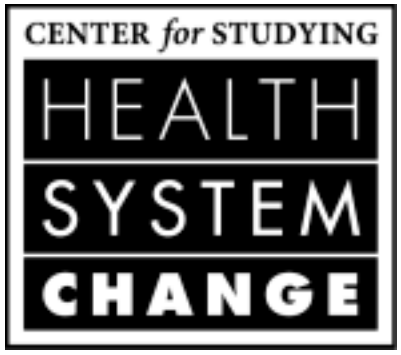
Community Tracking Study

2000-01 Physician Survey Summary File: User's Guide and Codebook

(Release 1)



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PREFACE

The Community Tracking Study (CTS) provides information to help policy makers and health care leaders make sound decisions. The CTS collects information on how the health system is evolving in 60 communities across the United States and the effects of those changes on people. Funded by the Robert Wood Johnson Foundation, the study is being conducted by the Center for Studying Health System Change (HSC).

The CTS relies on periodic site visits and surveys of households and physicians, with occasional surveys of employers and health insurance plans. One component of the CTS, the Physician Survey, provides information about source of practice revenue, problems physicians face in practicing medicine, how they are compensated, and what effect various care management strategies have on their practices, as well as questions about their practice arrangements. This document gives researchers the information necessary for using the 2000-01 Physician Survey Summary File.

Data collection for the 2000-01 Physician Survey began in August 2000 and was completed in November 2001. Earlier versions of the survey were conducted in 1996-97 and 1998-99. Each survey was designed to allow separate cross-sectional estimates. Researchers can use each year of the CTS Physician Survey for separate cross-sectional analyses or combine the years to study changes in the health care system over time.

Data from the CTS Round Two Physician Survey is available both as microdata, with separate data records for each physician who responded to the survey, and also in summary form, with data aggregated for each CTS site and the nation as a whole.

A microdata record contains data on a single physician's attributes, such as the physician's age and gender. Due to the need to maintain respondent confidentiality, the Physician Survey microdata has two forms: the *Public Use File* and the *Restricted Use File*. The Physician Survey public use microdata file masks or omits geographic identifiers and other potentially sensitive information. The restricted use version of the microdata file retains much of this confidential information, but access is restricted and users must apply for a special license to use the data.

A Summary File record combines the microdata into a single measure, such as the average age of physicians in a site or the percentage of physicians in a site who are males. The Summary File allows researchers to use site-level averages in their analyses without having to calculate them from the information on the restricted use microdata file, which would require not only more effort but also application for access to the Restricted Use File. This Summary File reflects most of the information collected in the CTS 2000-01 Physician Survey. For each of the selected attributes from the 2000-01 Physician Survey, the Summary File includes averages or percentages and the standard errors of these estimates.

Those interested in using the Summary File may also be interested in the user's guides and codebooks for the Physician Survey public and restricted use files. Those documents are included in the list of references in this user's guide.

OBTAINING TECHNICAL ASSISTANCE

Information on the CTS Physician Survey, and the CTS in general, can be obtained through the HSC Internet home page at http://www.hschange.org. The public use, restricted use, and summary files, as well as the documentation, are available through the Inter-university Consortium for Political and Social Research at http://www.icpsr.umich.edu.

Technical assistance on issues related to the data file can be obtained by contacting the CTS Help Desk by e-mail at ctshelp@hschange.org or fax (202-863-1763).

VISIT THE HSC WEB SITE

www.hschange.org

For users of the CTS data files, the HSC Web site can be a valuable resource. In addition to the HSC technical publications and descriptions of the different CTS data collection activities, it has these useful features.

CTSonline user-specified tables. CTSonline is an interactive Web-based system that allows users to request a wide variety of tables with estimates from the CTS Physician Survey and the CTS Household Survey.

Lists of papers published from the public use and restricted use data files. In the section of the Web site that discusses the public and restricted use data, you can view a list of journal articles that have been published by users of the CTS public use and restricted use data files. If you have a paper based on the CTS data that is not included on the list, please let us know by sending an email to CTSonline@hschange.org.

Email list for updates on the CTS data. If you would like to receive email announcements when new versions of the CTS data files are released, go to the Web site and click on "Sign up for email alerts." Then fill out the sign-up form and check the box specific to CTS email.

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CHAPTER 1

OVERVIEW OF THE COMMUNITY TRACKING STUDY AND THE PHYSICIAN SURVEY

This guide is intended to assist researchers in using the Community Tracking Study (CTS) 2000-01 Physician Survey Summary File. The CTS is a national study of the rapid changes in the health care market and the effects of those changes on people.[1] Funded by the Robert Wood Johnson Foundation, the study is being conducted by the Center for Studying Health System Change (HSC). Information about other aspects of the CTS is available from HSC at www.hschange.org. Technical assistance on issues related to the data file may be obtained by contacting the CTS Help Desk by e-mail at ctshelp@hschange.org or fax (202-863-1763).

1.1. CTS OBJECTIVES

The CTS is designed to provide a sound information base for decisions made by health care leaders by collecting information on how the health system is evolving in 60 communities across the United States and the effects of those changes on people. Underway since 1996, the CTS is a longitudinal project that relies on periodic site visits and surveys of households and physicians.[2] While many studies have examined leading markets in California and Minnesota and analyzed local or selected data, there has been no systematic study of change in a broad cross-section of U.S. markets or analysis of the effects of those changes on service delivery, cost and quality. The Community Tracking Study is designed to provide sound empirical evidence that will inform the debate about health system change. The study addresses two broad questions that are important to public and private health decision-makers:

How is the health system changing? How are hospitals, health plans, physicians, safety net providers and other provider groups restructuring, and what key forces are driving organizational change?

How do these changes affect people? How are insurance coverage, access to care, use of services, health care costs and perceived quality of health care changing over time?

