

PRIMARY CARE ASSESSMENT TOOL – EXPANDED VERSION
(Provider survey)

Primary Care Policy Center
Johns Hopkins University
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Developed by

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This questionnaire is about the characteristics of physicians' practices. In the questions, we refer to "your office"; this is meant to refer to you and the people who work immediately with you. Please try to reflect the care you provide as a practitioner in an office context and answer as accurately as you can; there are no "right" or "wrong" answers. If you do not know, please answer "Not sure/don't know."

ADMINISTRATIVE INFORMATION

Date survey completed: |_|_| |_|_| |_|_|
 M M D D Y Y

Name and title of person completing the questionnaire:

Organization/office address:

Facility code: |_|_|_|

Phone number: |_|_|_| |_|_|_| |_|_|_|_|

GENERAL

1. Type of practice (Check one.) _____

- 1 Solo practice
- 2 Single specialty group practice
- 3 Multi-specialty group practice
- 4 Public health clinic
- 5 Community health clinic or neighborhood health center
- 6 Hospital clinic
- 7 Rural health clinic
- 8 Other (Please specify.) _____

2. Your specialty (Check one.) _____

- 1 General pediatrics
- 2 Family practice
- 3 General internal medicine
- 4 General pediatrics with sub-specialty focus (Please specify.) _____
- 5 General internal medicine with sub-specialty focus (Please specify.) _____
- 6 Pediatric sub-specialist (Please specify.) _____
- 7 Nurse practitioner: PNP FNP Other _____
- 8 Physician's assistant
- 9 Certified nurse midwife
- 10 Other (Please specify.) _____

3. Of patients you care for, what is the approximate percent in the following types of plans? (If none, place a 0.)

	<u>Percent</u>
Private	
Fee-for-service unrestricted	_____
Fee-for-service PPO	_____
HMO – capitated physicians	_____
Medicaid	
Fee-for-service unrestricted	_____
PCCM – fee-for-service primary care case management	_____
PCCM – capitated primary care case management	_____
HMO – capitated physicians	_____
Direct payment from uninsured patients	_____
Un-reimbursed (charity care)	_____
Other (Please specify.) _____	_____
Don't know/not sure	_____
<u>Total</u>	<u>100%</u>

4. Of patients you care for, what is the approximate percent for whom you receive:

	<u>Percent</u>
Usual fee-for-service	_____
Discounted fee-for-service	_____
Salary	_____
Capitation	_____
Capitation with performance incentives	_____
Capitation with withholds	_____
Direct payment from patients	_____
Other	_____
<u>Total</u>	<u>100%</u>

Please check the one best answer.							Not sure/ don=t know
	0- 20%	21- 40%	41- 60%	61- 80%	81- 100%		
5. About what percent of your patients are in insurance plans where your income is affected by the number of referrals or costs you generate?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
6. What percent of your patients have health coverage that limits referrals, limits to whom you can refer, or requires approval for referrals?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
7. About what percent of your patients have health coverage that requires pre-approval for non-emergency hospitalizations?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
8. About what percent of your patients must pay a fee or copayment at each visit?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
9. What percent of your patients have long-term medical or behavioral problems or disabilities?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
10. On average, about <i>how long</i> do patients stay with you in your practice? (Check one.)							
1 <input type="checkbox"/> Less than 6 months							
2 <input type="checkbox"/> 6 months to 1 year							
3 <input type="checkbox"/> 1 – 2 years							
4 <input type="checkbox"/> 3 – 4 years							
5 <input type="checkbox"/> 5 or more years							
6 <input type="checkbox"/> Too variable to specify							
9 <input type="checkbox"/> Don't know							
11. Do you have a geographically defined population that you serve? (Check one.)							
1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> Not sure/don't know					

Please check the one best answer.							Not sure/ don=t know
	0- 20%	21- 40%	41- 60%	61- 80%	81- 100%		
12. What percent of your patients are “enrolled,” or are assigned to receive all their non-referred care at your practice?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
13. About what percent of your patients are on a list or computerized roster that identifies them as your patients?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____
14. What percent of your patients do you think use your practice for <i>all</i> their well and sick health care needs (with the exception of true emergencies and referred care)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	_____

C. FIRST CONTACT - ACCESS

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
C1. Is your office open on Saturday or Sunday?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C2. Is your office open on at least some weekday evenings until 8 PM?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C3. When your office is open and patients get sick, would someone from your office see them that day?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C4. When the office is open, can patients get advice quickly over the phone when they think they need it?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C5. When your office is closed, do you have a phone number patients can call when they get sick?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C6. When your office is closed on Saturday or Sunday and patients get sick, would someone from your office be able to see them that day?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C7. When your office is closed during the night and patients get sick, would someone from your office be able to see them that night?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C8. Can a patient easily get an appointment for routine checkups at your office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
C9. On average, do patients have to wait more than 30 minutes after arriving before they are examined by the doctor or nurse?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

