*Research Now Questionnaire*

**Center for Vein Restoration – Venous Insufficiency**

Questions/comments are highlighted.

The following is a draft for an online survey questionnaire. Programming instructions are in **BOLD CAPS** and will not appear to the survey participant. Section headers are indicated by a double horizontal line and will not appear in the questionnaire - they are for reference only.

Each question will appear alone on a single screen unless otherwise indicated. A completion meter will be shown on each page. Round radio buttons will be used to indicate that only a single response is allowed, square buttons indicate multi-responses. All survey questions require a response.

No branding will be shown. (This means that CVR will not be identified; the survey will be conducted blind.

Quotas

* 100-200 online interviews among PCPs, GPs and other specialties within 20 mile radius of CVR locations
* Also fielding to about 250 CVR list contacts who referred patients in 2015 but not in 2016 (expected to yield 5-15 respondents)

**Introduction**

We are very interested in your opinion. Please be assured that all answers you give will be held in the strictest confidence and will be used for research purposes only. Your data will be treated in accordance with data protection laws, and all analyses will be conducted anonymously on an aggregated level.

Thank you very much for participating!

**Screener**

1. Please select your professional title.
2. Physician CONTINUE
3. Materials Manager TERMINATE
4. Hospital Administrator TERMINATE
5. Nurse, Nurse Practitioner CONTINUE
6. Physician Assistant CONTINUE
7. Other (Please specify) **(TEXT BOX)** TERMINATE
8. What is yourprimary medical specialty?
9. Primary Care (GP, FP, IM)
10. Internal Medicine
11. Podiatry
12. Dermatology
13. Orthopedics
14. Wound Care
15. Obstetrics/Gynecology
16. Other (Please specify) **(TEXT BOX)**
17. I do not currently work in the medical/healthcare industry **[TERMINATE]**
18. What is the zip code of your primary practice location? **(TEXT BOX; CONFIRM THAT GEO QUALIFIES)**
19. Please select which of the following conditions you currently treat.
20. Skin conditions
21. Venous insufficiency (**MUST SELECT TO QUALIFY**)
22. Blood clotting
23. Chronic pain
24. Other (Please specify) **(TEXT BOX)**
25. Approximately how many patients per month do you currently see with venous insufficiency?
26. 1-4 **CONTINUE**
27. 5-9 **CONTINUE**
28. 10-14 **CONTINUE**
29. 15-19 **CONTINUE**
30. 20-24 **CONTINUE**
31. 25 or more **CONTINUE**
32. How has the number of patients you see with venous insufficiency changed over the past year or two?
33. Increased
34. Decreased
35. Remained the same
36. A. Please select up to two of the following ways that the medical community might become better informed about treatment options for venous insufficiency that you think would be **most** effective. **(RANDOMIZE; ALLOW SELECTION OF 1 OR 2)**
37. Brochures and materials mailed to physicians
38. Emails to physicians linking to venous educational websites
39. Online seminars and CMEs on venous insufficiency
40. In-person seminars and CMEs on venous insufficiency
41. Medical journal article
42. TV or radio advertising
43. Print advertising
44. Online advertising, pop-up or banner ads
45. Social media posts
46. Online website
47. Colleague, peer, partner in practice
48. Visits by pharmaceutical reps
49. Visits by reps for facilities that treat venous insufficiency patients
50. Visits by medical device reps
51. Other (Please specify) \_\_\_\_\_ **(ANCHOR)**

B. Also please select up to two of the following ways that patients might become better informed about treatment options for venous insufficiency that you think would be **most** effective. **(RANDOMIZE; ALLOW SELECTION OF 1 OR 2)**

1. Brochures and materials mailed to physicians
2. Emails to physicians linking to venous educational websites
3. Online seminars and CMEs on venous insufficiency
4. In-person seminars and CMEs on venous insufficiency
5. Medical journal article
6. TV or radio advertising
7. Print advertising
8. Online advertising, pop-up or banner ads
9. Social media posts
10. Online website
11. Colleague, peer, partner in practice
12. Visits by pharmaceutical reps
13. Visits by reps for facilities that treat venous insufficiency patients
14. Visits by medical device reps
15. Other (Please specify) \_\_\_\_\_ **(ANCHOR)**
16. Which of the following treatment options do you typically discuss with your patients with venous insufficiency? (Check all that apply)
17. Lifestyle changes
18. Elevation and compression
19. Medications (diuretics, aspirin, etc.)
20. Ablation
21. Sclerotherapy
22. Surgery
23. Other (Please specify) \_\_\_\_\_ **(TEXT BOX)**