Focusing on communities is central to the design of the CTS. Understanding market changes requires studying local markets, including their culture, history, and public policies relating to health care. HSC researchers randomly selected 60 communities to provide a representative profile of change across the United States (see Table 1.1). Of these communities ("sites"), 12 are studied in depth, with site visits ("case studies") and survey samples large enough to draw conclusions about change in each community. These 12 communities are referred to as the "high-intensity sites."

[1] An overview of the Community Tracking Study is contained in Kemper et al. (1996).

[2] Surveys of employers and insurance plans have also been conducted.

1.2. ANALYTIC COMPONENTS OF THE COMMUNITY TRACKING STUDY

The CTS has both quantitative and qualitative components. The quantitative component consists of surveys, and the qualitative component consists of site visits.

In all 60 sites, HSC has conducted independent surveys of households and physicians, enabling researchers to explore relationships among purchasers, providers, and consumers of health care. The Household Survey has been conducted in 1996-97, 1998-99, and 2000-01, and data collection for the fourth survey is scheduled for calendar year 2003. The Physician Survey has also been conducted in 1996-97, 1998-99, and 2000-01, and data collection for the fourth survey is scheduled for calendar year 2004.

In addition to the household and physician surveys, the quantitative component of the CTS has also included two other surveys. The Followback Survey was conducted as a supplement to the 1996-97 Household Survey and the 1998-99 Household Survey. For this survey, the privately financed health insurance policies covering Household Survey respondents were "followed back" to the organization that administered the policy. The purpose of the Followback Survey was to obtain more detailed and accurate information about those private policies than Household Survey respondents could provide. A CTS survey of employers that was sponsored by the Robert Wood Johnson Foundation was conducted by RAND in 1996 and 1997.[3]

Case studies in the 12 high-intensity sites make up the qualitative component of the CTS. The first four rounds of comprehensive case studies of the health systems in the 12 communities are completed. The first round was conducted in 1996-97, the second in 1998-99, the third in 2000-01, and the fourth in 2002-03. The findings are available from HSC.[4]

[3] The household and physician surveys were conducted by HSC. The Employer Survey was conducted by RAND in collaboration with HSC. The surveys are available separately as both public and restricted use files. While these three surveys were conducted in the same communities, they were independent of one another and do not allow for the linking of persons, employers, or physicians.

[4] Community reports from each round are available through the HSC web site at www.hschange.org.

TABLE 1.1

SITES SELECTED FOR THE COMMUNITY TRACKING STUDY

High-Intensity Sites	Low-Intensity Sites	
Metro areas >200,000 population	Metro areas >200,000 population	Metro areas <200,000 population
01-Boston (MA)	13-Atlanta (GA)	49-Dothan (AL)
02-Cleveland (OH)	14-Augusta (GA/SC)	50-Terre Haute (IN)
03-Greenville (SC)	15-Baltimore (MD)	51-Wilmington (NC)
04-Indianapolis (IN)	16-Bridgeport (CT)	
05-Lansing (MI)	17-Chicago (IL)	Nonmetropolitan Areas
06-Little Rock (AR)	18-Columbus (OH)	
07-Miami (FL)	19-Denver (CO)	52-West Central Alabama
08-Newark (NJ)	20-Detroit (MI)	53-Central Arkansas
09-Orange County (CA)	21-Greensboro (NC)	54-Northern Georgia
10-Phoenix (AZ)	22-Houston (TX)	55-Northeastern Illinois
11-Seattle (WA)	23-Huntington (WV/KY/OH)	56-Northeastern Indiana
12-Syracuse (NY)	24-Killeen (TX)	57-Eastern Maine
	25-Knoxville (TN)	58-Eastern North Carolina
	26-Las Vegas (NV/AZ)	59-Northern Utah
	27-Los Angeles (CA)	60-Northwestern Washington
	28-Middlesex (NJ)	
	29-Milwaukee (WI)	
	30-Minneapolis (MN/WI)	
	31-Modesto (CA)	
	32-Nassau (NY)	
	33-New York City (NY)	
	34-Philadelphia (PA/NJ)	
	35-Pittsburgh (PA)	
	36-Portland (OR/WA)	
	37-Riverside (CA)	
	38-Rochester (NY)	
	39-San Antonio (TX)	
	40-San Francisco (CA)	
	41-Santa Rosa (CA)	
	42-Shreveport (LA)	
	43-St. Louis (MO/IL)	
	44-Tampa (FL)	
	45-Tulsa (OK)	
	46-Washington (DC/MD)	
	47-West Palm Beach (FL)	
	48-Worcester (MA)	

Note: The numbers listed above are site identifiers and are provided in the data file as the variable SITEID.

1.3. THE PHYSICIAN SURVEY

The Physician Surveys, funded by the Robert Wood Johnson Foundation, were conducted under the direction of HSC. The Gallup Organization was the primary data collection contractor. Mathematica Policy Research, Inc. (MPR) managed the Gallup subcontract for HSC and was responsible for sample design, weighting, variance estimation and tracking of physicians who could not be located. Project Hope and CODA, Inc. assisted in developing the original survey instrument (for 1996-97), including cognitive testing. Social and Scientific Systems, Inc. (SSS) was instrumental in converting the raw survey data into a data file suitable for analysis. MPR, SSS, and HSC collaborated to prepare the documentation for the Summary File.

The Physician Survey instrument collected information on physician supply and specialty distribution; practice arrangements and physician ownership; physician time allocation; sources of practice revenue; level and determinants of physician compensation; provision of charity care; physicians' perception of their ability to deliver care and of career satisfaction; effects of care management strategies; and various aspects of physicians' practice of medicine.

The sample frame was developed by combining lists of physicians from the American Medical Association (AMA) and the American Osteopathic Association (AOA). The survey was administered completely by telephone, using computer-assisted telephone interviewing technology. Bilingual interviewers were used in the few cases where needed. Interviews with 12,389 physicians were completed between August 2000 and November 2001.

