you provide will contribute to analyses on topics of importance to physicians and policy makers. The enclosed fact sheet includes a sample of articles published from previous rounds of this survey, on topics such as whether physicians are accepting Medicare patients, whether pay-for-performance programs could work, and the consequences of physicians' career dissatisfaction.

Your participation is voluntary and greatly appreciated. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

Your identifying information will remain confidential and will not be redistributed. Your answers will be aggregated with those of thousands of other physicians and only used for statistical analyses. Access to all data is tightly restricted. Survey data are made available to researchers only under strict data confidentiality procedures consistent with Federal guidelines. Researchers may request data through the Inter-university Consortium for Political and Social Research, which maintains an archive of survey data for research and instruction. Some HSC analyses may involve linking your survey data to your practice's claims data (such as Medicare claims or other insurer claims) obtained in accordance with the Health Insurance Portability and Accountability Act of 1996 and other strict Federal privacy regulations. In accordance with procedures established during prior rounds of the CTS Physician's Survey, you, your practice, and your patients will NEVER be identifiable from publicly released reports or analyses.

If you have any questions about the study, the lost postage-paid return envelope or the honoraria, please direct your call to the Westat survey staff toll free at 1-888-219-8861.

*Please return your completed questionnaire in the enclosed postage-paid envelope.
If another envelope is used, please send to:*

Center for Studying Health System Change
c/o WESTAT
1650 Research Boulevard
Room RB3280
Rockville, MD 20850-3195



INSTRUCTIONS

Your answers are important to us. Following the instructions below will allow your answers to be correctly recorded

- Please put an “X” to mark your answer like this .
Fill in only one answer unless the instructions are to “Mark all that apply.”
- Use a blue or black ball-point pen. Please do not use a pencil, your answers will not be recorded.
- If you make a mistake and fill in the wrong box, please draw a line through the incorrect choice, like this . Then, fill in the correct box.
- If you write an incorrect answer, please draw a line through the incorrect answer and write the correct answer next to it.
- When filling in numbers, print each number clearly. Please avoid touching the sides of the boxes; fill in the boxes like this:

| | | |
|---|---|---|
| 3 | 5 | 9 |
| % | | |

SURVEY ELIGIBILITY

A. Are you currently a resident or fellow?

1 Yes → Do not continue. Please return the questionnaire in the enclosed envelope and we will remove your name from our list.

0 No → **GO TO B**

B. 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?

1 Yes → Do not continue. Please return the questionnaire in the enclosed envelope and we will remove your name from our list.

0 No → **GO TO C**

C. Do you currently provide direct patient care for at least 20 hours a week? Include all practices if you work in more than one practice.

Direct patient care includes seeing patients, performing surgery, and time spent on patient record-keeping, patient-related office work and travel time connected with seeing patients. It does not include 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 → **GO TO Q1**

0 No → Do not continue. Please return the questionnaire in the enclosed envelope and we will remove your name from our list.



SATISFACTION WITH MEDICINE

- 1.** Thinking very generally about your satisfaction with your overall career in medicine, would you say that you are currently . . .

- 0 1 Very satisfied
0 1 Somewhat satisfied
0 1 Neither satisfied nor dissatisfied
0 1 Somewhat dissatisfied
0 1 Very dissatisfied

PRACTICE CHARACTERISTICS

- 2.** In what year did you begin medical practice after completing your undergraduate and graduate medical training?

A residency or fellowship is considered graduate medical training.

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

 Year

- 3.** We define your primary specialty as the one in which you spend the most hours.

What is your primary specialty?

MARK (X) ONE ANSWER

- | | |
|--|--|
| 0 <input type="checkbox"/> 1 Cardiovascular Diseases | 0 <input type="checkbox"/> 1 Obstetrics and gynecology |
| 0 <input type="checkbox"/> 1 Dermatology | 0 <input type="checkbox"/> 1 Oncology |
| 0 <input type="checkbox"/> 1 Emergency Medicine | 0 <input type="checkbox"/> 1 Ophthalmology |
| 0 <input type="checkbox"/> 1 Family Practice | 0 <input type="checkbox"/> 1 Orthopedic Surgery |
| 0 <input type="checkbox"/> 1 General Practice | 0 <input type="checkbox"/> 1 Otolaryngology |
| 0 <input type="checkbox"/> 1 General Pediatrics | 0 <input type="checkbox"/> 1 Psychiatry |
| 0 <input type="checkbox"/> 1 Gastroenterology | 0 <input type="checkbox"/> 1 Pulmonology |
| 0 <input type="checkbox"/> 1 General Surgery | 0 <input type="checkbox"/> 1 Urology |
| 0 <input type="checkbox"/> 1 General Internal Medicine | 0 <input type="checkbox"/> 1 Other Specialty |
| 0 <input type="checkbox"/> 1 Neurology | (Please describe your specialty below) |

| |
|--|
| |
|--|

- 4.** Are you board-certified in your primary specialty?

- 1 Yes
0 No

- 5.** Please check the box that best describes where you work. If you work in more than one practice, check the one where you work the most hours.

MARK (X) ONE ANSWER

1 A solo practice → **GO TO Q6**

1 A two physician practice → **GO TO Q6**

1 A group practice with three or more physicians → **GO TO Q6**

1 A group or staff model HMO → **GO TO Q6**

1 A community health center → **GO TO Q6**

1 A *hospital* run by state, county, or city government → **GO TO Q5a**

1 A *hospital* run by a private for-profit or non-profit organization → **GO TO Q5a**

1 A *medical school* or *university* (private or government) → **GO TO Q5a**

1 Some other setting (Please describe)

- 5a.** If you work in a hospital, medical school, or university, in which of the following settings do you spend most of your time seeing patients?

1 Office practice owned by the hospital, medical school, or university

1 On hospital staff

1 In the emergency room

1 In a hospital or medical school clinic

1 Somewhere else (Describe)

- 6.** This question is about your main practice, that is, the business or organization that compensates you. In your main practice, are you a full owner, a part owner (e.g., with one or more other physicians), an employee with no ownership, or an independent contractor?

1 Full owner → **GO TO Q7**

1 Part owner → **GO TO Q6A**

1 Employee (Not an owner) → **GO TO Q6a**

1 Independent contractor → **GO TO Q8**



6a. If you are a part owner or employee, do any of the following have an ownership interest in your main practice? Check all that apply:

- 1 Other physician(s) in the practice
- 1 Another physician practice
- 1 A hospital or hospital group
- 1 Insurance company, health plan or HMO
- 1 Medical school or university
- 1 Other (specify)

7. Including yourself, how many physicians are in your main practice?

PLEASE INCLUDE ALL LOCATIONS OF THE PRACTICE.