**Referrals**

1. Do you currently refer patients with venous insufficiency to other physicians or facilities for treatment?
2. Yes **SKIP NEXT Q**
3. No **ASK NEXT Q AND THEN SKIP TO NEXT SECTION**
4. Why don’t you currently refer patients with venous insufficiency to other physicians or facilities for treatment? (Check all that apply)
5. No local treatment facilities or clinics
6. Not familiar with treatments offered by local facilities or clinics
7. Don’t know of any physicians that specialize in venous insufficiency
8. Have had bad experiences referring patients
9. Don’t think a referral is necessary; prefer to treat patient myself
10. Have not had any patients with severe enough venous insufficiency to refer to a specialist
11. Other reasons (Please specify) \_\_\_\_\_ **(TEXT BOX)**

**SKIP TO NEXT SECTION**

1. Do you refer patients with venous insufficiency to more than one other physician or facility for treatment?
2. Yes
3. No
4. I do not think treatments help patients
5. For how long have you referred patients with venous insufficiency?
6. 1-2 years **CONTINUE**
7. 3-5 years **CONTINUE**
8. 6-10 years **CONTINUE**
9. More than 10 years **CONTINUE**
10. How has the number of patients with venous insufficiency that you refer out changed over the past five years?
11. Increased
12. Decreased
13. Remained the same
14. To which of the following do you refer your patients with venous insufficiency? (Check all that apply)
15. Independent treatment facilities or clinics
16. University medical centers
17. Vascular physicians/phlebologists
18. Radiologists
19. Walk-in centers
20. Other (Please specify) \_\_\_\_\_ **(TEXT BOX)**
21. Do you typically give your patients options in terms of treatments or where they are referred?
22. Always **CONTINUE**
23. Sometimes **CONTINUE**
24. Never **SKIP NEXT Q**
25. About how many different treatment or referral options do you typically give to a patient?  **(NUMERIC TEXT BOX; 1-99)**
26. How important to you are the following when deciding to whom or where to refer your patients with venous insufficiency for treatment? **(RANDOMIZE ROWS)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 5 – Extremely Important | 4 | 3 | 2 | 1 –  Not at all important |
| a | Reputation |  |  |  |  |  |
| b | Professional relationship with Rep |  |  |  |  |  |
| c | Professional relationship with specialist |  |  |  |  |  |
| d | Past personal experience |  |  |  |  |  |
| e | Proximity; easy patient access |  |  |  |  |  |
| f | Insurance coverage |  |  |  |  |  |
| g | Breadth of services available |  |  |  |  |  |
| h | Availability; short wait time for appointments |  |  |  |  |  |
| i | High level of service to referring physicians |  |  |  |  |  |
| j | Good customer service for patients |  |  |  |  |  |
| k | Patient satisfaction |  |  |  |  |  |
| l | Good communication and follow-up |  |  |  |  |  |
| m | Cost |  |  |  |  |  |
| n | Electronic communication of results |  |  |  |  |  |
| o | In-network with your practice |  |  |  |  |  |
| p | Past outcome success |  |  |  |  |  |