1.4. PHYSICIAN SURVEY DATA FILES

Three versions of the CTS Physician Survey data are available to researchers: the Restricted Use File, the Public Use File, and the Summary File. Both the restricted use and public use files are microdata, with a separate data record for each physician who responded to the survey. The Summary File contains summary estimates for the CTS sites and the nation as a whole.

The ***Restricted Use File*** contains most of the data collected during the CTS Physician Survey. Other than deleting individual identifiers such as name and address, minimal data confidentiality masking was performed on the data. Since some of the data on the Restricted Use File could compromise the confidentiality of survey respondents, the Restricted Use File may be used only under the conditions listed in the *Community Tracking Study Physician Survey Restricted Data Use Agreement.* This agreement provides details on ownership of the data, when the data may be obtained and by whom, how the data may be used, the data security procedures that must be implemented, and the sanctions that will be imposed in the case of data misuse. Researchers must specifically apply for use of the Restricted Use File. Copies of the agreement and a description of the application process are available from the ICPSR web site at www.icpsr.umich.edu. The Restricted Use File is provided to researchers for use on only a specific research project (new applications would be required for subsequent analyses) and for a limited time period, after which all copies of the data must be destroyed. Moreover, researchers using the Restricted Use File may be required to undertake costly or inconvenient security measures.

The ***Public Use File*** is available from ICPSR with minimal restrictions. Researchers need not specifically apply for use of the Public Use File. It is suitable for most researchers who wish to perform analysis at the national level and do not anticipate using the site-level information in their analysis. The Public Use File does not support analysis at the site level or analysis that uses site-level information. Although it contains all of the same observations as the Restricted Use File, several variables have been deleted or modified slightly for data confidentiality reasons. Moreover, information necessary for using statistical software programs that account for the survey design is not included in the Public Use File. This means that the Public Use File does not allow researchers to calculate standard errors and perform significance tests correctly. The primary purpose of the Public Use File is to do preliminary investigation of the data in order to determine whether it is worthwhile to obtain the Restricted Use File to pursue an analysis further.

The ***Summary File*** allows researchers access to certain site-level estimates without applying for the use of the Restricted Use File. The Summary File, described in this document, provides information from the Physician Survey aggregated to the level of the CTS sites and the nation as a whole. This information will be useful to researchers who are interested in market-level attributes when analyzing the CTS surveys or who want to link the CTS data to other sources. Ideally, the Summary File is best merged with other surveys that follow the CTS sample design, including the CTS Household Survey and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey. The Summary File also allows researchers to access summary information without having to process the CTS Physician Survey microdata.

When using the CTS Physician Survey data, researchers may wish to consult the ***Crosswalk File***. This file identifies the specific counties, by FIPS code, that make up each CTS site and facilitates linking data from the CTS with other data sources. The Crosswalk File is available from ICPSR at www.icpsr.umich.edu.

We encourage researchers to review documentation for all three files and the *Community Tracking Study Physician Survey Restricted Data Use Agreement* before deciding which file will meet their needs.

CHAPTER 2

THE STRUCTURE AND CONTENT OF THE COMMUNITY TRACKING STUDY PHYSICIAN SURVEY

This chapter describes the CTS Physician Survey sample design, the process of conducting the survey, the survey content, and survey administration and processing. Chapter 3 provides information specifically about the Summary File.

The Physician Survey was administered to a sample of physicians in the 60 CTS sites and to an independent national sample of physicians. The survey's three-tiered sample design makes it possible to develop estimates at the national and community (site) levels.

- The first tier is a sample from 12 communities, in each of which a large number of physicians were surveyed. The sample in each of these "high-intensity" sites is large enough to support estimates in each site.
- The second tier is a sample from 48 communities, in each of which a smaller sample of physicians were surveyed. This sample of "low-intensity" sites allows us to validate results from the high-intensity sites and permits findings to be generalized to the nation. The first and second tiers together are known as the *site sample*.
- The third tier is a smaller, independent national sample known as the *supplemental sample*. This sample augments the site sample and increases the precision of national estimates with a relatively modest increase in the total sample size.

2.1. SITE SAMPLE

As discussed in Chapter 1, the primary goal of the CTS is to track health system change and its effects on people at the local level. Therefore, we selected 60 communities (*sites*) to provide a representative profile of change across the U.S.; the sample drawn from those sites constitutes the *site sample*. The first step in designing the CTS site sample was to determine the appropriate sites to study. Three issues were central to the sample design: the definition of the sites, the number of sites, and the selection of the sites.

2.1.1. Definition of Sites

The sites encompass local health care markets. Although there are no set boundaries for these local markets, the intent was to define areas such that residents predominately used health care providers in their area and providers served predominately area residents. The sites generally conform to the metropolitan statistical areas (MSAs) defined by the Office of Management and Budget and the nonmetropolitan portions of the economic areas defined by the Bureau of Economic Analysis (BEAEAs).[5]

2.1.2. Number of Sites

The next step in creating the site sample was to determine the number of high-intensity sites. The high-intensity sites have larger samples, and they are also the sites used for the case studies described in Chapter 1. In making this decision, we considered the tradeoffs between data collection costs (case studies plus survey costs) and the research benefits of a large sample of sites. The research benefits of a larger number of sites include a greater ability to empirically examine the relationship between health system change and its effect on care delivery and consumers and to make the study findings more "generalizable" to the nation. Despite the cost advantages of conducting intensive case studies in fewer sites, focusing on a smaller number of communities makes it more difficult to distinguish between changes of general importance and changes or characteristics unique to a community. Solving this problem by increasing the number of case study sites would make the cost of data collection and analysis prohibitively high.