- 1 100 or fewer physicians → How many?
- 2 More than 100 physicians

8. On balance, do the overall personal financial incentives in your practice favor reducing services to individual patients, favor expanding services to individual patients, or favor neither?

MARK (X) ONE ANSWER

- Reducing services to individual patients
- Expanding services to individual patients
- Favor neither

9. Thinking about your practice specifically, how would you describe the competitive situation your practice faces?

By competition among physicians, we mean the pressure to undertake activities to attract and retain patients.

MARK (X) ONE ANSWER

- Very competitive
- Somewhat competitive
- Not at all competitive

HOURS WORKED AND PATIENT VISITS

10. Approximately how many weeks did you practice medicine in 2006?

Exclude time missed due to vacation, illness, family leave, military service, professional conferences, and other absences.

| | |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|

Weeks practicing medicine in 2006

11. During your LAST COMPLETE WEEK OF WORK, approximately how many hours did you spend in all medically-related activities?

Please record all time spent in direct patient care in (a) and in other medically-related activities (e.g., administrative tasks and professional activities) in (b). Record the sum of (a) and (b) in total hours (c).

Direct patient care includes seeing patients, performing surgery, and time spent on patient record-keeping, patient-related office work and travel time.

Your best estimate is fine.

- a.

| | |
|--|--|
| | |
|--|--|

 Hours in direct patient care
- b.

| | |
|--|--|
| | |
|--|--|

 Hours in administrative tasks and professional activities
- c.

| | |
|--|--|
| | |
|--|--|

 Total hours in medically-related activities

12. During 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.

Your best estimate is fine.

- | | |
|--|--|
| | |
|--|--|

 Visits in the office and out-patient clinics
- | | |
|--|--|
| | |
|--|--|

 Visits on hospital rounds
- | | |
|--|--|
| | |
|--|--|

 Visits in nursing homes and patients' homes

13. During a TYPICAL WORK DAY, how much time do you spend on each of the following activities?

MARK (X) ONE ANSWER FOR EACH ITEM

| | None | Less than a half hour | 1/2 to 1 hour | 1-2 hours | More than 2 hours |
|---|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|
| a. E-mail communications with patients and their families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Telephone conversations with patients and their families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. E-mail communications with physicians and other clinicians | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Telephone conversations with physicians and other clinicians | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

0 1 2 3 4



14. Is your practice reimbursed by any health insurance plans for these activities?

MARK (X) ONE ANSWER FOR EACH ITEM

| | Reimbursed 1 | Not Reimbursed 2 | Unsure if Reimbursed 3 |
|---|--------------------------|---------------------------------|---------------------------------------|
| a. E-mail communications with patients and their families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Telephone conversations with patients and their families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. E-mail communications with physicians and other clinicians | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Telephone conversations with physicians and other clinicians | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

15. During the LAST MONTH, how many hours, if any, did you spend providing charity care?

By charity care, we mean that you charged either no fee or a reduced fee because of the financial need of the patient.

Charity care does not include time spent providing services for which you expected, but did not receive payment, bad debts, time spent providing services under a discounted fee for service contract, or seeing Medicare or Medicaid patients.

Your best estimate is fine.

| | |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|

Hours spent providing charity care

None → **IF NONE, GO TO Q16**

15a. Where do you typically provide charity care?

MARK (X) ONE ANSWER

1 In your main practice

1 On-call or at a hospital emergency department

1 In another practice or clinic

1 Somewhere else

| |
|--|
| |
|--|

PATIENT CHARACTERISTICS

16. About what percentage of your patients belong to the following groups?

Your best estimate is fine. If you treat few or no patients in a group, check the box instead of recording a percentage.

Record Percentage

- | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|
| a. African-American or Black | <table border="1" data-bbox="698 483 845 544"><tr><td></td><td></td><td></td></tr></table> | | | | % | <input type="checkbox"/> 1 Few or None |
| | | | | | | |
| b. Hispanic or Latino | <table border="1" data-bbox="698 544 845 606"><tr><td></td><td></td><td></td></tr></table> | | | | % | <input type="checkbox"/> 1 Few or None |
| | | | | | | |
| c. Asian or Pacific Islander | <table border="1" data-bbox="698 606 845 667"><tr><td></td><td></td><td></td></tr></table> | | | | % | <input type="checkbox"/> 1 Few or None |
| | | | | | | |
| d. Native American or Alaska Native | <table border="1" data-bbox="698 667 845 728"><tr><td></td><td></td><td></td></tr></table> | | | | % | <input type="checkbox"/> 1 Few or None |
| | | | | | | |
| e. Has a chronic medical condition | <table border="1" data-bbox="698 728 845 760"><tr><td></td><td></td><td></td></tr></table> | | | | % | <input type="checkbox"/> 1 Few or None |
| | | | | | | |

17. About what percentage of your patients do you have a hard time speaking with or understanding because you speak different languages?

Your best estimate is fine.

Record Percentage

| | | |
|--|--|--|
| | | |
|--|--|--|

 %

18. Does your practice provide interpreter services for any non-English languages?

MARK (X) ONE ANSWER

1 Yes → **ANSWER Q18a**

0 No → **SKIP TO Q19**

2 Do not have non-English speaking patients → **SKIP TO Q19**

18a. For which languages does your practice provide interpreter services?

MARK (X) ALL THAT APPLY

0 1 Spanish

0 1 Portuguese

0 1 Chinese

0 1 Other

| |
|--|
| |
|--|

0 1 Other

| |
|--|
| |
|--|

19. Have you ever attended any professional meetings, workshops, or Continuing Medical Education activities that discuss improving the health of minority patients (such as cultural competence training)?

1 Yes 0 No



INFORMATION TECHNOLOGY IN MEDICINE

- 20.** 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. For each of the following activities, please check whether or not computers or other forms of information technology are used in YOUR PRACTICE.