1. In your practice, how are the referral options for a patient determined? (Check one)
2. By you alone
3. By you and other medical professionals in your practice (physicians, nurses, nurse practitioners, physician assistants, etc.)
4. By you along with your practice administrators
5. Other (Please specify) \_\_\_\_\_ **(TEXT BOX)**
6. In the past five years, have you made any changes in the physicians or locations to whom you refer venous insufficiency patients? (Check one)
7. Yes **CONTINUE**
8. No **SKIP NEXT Q**
9. What changes did you make, and why? **OPEN ENDED TEXT BOX**
10. Thinking about the providers to whom you refer venous insufficiency patients, have you ever had any of the following negative experiences? (Check all that apply) **(RANDOMIZE)**
11. Ineffective patient care
12. Lack of insurance coverage
13. Unavailability of necessary services or treatments
14. Patient dissatisfaction
15. Poor communication and follow-up
16. Other (Please specify) \_\_\_\_\_ **(TEXT BOX) (ANCHOR)**
17. Have not had any negative experiences **(ANCHOR)** **SKIP NEXT Q**
18. How did you become aware of these negative experiences? (Check all that apply)
19. By my patients
20. By other physicians
21. By the provider or facility
22. By the media
23. By online sources, social media
24. Other (Please specify) \_\_\_\_\_ **(TEXT BOX)**
25. Please select up to two of the following ways that providers of venous insufficiency treatments can improve the patient experience **most** effectively. **(RANDOMIZE; ALLOW SELECTION OF 1 OR 2)**
26. Providing more/better educational materials to referring physicians
27. Being more responsive in servicing referring physicians
28. Providing better customer service to the patient
29. Having a specialist more accessible for consultation
30. Providing better communication and follow-up
31. Open longer hours
32. More locations; more convenient locations
33. Quicker diagnosis and treatment
34. Less time-consuming treatment
35. Lower cost
36. Less painful treatments
37. Other (Please specify) \_\_\_ **(TEXT BOX)**

**Providers**

1. How familiar are you with the following venous insufficiency treatment centers? **RANDOMIZE ROWS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Very Familiar  4 | Familiar  3 | Somewhat Familiar  2 | Not Familiar  1 |
| a | Center for Vein Restoration |  |  |  |  |
| b | Vein Clinics of America |  |  |  |  |
| c | USA Vein Clinics |  |  |  |  |
| d | Maryland Vein |  |  |  |  |
| e | Capitol Vein and Laser |  |  |  |  |
| f | CVI Cleveland Clinic |  |  |  |  |
| g | Tufts Medical Center |  |  |  |  |

**24a**. Please select which centers you’ve referred patients for venous insufficiency.

**PIPE IN FROM Q24, ALL EXCEPT ‘NOT FAMILIAR’; SINGLE SELECT RESPONSE PER ROW**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | 5+ Patients/Month | 3 – 4 Patients/Month | 1 – 2 Patients/Month | I have not referred any Patients |
| a | Center for Vein Restoration |  |  |  |  |
| b | Vein Clinics of America |  |  |  |  |
| c | USA Vein Clinics |  |  |  |  |
| d | Maryland Vein |  |  |  |  |
| e | Capitol Vein and Laser |  |  |  |  |
| f | CVI Cleveland Clinic |  |  |  |  |
| g | Tufts Medical Center |  |  |  |  |

**24b.** How did you become familiar with these centers?

**PIPE IN FROM Q24, ALL EXCEPT ‘NOT FAMILIAR’**

a) Visited frequently by a rep from the practice

b) Know the physician personally or professionally

c) Hospital affiliate or partner

d) Local to my practice so I choose to send because they are close by

e) Researched and networked and selected this doctor based off of recommendations

f) Refer patients to one another (cross-refer partnership)

g) Other, please specify

1. **(LIST ONLY THOSE WHO DO NOT CHECK “I HAVE NOT REFERRED ANY PATIENTS” IN PREV Q)** How satisfied are you with your experiences referring your venous insufficiency patients to these centers? **RANDOMIZE ROWS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Extremely Satisfied  5 | 4 | 3 | 2 | Not at all Satisfied  1 |
| a | Center for Vein Restoration |  |  |  |  |  |
| b | Vein Clinics of America |  |  |  |  |  |
| c | USA Vein Clinics |  |  |  |  |  |
| d | Maryland Vein |  |  |  |  |  |
| e | Capitol Vein and Laser |  |  |  |  |  |
| f | CVI Cleveland Clinic |  |  |  |  |  |
| g | Tufts Medical Center |  |  |  |  |  |

25a. Please provide any additional centers that you are familiar with for venous insufficiency. *(Optional)*

25b. Would you be open to referring to other centers that you are **not** familiar with right now but became comfortable and familiar with over time?

Yes

No

**ASK IF 25 B = NO**

25c. Why would you not be comfortable referring to other centers you become comfortable and familiar with over time?