We chose 12 sites for intensive study and added 48 sites for less-intensive study. These 60 high-intensity and low-intensity sites form the *site sample*. Although there was no formal scientific basis for choosing 12 high-intensity sites, this number reflects a balance between the benefits of studying a range of different communities and the costs of doing so. The addition of 48 low-intensity sites solves the problem of limited generalizability associated with only 12 sites and provides a benchmark for interpreting how representative the high-intensity sites are.

[5]For more details on the definition of CTS sites, refer to Metcalf et al. (1996).

2.1.3. Site Selection

Once the number of sites for the site sample had been determined, we selected the actual sites, shown previously in Table 1.1. Sites were sampled by stratifying them geographically by region and selecting them randomly, with probability in proportion to their 1992 population. There were separate strata for large MSAs (population of more than 200,000), small MSAs (population of less than 200,000), and nonmetropolitan areas. The 12 high-intensity sites were selected randomly from the large MSAs. Among the 48 low-intensity sites, 36 are large MSAs, 3 are small MSAs, and 9 are nonmetropolitan sites. The *Community Tracking Study Site-County Crosswalk* identifies the specific counties, by FIPS code, that make up each CTS site. This sampling approach provided maximum geographic diversity, judged critical for the 12 high-intensity sites in particular, and acceptable natural variation in city size and degree of market consolidation.[6]

2.2. SUPPLEMENTAL SAMPLE

Although the site sample alone will yield national estimates, the estimates will not be as precise as they could have been if more communities had been sampled or if the sample had been a simple random sample of the entire U.S. population. The *supplemental sample*, the third tier in the design of the CTS Physician Survey sample, was added to increase the precision of national estimates at a relatively small incremental increase in survey costs. The supplemental sample is a relatively small, nationally representative sample made up of physicians randomly selected from the 48 states in the contiguous United States. It is stratified by region but essentially uses simple random sampling techniques within strata.

2.3. RELATIONSHIP BETWEEN THE SITE AND SUPPLEMENTAL SAMPLES

The site sample accounts for about 90 percent of the Physician Survey respondents, and the remaining 10 percent come from the supplemental sample. In many cases it can be useful to combine the two samples to make estimates. The relationship between the two samples is discussed here.

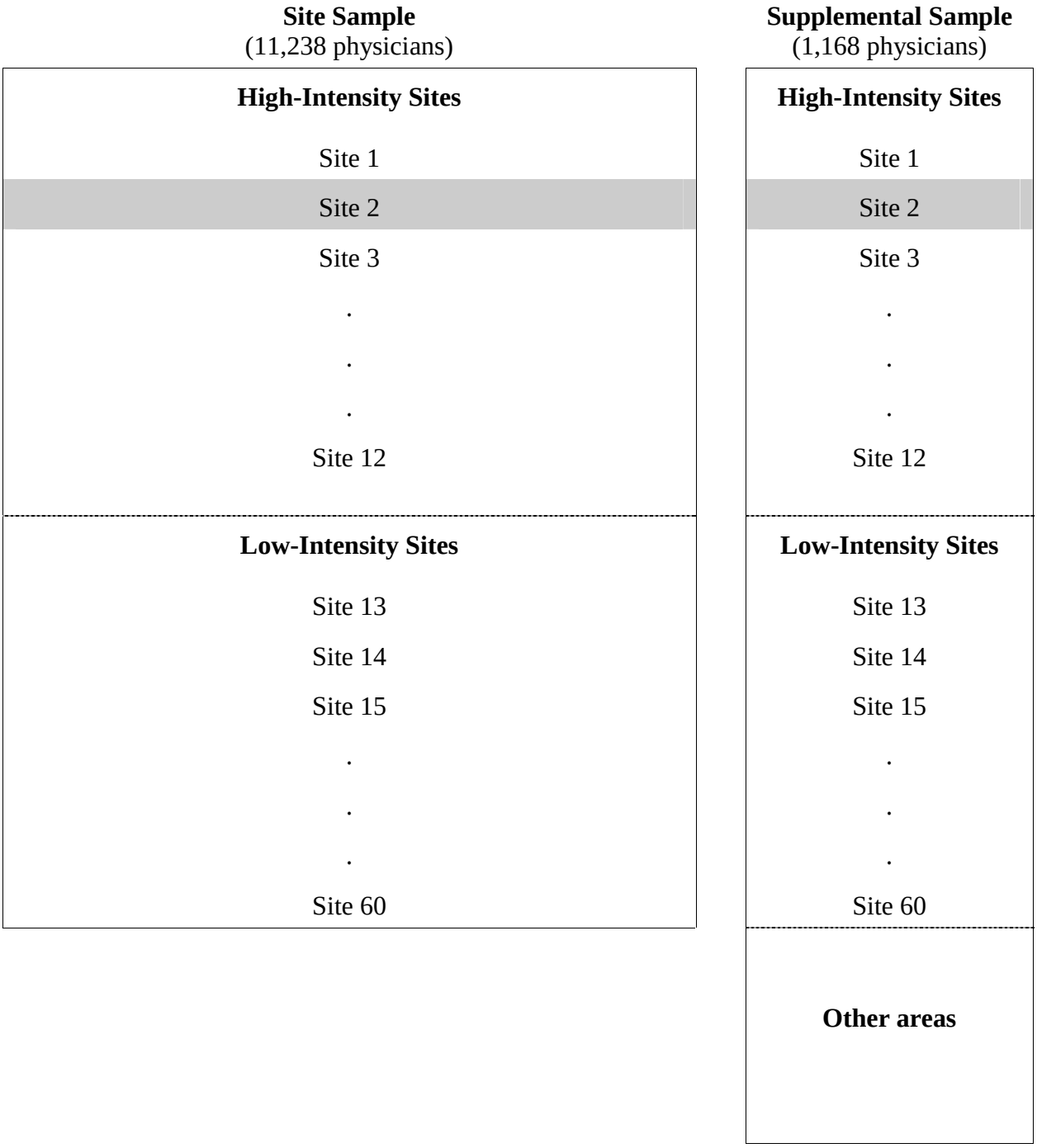
The purpose of the supplemental sample is to increase the precision of national estimates relative to the site sample alone. When it is added to the site sample to produce national estimates, the resulting sample is called the *combined sample*.