For each activity where information technology is used, indicate whether YOU PERSONALLY use the technology routinely, occasionally, or not at all.

| | Is Information Technology Available in YOUR PRACTICE for Activity? | | IF YES, How often do YOU PERSONALLY use the technology? | | |
|--|--|----------------------------|---|--------------------------|--------------------------|
| | NO 0 | YES 1 | Routinely 1 | Occasionally 2 | Not at all 3 |
| ACTIVITY: | | | | | |
| CLINICAL PRACTICE: | | | | | |
| a. Obtain information about treatment alternatives or recommended guidelines | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Obtain up-to-date decision support for diagnostic and treatment recommendations based on data about your patients and practice guidelines | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Generate reminders for clinicians about preventive services | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Generate reminders for clinicians about other needed patient follow-up | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Generate reminders to patients about preventive services | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Communicate about clinical issues with patients by e-mail | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PATIENT INFORMATION: | | | | | |
| a. Access patient notes, medication lists, or problem lists | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Order laboratory, radiology, or other diagnostic tests | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. View results of laboratory, radiology, or other diagnostic tests | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Exchange clinical data and images with other physicians | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Exchange clinical data and images with hospitals and laboratories | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Access information on patients' preferred language | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PRESCRIPTION DRUGS: | | | | | |
| a. Obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Obtain information on formularies | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Write prescriptions | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Transmit prescriptions to pharmacy | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



- 21.** An electronic medical record (EMR) is a computer-based patient medical record. Does your main practice use electronic medical records?

MARK (X) ONE ANSWER

- 1 Yes, all electronic
2 Yes, part electronic and part paper
0 No, all paper
8 Don't know

- 22.** Does your main practice receive any financial incentives from health plans and other organizations that are tied to the types of information technology systems (e.g., electronic health records or electronic prescribing systems) it adopts?

MARK (X) ONE ANSWER

- 1 Yes
0 No
8 Don't know

HOSPITAL CARE

- 23.** Medical errors include events such as dispensing incorrect medication doses, surgical mistakes, or errors 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?

MARK (X) ONE ANSWER

- 1 Yes
0 No
3 I do not admit patients
8 Don't know

- 24.** 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?

IF YOU DID NOT ADMIT ANY PATIENTS TO A HOSPITAL IN THE LAST YEAR OR YOU ARE A PRACTICING HOSPITALIST, CHECK THE APPROPRIATE BOX FOR THAT RESPONSE.

Record Percentage

| | | |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|

%

- 1 I did not admit patients to a hospital in the last year
1 I am a practicing hospitalist



25. **Intensivists are physicians who are board certified to care for critically ill patients in settings such as medical intensive care units. Does the hospital where you admit the greatest number of your patients have intensive care units that are always covered by intensivists?**

IF YOU DID NOT ADMIT ANY PATIENTS TO A HOSPITAL IN THE LAST YEAR OR YOU ARE A PRACTICING INTENSIVIST, CHECK THE APPROPRIATE BOX FOR THAT RESPONSE.

- 1 Yes
0 No
2 I did not admit patients to a hospital in the last year
3 I am a practicing intensivist

QUALITY AND COORDINATION OF PATIENT CARE

26. **How large an effect does your use of formal, written practice guidelines, such as those generated by physician organizations, insurance companies, HMOs, or government agencies, have on your practice of medicine?**

If you are unaware of formal, written guidelines that apply to your practice, check the last box.

MARK (X) ONE ANSWER

- 01 Very large
02 Large
08 Moderate
04 Small
05 Very small
06 No effect
07 Unaware of guidelines that apply

27. **Please indicate your level of agreement or disagreement with the following statements.**

MARK (X) ONE ANSWER FOR EACH ITEM

| | Agree Strongly 1 | Agree Somewhat 2 | Disagree Somewhat 3 | Disagree Strongly 4 | Neither Agree nor Disagree 5 |
|--|-----------------------------|-----------------------------|--------------------------------|--------------------------------|---|
| a. I have adequate time to spend with my patients during their office visits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. It is possible to provide high quality care to all of my patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

28. Please indicate whether or not you receive the following types of reports for your own patients or for the practice as a whole. These reports could be generated by your main practice or by other organizations, such as insurance companies or hospitals.

MARK (X) ONE ANSWER FOR OWN PATIENTS AND MARK (X) ONE ANSWER FOR THE ENTIRE PRACTICE

| TYPE OF REPORT | OWN PATIENTS | | ENTIRE PRACTICE | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes 1 | No 0 | Yes 1 | No 0 |
| a. Quality of preventive care delivered to eligible patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Quality of care delivered to patients with specific chronic conditions (such as asthma, diabetes, depression, or congestive heart failure) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Demographic information on patients' race, ethnicity, or preferred language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Quality of care delivered to patients of different races or ethnic backgrounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Patient lists or registries (e.g., lists of patients with specific clinical conditions, medications, or laboratory results) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

29. Do you personally participate in quality reporting programs sponsored by organizations outside of your practice (e.g., Bridges to Excellence, or the Centers for Medicare & Medicaid Services)?

1 Yes

0 No

30. Do physicians in your main practice routinely treat patients with the following chronic conditions?

MARK (X) ONE ANSWER FOR EACH ITEM

| CHRONIC CONDITION | Yes 1 | No 0 |
|-----------------------------|--------------------------|--------------------------|
| a. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU ANSWERED "YES" TO ONE OR MORE CHRONIC CONDITIONS (Q30a-d), GO TO Q31

IF YOU ANSWERED "NO" TO ALL FOUR CHRONIC CONDITIONS (Q30a-d), SKIP TO Q32



- 31.** Does your main practice provide the following services to patients with asthma, diabetes, depression, or congestive heart failure?

MARK (X) FOR EACH SERVICE PROVIDED FOR PATIENTS WITH THE CONDITIONS ROUTINELY TREATED BY YOUR MAIN PRACTICE

| TYPES OF PATIENT SERVICES | Asthma | Diabetes | Depression | Congestive Heart Failure |
|--|------------------------------|------------------------------|------------------------------|---------------------------------|
| a. Written materials that explain guidelines for recommended care in English | 0 <input type="checkbox"/> 1 |
| b. Written materials that explain guidelines for recommended care in languages other than English | 0 <input type="checkbox"/> 1 |
| c. Nurse care managers to monitor and coordinate the care of patients with that condition | 0 <input type="checkbox"/> 1 |
| d. Non-physician staff to educate patients in managing that condition | 0 <input type="checkbox"/> 1 |
| e. Group visits in which patients with that condition meet with staff who provide routine medical care or address educational or personal concerns | 0 <input type="checkbox"/> 1 |

- 32.** Disease management programs are intended to reduce costs and improve quality of life for patients with chronic diseases by integrating delivery of care and involving the patient in self-care. Are any of your patients in disease management programs sponsored by health plans or employers?