**Reps**

1. For the treatment centers with which you are familiar, which ones have venous insufficiency reps that visit you? (Check all that apply) **(LIST FACILITIES FROM PREV Q WITH RESPONSES 2 OR 3; IF NONE, SKIP TO NEXT SECTION)**

**PIPE IN FROM Q24, ALL EXCEPT ‘NOT FAMILIAR’; SINGLE SELECT RESPONSE PER ROW**

1. Center for Vein Restoration
2. Vein Clinics of America
3. USA Vein Clinics
4. Maryland Vein
5. Capitol Vein and Laser
6. CVI Cleveland Clinic
7. Tufts Medical Center
8. No reps visit me with respect to venous insufficiency **SKIP TO NEXT SECTION**
9. How frequently do venous insufficiency reps from each of the following facilities visit you? **(LIST FACILITIES CHECKED IN PREV Q)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Once a month or more | Once every 2-3 months | Less than once every 3 months |
| a | Center for Vein Restoration |  |  |  |
| b | Vein Clinics of America |  |  |  |
| c | USA Vein Clinics |  |  |  |
| d | Maryland Vein |  |  |  |
| e | Capitol Vein and Laser |  |  |  |
| f | CVI Cleveland Clinic |  |  |  |
| g | Tufts Medical Center |  |  |  |

1. How valuable to you are the visits by venous insufficiency reps from each of the following facilities? **(LIST FACILITIES CHECKED IN PREV Q)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Extremely valuable | Somewhat valuable | Not at all valuable |
| a | Center for Vein Restoration |  |  |  |
| b | Vein Clinics of America |  |  |  |
| c | USA Vein Clinics |  |  |  |
| d | Maryland Vein |  |  |  |
| e | Capitol Vein and Laser |  |  |  |
| f | CVI Cleveland Clinic |  |  |  |
| g | Tufts Medical Center |  |  |  |

1. How well do each of the following attributes describe the most effective venous insufficiency reps that you interact with? **(RANDOMIZE ROWS)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 5 – Describe them very well | 4 | 3 | 2 | 1 –  Do not describe them at all |
| a | Does regular visits |  |  |  |  |  |
| b | Provides new information about treatment options |  |  |  |  |  |
| c | Consults about specific patient problems |  |  |  |  |  |
| d | Has a friendly personality |  |  |  |  |  |
| e | Treats my office personnel well |  |  |  |  |  |
| f | Understands the needs of my practice |  |  |  |  |  |
| g | Doesn’t waste my time |  |  |  |  |  |
| h | Presents information in a fair and unbiased manner |  |  |  |  |  |
| i | Asks me to refer to their facility; are direct |  |  |  |  |  |
| j | Is able to answer questions |  |  |  |  |  |
| k | Knows the facility well |  |  |  |  |  |
| l | Follows up on questions |  |  |  |  |  |
| m | Behaves professionally |  |  |  |  |  |
| N | Trustworthy/Credible |  |  |  |  |  |
| O | Persistent |  |  |  |  |  |

29a. Do you find it valuable for venous insufficiency reps to visit you?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | YES | NO | WHY? (**Could we make this a required text box section?)**  **This would have to be asked a separate question for each.** |
| a | Once a month or more |  |  |  |
| b | Once every 2-3 months |  |  |  |
| c | Less than once every 3 months |  |  |  |

1. When making a decision on where to refer patients, how helpful are the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Extremely helpful |  |  |  | Not at all helpful |
|  |  | 5 | 4 | 3 | 2 | 1 |
| a | Reps from a treatment facility visit you and bring along a physician from the facility who will be treating your patients |  |  |  |  |  |
| b | Physicians from a treatment facility sponsor “lunch and learn” sessions |  |  |  |  |  |
|  | ~~Other marketing activities?~~ |  |  |  |  |  |

**Final Demographics**

1. How many years have you been in practice? (Enter whole number) **(NUMERIC TEXT BOX; RANGE 1-99)**
2. Approximately what proportion of your total patients would you say have a venous insufficiency condition? \_\_\_\_\_% **(NUMERIC TEXT BOX; RANGE 0-100)**
3. In which of the following venues do you see patients with venous insufficiency? (Check all that apply)
4. Solo private practice
5. Group private practice
6. Hospital
7. Clinic – inpatient
8. Clinic - outpatient
9. Other (Please specify) \_\_\_\_\_ **(TEXT BOX)**

**CLOSE**

Thank you for your participation.