As illustrated in Figure 2.1, some of the supplemental sample falls inside of the boundaries of the 60 CTS sites. Therefore, in addition to making national estimates from the site sample more precise, the supplemental sample also slightly enhances site-specific estimates derived from the site sample. Specifically, when a site-specific estimate is made, the sample in a particular site can be augmented with observations from the supplemental sample. The resulting sample (the entire site sample plus the observations from the supplemental sample that fall inside the 60 sites) is known as the *augmented site sample*. The shaded area in Figure 2.1 shows the augmented site sample for site 2.

[6]Additional information about the number of sites and the random selection of the site sample is available in Metcalf et al. (1996).

FIGURE 2.1

THE CTS 2000-01 PHYSICIAN SURVEY SAMPLE STRUCTURE



2.4. CONDUCTING THE PHYSICIAN SURVEY

After selecting the sample sites, we randomly selected physicians within each site. In the 1996-97 (Round One) Physician Survey, the AMA and the AOA constructed the sample frames and drew the samples based on specifications provided to them. Physicians were also randomly selected in this manner for the supplemental sample. In the 1998-99 and 2000-01 surveys, we obtained sample frames from the AMA and the AOA but selected the sample ourselves.

In the 2000-01 Physician Survey, the sample design involved randomly selecting both physicians who were part of the 1998-99 survey and physicians who were not. This was true for both the site sample and the supplemental sample. Our goals in sampling the previous survey's physicians were to improve precision for estimates of overall change between the two rounds and to reduce costs. Furthermore, by sampling the previous survey's physicians, we were able to create a panel, allowing us to track changes for individual physicians between the two rounds. Our goal in also including physicians who were not part of the previous survey's sample was to account for the fact that the re-interviewed physicians might not be fully representative of all physicians. In the final sample of physicians for 2000-01, about 69 percent also participated in the 1998-99 survey.

2.4.1. Eligible Physicians

As the source for our sampling frame, we obtained the May 2000 version of the AMA Masterfile (which includes nonmembers) and the AOA membership file. To meet the initial eligibility criteria for sampling, physicians on the frame had to have completed their medical training,[7] be practicing in the contiguous United States, and be providing direct patient care for at least 20 hours per week.[8] Among those deemed initially eligible, the following types of physicians were specifically designated as ineligible for this survey and were removed from the frame:

- Specialists in fields in which the primary focus is not direct patient care[9]
- Federal employees
- Graduates of foreign medical schools who are only temporarily licensed to practice in the United States

[7] Residents, interns, and fellows were considered to be still in training.

[8] This criteria resulted in the exclusion of inactive physicians and physicians who were not office- or hospital-based (teachers, administrators, researchers, etc.).

[9] For example: radiology (including diagnostic, nuclear, pediatric, neuro-, radiation oncology, radiological physics, vascular, and interventional); anesthesiology; pain management; pain medicine; palliative medicine; pathology (including anatomic, clinical, dermato-, forensic, neuro-, chemical, cyto-, immuno-, pediatric, radioisotophic, selective); medical toxicology; aerospace medicine and undersea medicine; allergy and immunology/diagnostic laboratory; bloodbanking/transfusion medicine; clinical and laboratory dermatological immunology; forensic psychiatry; hematology; legal medicine; medical management; public health and general preventive medicine; nuclear medicine; clinical pharmacology; sleep medicine; other specialty; unspecified specialty.

We did not attempt to survey those who specifically requested to the AMA that their names not be released to outsiders. These physicians were later classified as nonrespondents for the purpose of weighting adjustments for nonresponse.

2.4.2. Stratification of Physician Sample Frames

Once we constructed our list of eligible physicians, we classified each physician on the list as either a primary care physician (PCP) or a non-primary care physician (non-PCP). PCPs were defined as those 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 non-PCPs.

After combining the AMA and AOA lists, we developed two sampling frames: one for the site sample and one for the supplemental sample. The physician's location for sampling purposes was determined by the AMA/AOA preferred mailing address.

For the site sample, we included only those physicians whose preferred mailing address fell within the boundary of one of the 60 sites. Within each site, we selected a probability sample of PCPs and a probability sample of non-PCPs, further stratified by disposition for the 1998-99 survey, and based upon an optimal sample-allocation plan. The plan resulted in 8 strata in each site.[10] PCPs were oversampled in the site sample.

For the supplemental sample, the sample frame was first divided into the following 10 geographic strata:

1. New England (CT, ME, MA, NH, RI, VT)
2. New York
3. Middle-South Atlantic (DE, NJ, PA, WV)
4. South Atlantic (DC, GA, MD, NC, SC, VA)
5. East South Central (AL, FL, KY, MS, TN)
6. West South Central (AR, LA, MO, OK, TX)
7. East North Central (IN, MI, OH)
8. North Central (IL, IA, MN, WI)
9. Mountain-Pacific (AZ, CO, ID, KS, MT, NE, NV, NM, ND, SD, OR, UT, WY, WA)
10. California

Within each of the 10 geographic strata, we selected a stratified random sample of physicians, independent of the site sample, with eight strata defined as above for the site sample. A probability sample was drawn within each of these strata.

[10] The eight strata were defined by two categories for physician type (PCP and specialist) and four categories for disposition in the previous survey (not in 1998-99 sample frame; in 1998-99 sample frame but not sampled for 1998-99; sampled for 1998-99 but did not complete 1998-99 interview; and completed 1998-99 interview).

2.4.3. Physicians Excluded from the Survey

Some physicians thought to be eligible based on the sample frame information were later classified as ineligible based on survey responses. This happened if it turned out that the physician was still in training, provided direct patient care for less than 20 hours per week, practiced in an excluded specialty, was a federal employee, or was deceased.