D. ONGOING CARE

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don= t know
D1. At your office, do patients see the same clinician each time they make a visit?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D2. Can you understand the questions that your patients ask you?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D3. Do you think your patients understand what you ask them or say to them?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D4. If patients have a question, can they call and talk to the doctor or nurse who knows them best?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D5. Do you think you give patients enough time to talk about their worries or problems?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D6. Do you think your patients feel comfortable telling you about their worries or problems?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D7. Do you think you know the patients in your practice "very well"?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D8. Do you know who lives with each of your patients?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D9. Do you think you understand what problems are most important to the patients you see?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D10. Do you think you know each patient's complete medical history?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D11. Do you think you know each patient's work or employment?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D12. Would you know if patients had trouble getting or paying for a prescribed medication?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
D13. Do you know <i>all</i> the medications that your patients are taking?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

E. COORDINATION

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
E1. Does your office phone or send patients the results of all lab tests?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E7. Do you think you know about all the visits that your patients make to specialists or special services?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E8. When patients need a referral, do you discuss different places the family might go to get help with their problem?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E9. Does someone at your office help the patient make the appointment for the referral visit?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E10. When patients are referred, do you give them any written information to take to the specialist?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E11. Do you receive useful information about your referred patients back from the specialists or special services?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
E12. After the visit, do you talk with patients about the results of visit(s) with the specialist or special service?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

F. COORDINATION (INFORMATION SYSTEMS)

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
F1. Are patients expected to bring their medical records, such as immunizations or medical care they received in the past?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F2. Would you allow patients to look at their medical records if they wanted to?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F3. Are patient records available when you see patients?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

Do you use the following methods to assure that indicated services are provided?

F4. Flow sheets in patients' charts for lab results	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F5. Printed guidelines in patients' records	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F6. Periodic medical record audits	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F7. Problem lists in patients' records	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F8. Medication lists in patients' records	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
F9. Other (Please specify.) _____					

G. COMPREHENSIVENESS (SERVICES AVAILABLE)

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don= t know
If patients need any of the following services, would they be able to get them <i>on-site</i> at your office?					
G1. Nutrition counseling by a nutrition specialist	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G2. Immunizations	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G3. Eligibility screening for social service programs or benefits	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G4. Dental checkups	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G5. Dental treatments	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G6. Family planning or birth control services	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G7. Substance or drug abuse counseling or treatment	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G8. Counseling for behavior or mental health problems	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G9. Tests for lead poisoning	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G10. Suturing for a minor laceration	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G11. Counseling and testing for HIV/AIDS	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G12. Tympanocentesis	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G13. Vision screening	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G14. Allergy shots	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G15. Splinting for a sprained ankle	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G16. Wart removal	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G17. Pap smears	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G18. Rectal exam or sigmoidoscopy	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G19. Smoking counseling	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G20. Prenatal care	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G21. Removal of an ingrown toenail	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G22. Advice on advance directives	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G23. Advice on preparing for changes consequent to aging	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G24. Suggestions on nursing home care	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
G25. WIC services (supplemental milk and food program)	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

H. COMPREHENSIVENESS (SERVICES PROVIDED)

If your office serves all ages, please answer all questions in this section (H1 – H18).

If your office serves *only children*, do not answer questions H3 – H13.

If your office serves *only adults*, do not answer questions H14 – H18.

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
Are the following subjects discussed with patients?					
H1. Nutritional/non-nutritional foods or getting enough sleep	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H2. Home safety, like using smoke detectors and storing medicines safely	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

Questions H3 – H13 apply to *adults only (ages 18 and older)*.

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
Are the following subjects discussed with patients?					
H3. Seat belt use	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H4. Handling family conflicts	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H5. Advice about appropriate exercise	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H6. Cholesterol levels	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H7. Medications being taken	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H8. Exposure to harmful substances at home, work, or in their neighborhood	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H9. Gun availability, storage, safety	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H10. Prevention of hot water burns	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H11. Prevention of falls	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H12. Prevention of osteoporosis or fragile bones in females	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H13. Care for common menstrual or menopausal problems	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

Questions H14 – H18 apply to children only (under age 18).

Please check the **one** best answer.