1 Yes → **GO TO Q32a**

0 No → **SKIP TO Q33**

- 32a.** Please indicate your level of agreement or disagreement with the following statements about disease management programs sponsored by *health plans or employers*.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Agree Strongly 1 | Agree Somewhat 2 | Neither Agree nor Disagree 3 | Disagree Somewhat 4 | Disagree Strongly 5 |
|---|-----------------------------|-----------------------------|---|--------------------------------|--------------------------------|
| 1. Disease management programs improve the overall quality of care for my patients with chronic conditions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Disease management programs improve my ability to provide high quality care to my patients with chronic conditions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

33. This question concerns your experiences coordinating patient care with other physicians.

- If you are a primary care physician (general and family practitioners, and internists and pediatricians who provide general care), answer items (a-d).
- If you are a specialist, answer items (a) and (e-g).
- If you provide both primary care and specialist care, answer all items.
- Check “not applicable” if you rarely or never coordinate patient care.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Always or Most of the Time 1 | Sometimes 2 | Seldom or Never 3 | Not Applicable 4 |
|---|---|--------------------------|------------------------------|-----------------------------|
| ALL PHYSICIANS | | | | |
| a. How often do you know about all the visits that your patients make to other physicians? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PRIMARY CARE PHYSICIANS ONLY | | | | |
| b. When you refer a patient to a specialist, how often do you send the specialist notification of the patient's history and reason for the consultation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. How often do you receive useful information about your referred patients from specialists? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. After your patient has seen a specialist, how often do you talk with the patient or family members about the results of the visit(s) with the specialist? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SPECIALISTS ONLY | | | | |
| e. When you see a patient referred to you by a primary care physician (PCP), how often do you receive notification about the patient's medical history and reason for consultation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. For the patients that were referred to you by a PCP, how often do you send the PCP notification of the results of your consultation and advice to the patient? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How often are new patients you see self-referred? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

34. During the last 12 months, were you *unable* to obtain the following services for your patients when you thought they were medically necessary?

If the service does not apply to your practice, please check “Not Applicable.”

MARK (X) ONE ANSWER FOR EACH ITEM

| SERVICE | Yes 1 | No 0 | Not Applicable 2 |
|--|--------------------------|--------------------------|-----------------------------|
| a. Referrals to high quality specialists | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Non-emergency hospital admissions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. High quality outpatient mental health services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Interpreter services for non-English speaking patients when they received care in your practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



35. What percentage of your patients have prescription coverage that includes the use of a formulary?

Your best estimate is fine.

Record Percentage

| | | |
|--|--|--|
| | | |
|--|--|--|

%

None

36. Please indicate how often you consider *insured* patients' out-of-pocket costs in making the following decisions.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Always 1 | Usually 2 | Sometimes 3 | Rarely 4 | Never 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. If a generic option is available, how often do you prescribe a generic over a brand name drug? | <input type="checkbox"/> |
| b. If there is uncertainty about diagnosis, how often do you consider an insured patient's out-of-pocket costs in deciding the types of tests to recommend? | <input type="checkbox"/> |
| c. If there is a choice between outpatient and inpatient care, how often do you consider an insured patient's out-of-pocket costs? | <input type="checkbox"/> |

37. The table below lists problems that may limit physicians' ability to provide high quality care. For each one, indicate whether you think it is a major problem, minor problem, or not a problem affecting your ability to provide high quality care.

MARK (X) ONE ANSWER FOR EACH ITEM

| PROBLEMS THAT MAY LIMIT A PHYSICIAN'S ABILITY TO PROVIDE HIGH QUALITY CARE: | Major Problem 1 | Minor Problem 2 | Not a Problem 3 |
|---|----------------------------|----------------------------|----------------------------|
| a. Inadequate time with patients during office visits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Patients' inability to pay for needed care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Rejections of care decisions by insurance companies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Lack of qualified specialists in your area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Not getting timely reports from other physicians and facilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulties communicating with patients due to language or cultural barriers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Patient non-compliance with treatment recommendations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Medical errors in hospitals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any other problems that you feel limit your ability to provide high quality care (Describe below for up to three problems) | | | |
| 1. <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PRACTICE ACCEPTANCE OF NEW PATIENTS

38. Is your practice accepting all, most, some, or no new patients who are insured through MEDICARE, including Medicare managed care patients?

MARK (X) ONE ANSWER

- 1 All new Medicare and Medicare Managed Care patients → **GO TO Q39**
- 2 Most new Medicare and Medicare Managed Care patients → **GO TO Q39**
- 3 Some new Medicare and Medicare Managed Care patients → **ANSWER Q38a**
- 4 No new Medicare and Medicare Managed Care patients → **ANSWER Q38a**

38a. If your practice accepts **some or no** new MEDICARE patients, please indicate the importance of each of the following reasons for your practice's decision.

| REASONS WHY PRACTICE ACCEPTS SOME OR NO NEW MEDICARE PATIENTS: | Very Important 1 | Moderately Important 2 | Not Very Important 3 | Not at all Important 4 |
|--|--------------------------|---------------------------|--------------------------|---------------------------|
| 1. Billing requirements, including paperwork, and filing of claims | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Concern about a Medicare audit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Inadequate reimbursement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Practice already has enough patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Medicare patients have high clinical burden | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

39. Is your practice accepting all, most, some, or no new patients who are insured through MEDICAID, including Medicaid managed care patients?

Include patients insured through state *Medicaid* programs that have adopted program names unique to your state.

MARK (X) ONE ANSWER

- 1 All new Medicaid and Medicaid Managed Care patients → **GO TO Q40**
- 2 Most new Medicaid and Medicaid Managed Care patients → **GO TO Q40**
- 3 Some new Medicaid and Medicaid Managed Care patients → **ANSWER Q39a**
- 4 No new Medicaid and Medicaid Managed Care patients → **ANSWER Q39a**



39a. If your practice accepts some or no new MEDICAID patients, please indicate the importance of each of the following reasons for your practice's decision.

| REASONS WHY PRACTICE ACCEPTS SOME OR NO NEW MEDICAID PATIENTS: | Very Important 1 | Moderately Important 2 | Not Very Important 3 | Not at all Important 4 |
|--|--------------------------|---------------------------|--------------------------|---------------------------|
| 1. Billing requirements, including paperwork, and filing of claims | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Delayed reimbursement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Inadequate reimbursement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Practice already has enough patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Medicaid patients have high clinical burden | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

40. Is your practice accepting all, most, some, or no new patients through PRIVATE OR COMMERCIAL INSURANCE PLANS, including managed care plans and HMOs with which the practice has contracts?

MARK (X) ONE ANSWER

- 1 All new privately insured patients
- 2 Most new privately insured patients
- 3 Some new privately insured patients
- 4 No new privately insured patients

SOURCES OF PRACTICE REVENUE

41. Approximately what percentage of the practice revenue from patient care comes from MEDICARE (including Medicare health plans) and what percentage comes from MEDICAID (including Medicaid managed care) and other public insurance for low income people?