2.5. SURVEY CONTENT

Respondents to the survey were questioned about the following:

- Basic information on practice, specialty, and board certification
- Career satisfaction
- Physician time allocation
- Medical information obtained by patients
- Practice arrangements and ownership
- Priorities within practice
- Computer use
- Medical care management strategies and gatekeeping
- Scope of care
- Ability to provide care
- Ability to obtain needed services for patients
- Acceptance of new patients
- Practice revenue
- Compensation
- Race/ethnicity

No proxy respondents were allowed for the Physician Survey. All physicians responded to the interview for themselves. Table 2.1 shows the topics covered in the survey in more detail. Detailed documentation for the computer-assisted telephone interview program, the equivalent of a survey instrument, is provided as an appendix to the user's guides for the Physician Survey microdata files (public use and restricted use files).

2.5.1. Changes in the Physician Survey Questionnaire

The questionnaire used for the 2000-01 survey was generally similar to the ones used in 1996-97 and 1998-99. The user's guides for the 1998-99 public and restricted use data files describe the differences between the 1996-97 and 1998-99 surveys, and the main changes made for the 2000-01 survey are listed below. In addition, an appendix to the user's guides for the public use and restricted use files for the 2000-01 survey provides a table listing which variables are on the data files for which years.

Questions dropped for the 2000-01 survey

- Questions numbered D1A, D1B, and D1C in the 1998-99 survey, all related to medical care management techniques. These questions were replaced with similar questions in Section D.
- All patient care vignettes [Section E]
- Questions on practice revenue from practice's largest managed care contract [Section G]

Questions added for the 2000-01 survey

- Prevalence and effect of medical information obtained by patients from sources other than the physician [Section B]
- For physicians in medical school or non-governmental hospitals, the setting in which they spend the most time seeing patients [Section C]
- Importance of various elements of practice, such as control over working hours and clinical decisions [Section C]
- Physician's use of computers in his/her practice [Section D]
- Additional questions on awareness and effect of various medical care management techniques [Section D]
- Reasons for difficulties obtaining referrals, hospital admissions, and outpatient mental health care [Section F]
- Practice's acceptance of new uninsured patients and new patients under capitated contracts [Section F]
- Influence of physician's overall personal financial incentives on services to patients [Section H]
- Competitive situation that practice faces [Section H]

2.6. SURVEY ADMINISTRATION AND PROCESSING

The survey was administered completely by telephone, using computer-assisted telephone interviewing technology. As described earlier, all physicians were selected from list frames received from the AMA and the AOA. The survey was fielded between August 2000 and November 2001. For PCPs, the average interview length was 21.7 minutes; for non-PCPs, the average length was 20.5 minutes.

The total number of completed interviews was 12,389, with a response rate among eligibles of 58.6 percent, which is close to the response rate for the 1998-99 survey (60.1 percent when calculated using the same method used for 2000-01).[11]

Physicians were sent advance letters from the Robert Wood Johnson Foundation and were offered a $25 honorarium for participating in the survey, with the option of forwarding the honorarium to a charity.

[11] The original assumptions about unlocatable physicians used for calculating the response rate for the 1998-99 survey yielded a response rate of 60.9 percent. For information on the how the response rate for 2000-01 was calculated, see Diaz-Tena et al. (2003), which is the methodology report for the 2000-01 survey.

TABLE 2.1

CONTENTS OF THE 2000-01 PHYSICIAN SURVEY

Topic	Description
Basic Practice Information / Specialty and Certification / Career Satisfaction (Questionnaire Section A)	
Eligibility for survey	Federal employee Less than 20 hours/week Excluded specialty
Practice information	Number of practices Location of primary practice Year began medical practice
Specialty and certification	Primary specialty Board eligibility and certification
Satisfaction	Current level of satisfaction with overall career in medicine
Physician Time Allocation / Medical Information Obtained by Patients (Questionnaire Section B)	
Weeks worked	Number of weeks practiced medicine in 1999
Hours worked during last complete week of work	Hours worked in medicine during last complete week of work Hours spent in direct patient care during last complete week of work
Charity care in the last month	Hours spent in charity care in the last month
Medical information obtained by patients	Percentage of patients who obtained medical information from sources other than physician Percentage of patients for whom physician ordered tests, procedures, or prescriptions he or she would not otherwise have ordered Effect on ability to provide high-quality care Effect on efficiency
Practice Arrangements and Ownership / Priorities Within Practice (Questionnaire Section C)	
Ownership of practice	Respondent ownership Other owners Whether physician was part of a practice that was purchased during the past two years
Practice description	Type of practice Number of physicians employed Number of non-physician medical practitioners employed
Physician priorities within practice [new for 2000-01]	Importance of control over working hours Importance of control over clinical decisions Importance of potential income Importance of control over practice's business decisions

Not all items in the Physician Survey are represented on the Summary File. See Chapter 3 for a discussion of why some items were excluded.

TABLE 2.1

CONTENTS OF THE 2000-01 PHYSICIAN SURVEY
(Continued)

Computer Use / Medical Care Management Strategies / Gatekeeping / Scope of Care (Questionnaire Section D)	
Use of computers in medical practice [new for 2000-01]	Use of computers Treatments Formularies Preventive service reminders Patient notes Prescriptions Exchange of clinical data Email Internet access
Medical care management [some new questions for 2000-01]	Effect of various care management techniques on practice of medicine Practice guidelines Practice profiles Patient satisfaction surveys Formularies
PCPs	Percentage of patients for whom physician acts as gatekeeper Change in severity or complexity of patients' conditions for which care is provided without referral to specialists Appropriateness Change in number of referrals made
Non-PCPs	Changes in complexity or severity of patients' conditions at time of referral Appropriateness Change in number of referrals received
Practice Styles of Primary Care Physicians (Questionnaire Section E)	
Section E was dropped from the questionnaire for the 2000-01 survey.	