		Definitely	Probably	Probably not	Definitely not	Not sure/don= t know
Are the following subjects discussed with the child and parent/guardian?						
H14.	Ways to handle problems with child's behavior	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H15.	Changes in growth and behavior that parents can expect at certain ages	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H16.	Safety issues for children under 6: teaching them to cross the street safely, and using child safety seats in cars	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H17.	Safety issues for children between 6 and 12: staying away from guns, and using seatbelts and bicycle helmets	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
H18.	Safety issues for children over 12: safe sex, saying no to drugs, not drinking and driving	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

I. FAMILY-CENTEREDNESS

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
I1. Does your office ask patients about <i>their</i> ideas and opinions when planning treatment and care for the patient or family member?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I2. Does your office ask about illnesses or problems that might run in the patients' families?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I3. Is your office willing and able to meet with family members to discuss a health or family problem?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Are the following included as a routine part of your health assessment?					
I4. Use of familiograms, family APGAR	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I5. Discussion of family health risk factors, e.g., genetics	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I6. Discussion of family economic resources	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I7. Discussion of social risk factors, e.g., loss of employment	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I8. Discussion of living conditions, e.g., working refrigerator, heat	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I9. Discussion of health status of other family members	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I10. Discussion of parenting	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I11. Assessment of signs of child abuse	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I12. Assessment of indications of family in crisis	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I13. Assessment of impact of patient's health on family functioning	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
I14. Assessment of development level	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

J. COMMUNITY ORIENTATION

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
J1. Does your office make home visits?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J2. Do you think your office has adequate knowledge about the health problems of the communities you serve?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J3. Does your office get opinions and ideas from people that might help to provide better health care?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J4. Is your office able to change health care services or programs in response to specific health problems in the communities?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Does your office use the following types of data to determine what programs/services are needed by the communities you serve?					
J5. Mortality data (data on deaths)	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J6. Public health communicable disease data (e.g., STDs, TB)	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J7. Community immunization rates	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J8. Public health data on health or occupational hazards	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J9. Clinical data from your practice	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J10. Other (Please specify.) _____					
Does your office use the following methods to monitor and/or evaluate the effectiveness of services/programs?					
J11. Surveys of your patients	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J12. Community surveys	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J13. Feedback from community organizations or community advisory boards	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J14. Feedback from your practice staff	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J15. Analysis of local data or vital statistics	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J16. Systematic evaluations of your programs and services provided	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J17. Community health workers	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J18. Have a consumer on the board of directors or advisory committee	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J19. Other (Please specify.) _____					

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
Does your office use any of the following activities to reach out to populations in the communities you serve?					
J20. Networking with state and local agencies involved with culturally diverse groups	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J21. Linkages with religious organizations/services	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J22. Involvement with neighborhood groups/community leaders	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J23. Outreach workers	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
J24. Other (Please specify.) _____					

K. CULTURALLY COMPETENT

Please check the **one** best answer.

	Definitely	Probably	Probably not	Definitely not	Not sure/don't know
K2. Can your office communicate with people who do not speak English well?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K3. If needed, do you take into account a family's special beliefs about health care or use of folk medicine, such as herbs/homemade medicines?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K4. If needed, do you take into account a family's request to use alternative treatment, such as homeopathy or acupuncture?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

Does your office use any of the following methods to address the cultural diversity in your patient population?

K5. Training of staff by outside instructors	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K6. In-service programs presented by staff	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K7. Use of culturally-sensitive (language, visual images, religious customs) materials/pamphlets	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K8. Staff reflecting the cultural diversity of the population served	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K9. Translators/interpreters	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K10. Planning of services that reflect cultural diversity	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
K11. Other (Please specify.) _____					

OTHER

1. Does your office offer “sliding scale” or long-term payment plans for patients with financial difficulties? _____

1 Yes 2 No 9 Don’t know

2. Are your professional earnings mainly (Check one.) _____

1 Salary only

2 Capitation only

3 Fee-for-service only

4 Capitation and fee-for-service

5 Salary and fee-for-service

6 Salary, capitation, and fee-for-service

7 Share of practice earnings

8 Other (Please specify.) _____

3. Are you eligible for bonuses or subject to withholds depending on your utilization experience? _____

1 Yes 2 No 9 Don’t know

4. Are you eligible for bonuses if you achieve certain guidelines or outcomes? _____

1 Yes 2 No 9 Don’t know

5. In your practice, what are the current number of *visits* per day? (Please estimate.) _____ visits _____

6. In your practice, what are the current number of *visits* per week? (Please estimate.) _____ visits _____

7. What is the approximate percentage of *visits* by age? _____

Percent

Ages 0-4 _____

Ages 5-10 _____

Ages 11-14 _____

Ages 15-19 _____

Ages 20 and over _____

Total 100%

8. Is your practice currently accepting new patients? _____

1 Yes

2 Yes, but only non-Medicaid

3 No new patients

4 Other (Please specify.) _____

9. Is your practice able to determine how many *patients* (not *visits*) you have seen in a year? _____

1 Yes 2 No 9 Don’t know

10. We are aware that funding streams and staff shortages are the main resources that need to be addressed. Other than money and staff, are there other resources your practice needs to ensure appropriate primary care services to the communities you serve?

Please check to make sure you have not skipped any pages. Thank you.

Please indicate by checking the box below if you would like to receive a copy of the final report of this study.

Yes No

Thank you for taking the time to complete this survey. The information will be very valuable in planning to meet the health care needs in the communities you serve.