Your best estimate is fine.

If you work in more than one practice, answer for your main practice. If you are unsure of the percentages, your best estimate is fine.

Record Percentage of practice's patient care revenue from **MEDICARE**

| | | |
|--|--|--|
| | | |
|--|--|--|

%

Record Percentage of practice's patient care revenue from **MEDICAID** and other public insurance

| | | |
|--|--|--|
| | | |
|--|--|--|

%

- 42.** Under CAPITATION, a fixed amount is paid per patient per month regardless of the services provided. 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?

Your best estimate is fine.

Record Percentage of patient care revenue that is CAPITATED

| | | |
|--|--|--|
| | | |
|--|--|--|

%

- 43.** With how many health plans does your practice have managed care contracts?

Managed care contracts are contracts with health plans, such as HMOs, PPOs, IPAs, and Point-Of-Service plans that use financial incentives or specific controls to encourage utilization of specific providers associated with the plan.

Your best estimate is fine.

MARK (X) ONE ANSWER

- 0 None
1 1–4
2 5–9
3 10–19
4 20 or more

MEDICAL MALPRACTICE

- 44.** Considering the full range of patients that you see, indicate your level of agreement with the following statements about medical malpractice.

| | Strongly Disagree 1 | Disagree 2 | Not Sure 3 | Agree 4 | Strongly Agree 5 |
|---|--------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| 1. I am concerned that I will be involved in a malpractice case sometime in the next 10 years. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I feel pressured in my day-to-day practice by the threat of malpractice litigation. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I order some tests or consultations simply to avoid the appearance of malpractice. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sometimes I ask for consultant opinions primarily to reduce my risk of being sued. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Relying on clinical judgment rather than on technology to make a diagnosis is becoming riskier because of the threat of malpractice suits. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



MEDICAL EQUIPMENT & HOSPITAL OWNERSHIP

45. Physicians are relying on more diverse business models now than in the past.

- A. Does your main practice own (fully or in part) or lease the types of medical equipment listed below? (CHECK NO OR YES FOR EACH TYPE OF EQUIPMENT.)
- B. **FOR EACH TYPE OF MEDICAL EQUIPMENT CHECKED YES:** is the medical equipment located in your main practice, in a separate business, or in both your main practice and a separate business? By separate business, we mean a subsidiary or separate legal entity from your main practice.

| MEDICAL EQUIPMENT USED FOR: | A. OWN OR LEASE? | | B. LOCATION OF EQUIPMENT | | |
|---|--------------------------|----------------------------|--------------------------|--------------------------|--|
| | No 0 | Yes 1 | Main Practice 1 | Separate Business 2 | Both Practice and Separate Business 3 |
| a. Laboratory testing, including routine blood work | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. X-rays | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other diagnostic imaging, such as CT or MRI scans | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Non-invasive testing besides EKGs (e.g., Echocardiograms, treadmill, nuclear testing, sleep testing) | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Invasive procedures, such as endoscopy or cardiac catheterization | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

46. Excluding any medical equipment owned or leased by your main practice, do you personally own (fully or in part) or lease the following types of medical equipment?

MARK (X) ONE ANSWER FOR EACH ITEM

| MEDICAL EQUIPMENT USED FOR: | Yes 1 | No 0 | Unsure 2 |
|---|--------------------------|--------------------------|--------------------------|
| a. Laboratory testing, including routine blood work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. X-rays | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other diagnostic imaging, such as CT or MRI scans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Non-invasive testing besides EKGs (e.g., Echocardiograms, treadmill, nuclear testing, sleep testing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Invasive procedures, such as endoscopy or cardiac catheterization | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



47. Does your main practice own (fully or in part) a hospital?

MARK (X) ONE ANSWER

- 3 Main practice is a hospital or is owned by a hospital
1 Yes
0 No
2 Unsure

48. Excluding any hospitals owned by your main practice, do you personally own (fully or in part) a hospital?

MARK (X) ONE ANSWER

- 1 Yes
0 No
2 Unsure

COMPENSATION

49. Which of the following methods best describes your basic compensation?

MARK (X) ONE ANSWER

- 1 Fixed salary
2 Salary adjusted for performance (e.g., own productivity, practice's financial performance, quality measures, practice profiling)
3 Shift, hourly, or other time-based payment
4 Share of practice billings or workload
5 Other Method (Describe)

50. Are you eligible to earn income through any type of bonus or incentive plan?

Check Yes if you receive periodic adjustments, bonuses, returns on withhold, or any type of supplemental payments, either from your practice or from health plans.

MARK (X) ONE ANSWER

- 1 Yes
0 No



- 51.** Medical practices may take various factors into account in determining the compensation (salary, bonus, pay rate, etc.) paid to physicians in the practice. Please indicate whether each of the following factors is explicitly considered by the practice in determining your compensation.

IF THE FACTOR IS CONSIDERED, how important is it in determining your compensation?

| COMPENSATION FACTORS: | Is the factor explicitly considered in determining your compensation? | | IF YES, how important is the factor in determining your compensation? | | | |
|--|---|----------------------------|---|---------------------------|--------------------------|---------------------------|
| | No 0 | Yes 1 | Very important 1 | Moderately important 2 | Not very important 3 | Not at all important 4 |
| a. Factors that reflect your own productivity. | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Results of satisfaction surveys completed by your own patients. | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Specific measures of quality of care, such as rates of preventive care services for your patients. | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Results of practice profiling, i.e., comparing your pattern of using medical resources with that of other physicians. | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The overall financial performance of the practice. | <input type="checkbox"/> | <input type="checkbox"/> → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 52.** During 2006, did you personally receive any of the following from drug, device, or other medically-related companies? Include honoraria and payments from marketing and research firms working for medically-related companies.

MARK (X) ONE ANSWER FOR EACH ITEM

| | Yes 1 | No 0 |
|--|--------------------------|--------------------------|
| a. Food and/or beverages in your workplace? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Free drug samples? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Honoraria for speaking? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Honoraria for participating in surveys on prescribing practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Payment for consulting services? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Payment in excess of costs for enrolling patients in clinical trials? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Costs for travel for attending meetings? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Gifts that you received as a result of prescribing practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Complimentary tickets to cultural or sporting events? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Complimentary or subsidized admission to meetings or conferences for which CME credits are awarded? | <input type="checkbox"/> | <input type="checkbox"/> |

- 53.** Excluding any food, beverages, and drug samples you may have received in your workplace, please estimate the total value of all goods and services you received in 2006 from drug, device, or other medically-related companies? Include honoraria or payments from surveys on prescribing practices conducted by marketing or research firms for medically-related companies?