Not all items in the Physician Survey are represented on the Summary File. See Chapter 3 for a discussion of why some items were excluded.

TABLE 2.1

CONTENTS OF THE 2000-01 PHYSICIAN SURVEY
(Continued)

Ability to Provide Care / Ability to Obtain Needed Services for Patients / Acceptance of New Patients (Questionnaire Section F)	
Ability to provide care	Adequate time to spend with patients Freedom to make clinical decisions Providing high-quality care Making clinical decisions without negative effect on income Level of communication with other physicians Maintaining continuing patient relationships
Ability to obtain needed services for patients	Ability to obtain: Referrals Ancillary services Hospital admissions Adequate inpatient days Diagnostic imaging Inpatient mental health care Outpatient mental health care Reasons for difficulties obtaining: [new for 2000-01] Referrals Hospital admissions Outpatient mental health care
Acceptance of new patients	Practice accepts: New Medicare patients New Medicaid patients New privately insured patients New uninsured patients unable to pay [new for 2000-01] New patients under capitated contracts [new for 2000-01]
Practice Revenue (Questionnaire Section G)	
Public programs	Percentage of practice revenue from Medicare Percentage of practice revenue from Medicaid or other public insurance
Managed care	Percentage of practice revenue that is capitated/prepaid Number of managed care contracts Percentage of practice revenue from managed care

Not all items in the Physician Survey are represented on the Summary File. See Chapter 3 for a discussion of why some items were excluded.

TABLE 2.1

CONTENTS OF THE 2000-01 PHYSICIAN SURVEY
(Continued)

Topic	Description
Physician Compensation and Race/Ethnicity (Questionnaire Section H)	
Physician compensation	Whether physician is salaried Physician eligible to earn bonus or incentive income Factors used by practice to determine compensation
Income	Percentage of 1999 income earned in the form of bonuses, returned withholds, or other incentive payments Net income from practice of medicine in 1999
Financial incentives	Influence of physician's overall personal financial incentives on services to patients [new for 2000-01]
Competition	Competitive situation that practice faces [new for 2000-01]
Race/ethnicity	Hispanic origin Race

Not all items in the Physician Survey are represented on the Summary File. See Chapter 3 for a discussion of why some items were excluded.

CHAPTER 3

THE CTS PHYSICIAN SURVEY SUMMARY FILE

This Summary File provides summary statistics describing the characteristics of physicians in the 60 CTS sites and the nation as a whole. Those summary statistics have been calculated from data on individual physicians who were respondents for the CTS 2000-01 Physician Survey. More specifically, the summary statistics are estimates of site-level and national averages (or percentages) for selected variables from the Physician Survey's physician-level microdata files.[12] This chapter describes which information from the microdata files is included in the Summary File. The structure of the Summary File, as well as more details on its content, are described in Chapter 4.

3.1. SELECTION OF INFORMATION TO INCLUDE ON THE SUMMARY FILE

In developing the Summary File, we included summary measures for as many of the items in the Physician Survey as possible. However, we did decide to exclude most survey administration items and items for which we considered the summary estimates to be unreliable for a large number of sites, as discussed below.

In general, for each geographic area and the nation, the Summary File contains a single summary estimate (mean or percentage) for each variable on the Physician Survey microdata files. Here are examples of three different types of variables on the microdata files and how exactly they are represented on the Summary File:

- The variable GENDER from the microdata files identifies each individual physician as either male or female. On the Summary File, that variable is represented as estimates of the percentage of physicians who were males (in each site and for the nation), instead of estimates for two types of percentages (one for percentage of male physicians and another for percentage of female physicians).

- The variable PMCARE from the microdata files indicates the percentage of revenue that each individual physician's practice received from Medicare. On the Summary File, that variable is represented as estimates of the average percentage of revenue received from Medicare for physicians' practices (in each site and for the nation).

- The categorical variable CARSAT from the microdata files identifies each individual physician as being very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied, or neither satisfied nor dissatisfied with his/her overall career in medicine. On the Summary File, that variable is represented as estimates of the percentage of physicians who are very dissatisfied or somewhat dissatisfied with their overall career in medicine (in each site and for the nation).

[12] As described in the Preface and Chapter 1 of this document, the Physician Survey microdata files are data files in which each record contains data on a single physician's responses to the survey questions, such as specialty or practice size. The versions of the microdata files that are available to the public are the CTS Physician Survey Public Use File and Restricted Use File.

There are two types of exceptions to the general approach described above, and both occur infrequently. The first exception is the few cases in which the summary measure, although representing the same information as a variable on the microdata files, is not technically a mean or percentage for that variable.[13] The second exception is the few cases in which a variable from the microdata files that has multiple response categories is represented by multiple types of summary estimates on the Summary File instead of a single type of estimate.[14]

Some summary estimates were excluded from the Summary File because of concerns about their precision.[15] To determine which should be excluded, we reviewed both cell sizes and standard error for each estimate. An estimate for a particular site was included on the Summary File only when both of the following were true:

- 50 or more observations contributed to the site-level estimate,[16] and
- the relative standard error was less than 0.30.[17]

If either of these criteria was not met for an estimate for a particular site, a missing value was assigned to that estimate. If a variable from the microdata file had summary estimates that failed to match these criteria for 15 or more sites, then all summary estimates for that variable were excluded from the Summary File. Researchers interested in summary estimates for the excluded variables may want to apply for access to the Restricted Use File so that they can calculate those estimates themselves directly from the microdata.

3.2. CALCULATION OF AVERAGES AND PERCENTAGES

Weighted averages or percentages were calculated for each of the variables within each site and for the nation as a whole. The augmented site sample (site sample plus physicians from the supplemental sample that practiced within the site boundaries) was used to calculate the site-level statistics. The combined sample (site sample plus the supplemental sample) was used to calculate national-level statistics. SUDAAN statistical software was used to derive the estimates.