Your best estimate is fine. **MARK (X) ONE ANSWER**

- | | |
|---|--|
| 0 <input type="checkbox"/> None | 3 <input type="checkbox"/> \$1,001 to \$5,000 |
| 1 <input type="checkbox"/> \$1 to \$ 500 | 4 <input type="checkbox"/> \$5,001 to \$10,000 |
| 2 <input type="checkbox"/> \$501 to \$1,000 | 5 <input type="checkbox"/> More than \$10,000 |

- 54.** During 2006, what was your own net income from the practice of medicine, after expenses but before taxes?

Please include earnings (salaries, fees, bonuses, retainers, etc.) from all practices, not just your main practice, as well as contributions to retirement plans made for you by your practice(s). Exclude investment income, defined as income from investments in medically-related enterprises independent of your medical practice(s), such as medical labs or imaging centers.

Your best estimate is fine. **MARK (X) ONE ANSWER**

- | | |
|--|--|
| 01 <input type="checkbox"/> Less than \$100,000 | 04 <input type="checkbox"/> \$200,001 to \$250,000 |
| 02 <input type="checkbox"/> \$100,001 to \$150,000 | 05 <input type="checkbox"/> \$250,001 to \$300,000 |
| 03 <input type="checkbox"/> \$150,001 to \$200,000 | 06 <input type="checkbox"/> More than \$300,000 |

- 55.** What percent of your own net income from the practice of medicine is based on factors that reflect your own productivity?

- | | |
|---|--|
| 0 <input type="checkbox"/> None | 3 <input type="checkbox"/> 26 to 50 percent |
| 1 <input type="checkbox"/> 1 to 10 percent | 4 <input type="checkbox"/> 51 to 75 percent |
| 2 <input type="checkbox"/> 11 to 25 percent | 5 <input type="checkbox"/> 76 to 100 percent |

PERSONAL BACKGROUND

- 56.** Do you consider yourself to be of Hispanic origin, such as Mexican, Puerto Rican, Cuban, or other Spanish-speaking background? **MARK (X) ONE ANSWER**

- | | |
|--|---|
| 1 <input type="checkbox"/> Yes, Hispanic | 0 <input type="checkbox"/> No, Not Hispanic |
|--|---|

- 57.** What race do you consider yourself to be? **MARK (X) FOR ALL ANSWERS THAT APPLY**

- | | |
|--|---|
| 0 <input type="checkbox"/> 1 White | 0 <input type="checkbox"/> 1 Native American or Alaska Native |
| 0 <input type="checkbox"/> 1 Black or African-American | 0 <input type="checkbox"/> 1 Other <input style="width: 150px; height: 1.2em; border: 1px solid black;" type="text"/> |
| 0 <input type="checkbox"/> 1 Asian or Pacific Islander | |



58. Is your main medical practice located at the address to which this questionnaire was mailed?

1 Yes → **SKIP TO Q60**

0 No → **GO TO Q59**

59. What are the name and address of your main medical practice?

Your information is confidential and individuals or practices will not be identified. Your practice information will help us categorize types of physician practices and will be helpful if we select your practice for a follow-up study in future years.

Name of Practice

Street Address

City

State

Zip

60. What is the name of the hospital where you admit the largest number of patients?

This information is confidential and will be used solely for analytic purposes, for example, to define hospital referral regions. The hospital will not be contacted.

1 I do not admit patients

Thank you for taking the time to complete the survey.

Please return your questionnaire in the enclosed postage-paid envelope.

We appreciate your feedback and feel free to use this space to comment on the survey or health issues you would like to see addressed in future surveys.

Comments:

1 2 3 4 5 6 7 8 0 Bat

Attachment D

Cover Letters: First Mailing

FIRST MAILING TO EXPERIMENT ARMS 2 AND 3

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

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 Study's 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. This survey has been conducted periodically since 1996 by the Center for Studying Health System Change (HSC), an independent, non-partisan research organization, funded primarily 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. Hundreds of studies using the survey have been published, including many in top medical journals such as NEJM and JAMA. To give you a sense of the range of issues addressed by HSC, I have enclosed a fact sheet 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: www.hschange.org.

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

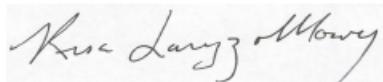
American Academy of Family Physicians
American Academy of Pediatrics
American Psychiatric Association

Please complete and return the questionnaire in the enclosed postage-paid envelope as soon as possible. It should take 20 minutes or less to complete. Although we cannot compensate you for your time, we have enclosed an honorarium of \$75 as a token of our appreciation. Your responses will be used for statistical purposes only and may be linked to claims or other administrative data. The information you provide will be kept strictly confidential and your identity will never be disclosed.

I hope we can count on your participation. If you have any questions about the study, please call Brian Quinn 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 about the health care debate.

Sincerely,



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

«PID»

FIRST MAILING TO EXPERIMENT GROUP A (part of Arm 1)

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

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 Study's 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. This survey has been conducted periodically since 1996 by the Center for Studying Health System Change (HSC), an independent, non-partisan research organization, funded primarily 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. Hundreds of studies using the survey have been published, including many in top medical journals such as NEJM and JAMA. To give you a sense of the range of issues addressed by HSC, I have enclosed a fact sheet 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: www.hschange.org.

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

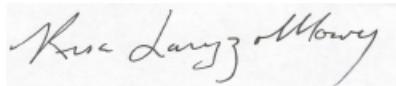
American Academy of Family Physicians
American Academy of Pediatrics
American Psychiatric Association

Please complete and return the questionnaire in the enclosed postage-paid envelope as soon as possible. It should take 20 minutes or less to complete. Although we cannot compensate you for your time, we have enclosed an honorarium of \$50 as a token of our appreciation. Your responses will be used for statistical purposes only and may be linked to claims or other administrative data. The information you provide will be kept strictly confidential and your identity will never be disclosed.

I hope we can count on your participation. If you have any questions about the study, please call Brian Quinn 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 about the health care debate.

Sincerely,



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

«PID»

FIRST MAILING TO ALL EXCEPT EXPERIMENT GROUP A AND ARMS 2 AND 3

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

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. The Community Tracking Study (CTS) Physician Survey, sponsored by The Robert Wood Johnson Foundation (RWJF), 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.

Please consider taking part in this important study. Although we cannot compensate you for your time, we have enclosed a {**\$50/\$75**} honorarium as a token of our appreciation for your help.

Previous rounds of the survey have been used in hundreds of studies of topics of importance to physicians, other providers, and policy makers. These have been published in top medical and health care policy journals.

For your information, the Agency for Health Care Research and Quality (AHRQ), the leading federal agency supporting research to improve the quality and effectiveness of health as well as the following physician organizations have reviewed the study and urge physicians to participate in the survey:

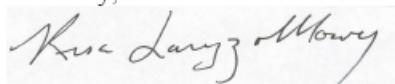
| | |
|---|---------------------------------------|
| American Academy of Family Physicians | American College of Surgeons |
| American Academy of Pediatrics | American Osteopathic Association |
| American College of Emergency Physicians | American Society of Clinical Oncology |
| American College of Obstetricians and Gynecologists | Society of Hospital Medicine |
| American College of Physicians | |

The Center for Studying Health System Change (HSC), a nonpartisan research organization, is conducting the study on behalf of RWJF. HSC has contracted with Westat to conduct the survey. Please complete and return the questionnaire in the enclosed postage-paid envelope to Westat as soon as possible.

Your participation in this study is entirely voluntary and you may refuse to answer any question in the interview. The information you provide will be kept confidential, and all data will be used in the aggregate for research purposes only. I have enclosed a fact sheet that includes a brief description of HSC, examples of studies of interest to physicians conducted using data from previous rounds of the CTS Physician Survey and more information on how the data you provide may be used.

Thank you in advance for your time and cooperation. I know you are extremely busy and appreciate your willingness to share your views on critical health care issues.

Sincerely,



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

«PID»

Attachment E

Cover Letter: Second Mailing

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

About two weeks ago, we sent you a nation-wide physician survey addressing changes in the health care system and the practice of medicine, and how these changes are affecting physicians and their patients. The survey is sponsored by The Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans.

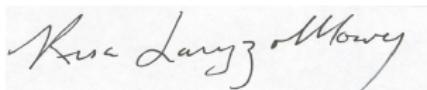
An honorarium check was enclosed in the original survey package in appreciation for your participation.

If you have already completed and returned the questionnaire, thank you for your response. If not, please return it in the enclosed postage-paid envelope as soon as possible. It should take approximately 20 to 30 minutes to complete. Your responses will be used for statistical purposes only, the information you provide will be kept confidential and your identity will never be disclosed.

If you have misplaced your questionnaire or honorarium check, or have any other questions, please call Westat at 1-888-925-5829.

I hope we can count on your participation. I know you are extremely busy and appreciate your willingness to share your views on critical health care issues. Thank you in advance for your time and cooperation. We look forward to your response.

Sincerely,



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

«PID»

Attachment F

Cover Letters: Third Mailing

THIRD MAILING TO PHYSICIANS WHO DID NOT CASH CHECK (other than Arm 1)

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

Some time ago, we sent you a questionnaire about your practice and the challenges facing physicians in today's rapidly changing health care environment. The Community Tracking Study's Physician Survey is the only ongoing research survey of physicians in the United States. Data from previous survey rounds have been a valuable research tool, reported in numerous articles in leading journals as well as in the popular press. Several of these articles are cited in the attached fact sheet.

Your input is extremely important to this study. Please fill out the enclosed questionnaire and return it to us as soon as is convenient.

We included a \$75 honorarium with the first questionnaire we sent you as a token of our appreciation. Since that check may have been misplaced, we have enclosed a replacement. Please destroy the original check if you still have it. If you have any questions, please contact the study staff at 1-888-925-5829.

Thank you again for your help with this important study.

Sincerely,



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

«PID»

THIRD MAILING TO ARM 1 PHYSICIANS WHO DID NOT CASH CHECK

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

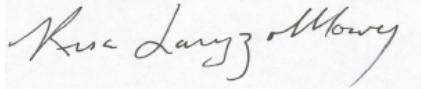
Some time ago, we sent you a questionnaire about your practice and the challenges facing physicians in today's rapidly changing health care environment. The Community Tracking Study's Physician Survey is the only ongoing research survey of physicians in the United States. Data from previous survey rounds have been a valuable research tool, reported in numerous articles in leading journals as well as in the popular press. Several of these articles are cited in the attached fact sheet.

Your input is extremely important to this study. Please fill out the enclosed questionnaire and return it to us as soon as is convenient.

We included a \$50 honorarium with the first questionnaire we sent you as a token of our appreciation. Because your participation is so important, we have enclosed a new check for \$75. Please destroy the original check if you still have it. If you have any questions, please contact the study staff at 1-888-925-5829.

Thank you again for your help with this important study.

Sincerely,



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

«PID»

THIRD MAILING TO PHYSICIANS WHO CASHED CHECK BUT DID NOT RETURN A SURVEY

November 20, 2008

«Name»
«CompanyName»
«AddressLine1»
«AddressLine2»
«City», «State» «Zip»

Dear Dr. «LastName»:

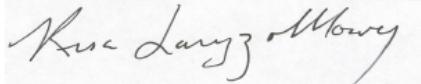
Some time ago, we sent you a questionnaire about your practice and the challenges facing physicians in today's rapidly changing health care environment. We included a {\$75/\$50} honorarium with the questionnaire as a token of our appreciation for completing the survey.

Our records indicate that the check has been cashed, but the questionnaire has not been returned.

Your input is extremely important to this study. Please fill out the enclosed questionnaire and return it to us as soon as is convenient. The Community Tracking Study's Physician Survey is the only ongoing research survey of physicians in the United States. Data from previous survey rounds have been a valuable research tool, reported in numerous articles in leading journals as well as in the popular press. Several of these articles are cited in the attached fact sheet.

If you have any questions, please contact the study staff at 1-888-925-5829. Thank you again for your help with this important study.

Sincerely,



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

«PID»

Attachment G

Fact Sheets

SENT IN 1ST MAILINGS TO
EXPERIMENT ARMS 2 AND
3



*Providing Insights that Contribute
to Better Health Policy*

About the Center for Studying Health System Change (HSC)

Founded in 1995, the Center is a nonpartisan research organization focused on the cost, quality, and accessibility of health care in the United States. HSC does not take positions on particular policies, but is a resource for decision makers on all sides of the issues because of its reliable data and objective analysis. Led by Dr. Paul Ginsburg, PhD, a nationally recognized economist and health policy expert, HSC's researchers have developed a research agenda to guide those crafting health care policy in government and private industry.

The Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans is HSC's principal funder.

HSC's main research tool is the Community Tracking Study (CTS), which consists of national surveys of consumer households and physicians and in-depth case studies in local communities. The physician survey is conducted by Westat and the household survey by Mathematica Policy Research.

Recent Studies of Particular Interest to Physicians

- Care Patterns in Medicare and Their Implications for Pay for Performance, *New England Journal of Medicine*, March 2007
- Potentially Avoidable Hospitalizations for COPD and Pneumonia, *Medical Care*, June 2007
- Physicians' Experience Using Commercial E-Prescribing Systems, *Health Affairs*, April 2007
- Predictors of the Growing Influence of Clinical Practice Guidelines, *Journal of General Internal Medicine*, March 2007
- Leaving Medicine, the Consequences of Physician Dissatisfaction, *Medical Care*, March 2006
- Exodus of Male Physicians from Primary Care Drives Shift to Specialty Practice, *HSC Tracking Report No. 17*, June 2007
- Distorted Payment System Undermines Business Case for Health Quality and Efficiency Gains, *Issue Brief 112*, July 2007
- Hospital-Physician Relations: Cooperation or Separation? *Health Affairs*, December 2006
- Losing Ground: Physician Income, 1995-2003, *HSC Tracking Report No. 15*, June 2006

How the information you provide may be used

Your responses to survey questions will be combined with those of thousands of other physicians nationwide and used in aggregate statistical analyses only. In some studies, physician responses may be linked to administrative data. For example, in previous rounds responses were combined with Medicare claims data in studies that addressed the extra challenges faced by physicians who treat large numbers of minority patients (Bach, et al., NEJM, 2004) and to document the difficulties the Medicare program will have in attributing the care of patients to specific physicians for purposes of developing pay-for-performance programs (Pham, et al., NEJM, 2007).

Additional Information

- For additional information on HSC, including links to the studies cited above, please visit <http://www.hschange.org/>
- For additional information on The Robert Wood Johnson Foundation, please visit <http://www.rwjf.org/>
- If you have any questions about the study, please call Jenné Johns at 877-843-7953 ext. 5788

SENT IN 1ST MAILINGS TO
EXPERIMENT GROUPS A, G,
H1, I AND J1 AND SENT IN
2ND MAILINGS TO
EXPERIMENT ARMS 2 AND

3.



*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 research organization focused on the cost, quality, and accessibility of health care in the United States. HSC does not take positions on particular policies, but is a resource for decision makers on all sides of the issues because of its reliable data and objective analysis. Led by Dr. Paul Ginsburg, PhD, a nationally recognized economist and health policy expert, HSC's researchers have developed a research agenda to guide those crafting health care policy in government and private industry.

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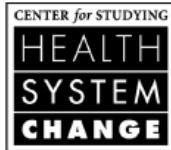
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- Distorted Payment System Undermines Business Case for Health Quality and Efficiency Gains, *Issue Brief 112*, July 2007
- Hospital-Physician Relations: Cooperation or Separation? *Health Affairs*, December 2006
- Losing Ground: Physician Income, 1995-2003, *HSC Tracking Report No. 15*, June 2006

Additional Information

- If you misplaced your questionnaire or honorarium check please contact Catherine Grundmayer at Westat at **1-888-219-8861**.
- For additional information on HSC, including links to the studies cited above, please visit <http://www.hschange.org/>
- For additional information on The Robert Wood Johnson Foundation, please visit <http://www.rwjf.org/>
- If you have any questions about the study, please call Ms. Jenné Johns at the Robert Wood Johnson Foundation at 877-843-7953 ext. 5788

SENT IN ALL OTHER
MAILINGS.



*Providing Insights that Contribute
to Better Health Policy*

About the Center for Studying Health System Change (HSC)

Founded in 1995, the Center is a nonpartisan research organization focused on the cost, quality, and accessibility of health care in the United States. HSC does not take positions on particular policies, but is a resource for decision makers on all sides of the issues because of its reliable data and objective analysis. Led by Dr. Paul Ginsburg, PhD, a nationally recognized economist and health policy expert, HSC's researchers have developed a research agenda to guide those crafting health care policy in government and private industry.

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Recent Studies of Particular Interest to Physicians

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- Potentially Avoidable Hospitalizations for COPD and Pneumonia, *Medical Care*, June 2007
- Physicians' Experience Using Commercial E-Prescribing Systems, *Health Affairs*, April 2007
- Predictors of the Growing Influence of Clinical Practice Guidelines, *Journal of General Internal Medicine*, March 2007
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- Distorted Payment System Undermines Business Case for Health Quality and Efficiency Gains, *Issue Brief 112*, July 2007
- Hospital-Physician Relations: Cooperation or Separation? *Health Affairs*, December 2006
- Losing Ground: Physician Income, 1995-2003, *HSC Tracking Report No. 15*, June 2006

How the information you provide may be used

Your responses to survey questions will be combined with those of thousands of other physicians nationwide and used in aggregate statistical analyses only. In some studies, physician responses may be linked to administrative data. For example, in previous rounds responses were combined with Medicare claims data in studies that addressed the extra challenges faced by physicians who treat large numbers of minority patients (Bach, et al., NEJM, 2004) and to document the difficulties the Medicare program will have in attributing the care of patients to specific physicians for purposes of developing pay-for-performance programs (Pham, et al., NEJM, 2007).

Additional Information

- If you misplaced your questionnaire or honorarium check please contact Westat at **1-888-219-8861**.
- For additional information on HSC, including links to the studies cited above, please visit <http://www.hschange.org/>
- For additional information on The Robert Wood Johnson Foundation, please visit <http://www.rwjf.org/>

Attachment H

AHRQ Letter of Support



DEPARTMENT OF HEALTH & HUMAN SERVICES

Agency for Healthcare
Research and Quality

540 Gaither Road
Rockville MD 20850
www.ahrq.gov

Dear fellow physician,

As director of the Agency for Healthcare Research and Quality (AHRQ), the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans, I encourage you to participate in the Community Tracking Study (CTS) Physician Survey.

The CTS Physician Survey is the largest nationally representative and continuing national survey of clinically active physicians in the country. Although AHRQ does not fund the survey, we, along with the National Institutes on Health (NIH) and other Federal Agencies, regularly support studies that use CTS data to address important health services research questions regarding quality, access to physician care, physician payment, adoption of health information technology, and other timely topics.

The quality of survey data rests heavily on achieving a high participation rate among selected individuals. I urge you to take the time to complete this survey so that we can continue to conduct high quality research to improve the quality and efficiency of healthcare in this nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Carolyn M. Clancy, MD".

Carolyn M. Clancy, MD
Director