[13] For example, the Summary File measures labeled AGE, YRSGRAD, and YRSPRAC.

[14] For example, the variable SPECX in the microdata files is represented by multiple types of estimates in the Summary File (labeled SPECX1, SPECX2, SPECX3, SPECX4, and SPECX5).

[15] Some element of uncertainty is always associated with sample-based estimates of population characteristics because the estimates are not based on the full population. The resultant sampling error is generally measured in terms of the standard error of the estimate, or its sampling variance, which indicates the precision of an estimate. The sampling variance, which is the square of the standard error, is a measure of the variation of an estimator attributable to having sampled a portion of the full population of interest using a specific probability-based sampling design.

[16] In other words, there were observations for at least 50 physicians in the site over which the percentage or average was calculated.

[17] The "relative standard error" is the standard error of an estimate divided by the estimate itself.

CHAPTER 4

CTS PHYSICIAN SURVEY SUMMARY FILE CODEBOOK

This chapter consists of the CTS Physician Survey Summary File Codebook and provides detailed information about the Summary File and its contents.

4.1. FILE DETAILS

The file is based on data from the CTS 2000-01 Physician Survey, which was conducted between August 2000 and November 2001. The file has a separate record for each combination of geographic area (CTS site or nation) and Physician Survey item selected for inclusion on the file (see Chapter 3 for a discussion of how those items were selected). Figure 4.1 shows the file structure. Each record includes the site name, site identifier, label indicating what the summary estimate represents (in other words, which variable from the physician microdata is being summarized), mean (the summary estimate), and standard error of the mean. For example, the first record on the file shows that 67.5 percent of Boston physicians are male and that the standard error for that estimate is 3.1 percentage points. With 78 types of summary estimates (indicated by different values of VARNAME) and 61 geographic areas (60 CTS sites and the nation), there are 4,758 records on the file.

4.1.1. File Format

The CTSR3PS1.TXT file is distributed in ASCII format. Each record has the following format:

Variable Name	Description	Type	Position	
			Start	End
VARNAME	Label indicating what the summary estimate represents (which variable from the microdata file is being summarized)	Character	1	10
SITEID	Site Identifier	Numeric	11	12
SITENAME	Site Name	Character	15	32
MEAN	Average (or percent) of the variable in VARNAME for that site	Numeric	33	43
SEMEAN	Standard error of MEAN	Numeric	46	56

The file is sorted by SITEID within each separate value of VARNAME. The order of the values for VARNAME is listed in Table 4.1.

FIGURE 4.1

THE STRUCTURE OF THE CTS PHYSICIAN SUMMARY FILE

Record	VARNAME	SITEID	SITENAME	MEAN	SEMEAN
1	GENDER	1	Boston	67.4714	3.050238
2	GENDER	2	Cleveland	74.7964	2.807400
3	GENDER	3	Greenville	83.7900	2.128306
.	.	.	.	.	.
.	.	.	.	.	.
.	.	.	.	.	.
61	GENDER	61	United States	76.4476	0.554236
62	AGE	1	Boston	47.8996	0.560986
63	AGE	2	Cleveland	47.7941	0.566871
64	AGE	3	Greenville	46.7941	0.633698
.	.	.	.	.	.
.	.	.	.	.	.
122	AGE	61	United States	47.8247	0.166479
.	.	.	.	.	.
.	.	.	.	.	.

Notes to Figure 4.1:

The CTS Physician Survey Summary File has five variables per record:

VARNAME identifies the variable from the microdata files for which the summary estimate (the variable MEAN) was calculated.
SITEID and **SITENAME** identify the geographic area (CTS site or the nation as a whole).
MEAN is the mean or percentage for the site or the nation.
SEMEAN is the standard error of MEAN.

For example, in the microdata files, the variable GENDER indicates whether a physician is male. On the Summary File, the value of MEAN in records 1 through 61 (for which VARNAME = GENDER) represents the percentage of physicians who are male in each CTS site and the nation. Thus, Figure 4.1 shows that roughly 67.5 percent of practicing physicians in Boston are male, and about 74.8 percent of practicing physicians in Cleveland are male. The value of SEMEAN = 3.050238 in the first record is the standard error associated with Boston's estimated proportion of physicians who are male (MEAN=67.4714).

4.1.2. Special Codes

A value of -3 for MEAN or SEMEAN indicates a missing value for that site. Site level averages or percentages are missing either because there were too few observations in that site to make a reliable estimate or because the relative standard error for the estimate was too high. Chapter 3 describes the criteria used to determine when a missing value was assigned.

4.2. LIST OF SURVEY ITEMS ON THE SUMMARY FILE

Table 4.1 is a list of the items from the Physician Survey that are included on the Summary File. The sequence of the items in the list reflects the order of the questions on the survey and also the order of the values of VARNAME on the Summary File. Table 4.1 also provides page numbers for the detailed descriptions provided in Table 4.3. Table 4.2 provides the same information as Table 4.1 but sorted alphabetically by the variable VARNAME.

4.3. DETAILED VARIABLE DESCRIPTIONS

The remainder of this codebook (Table 4.3) contains detailed descriptions of the estimates on the Summary File. Each description contains details on who answered the survey question on which the estimate is based, as well as other relevant information. For instance, the description for estimates associated with VARNAME = WKSWRKC notes that the survey question was not asked to physicians who started practicing medicine in 1999 or later. Therefore, the estimate on the Summary File is based on responses provided by only those physicians practicing prior to 1999.

Table 4.3 also provides information on the source question(s) from the survey, the questionnaire section, and the question number.[18] The summary estimates and their standard errors for the nation and for the twelve high-intensity sites are displayed.[19] Values for the remaining CTS sites are available on the data file itself.

[18] Copies of the survey questionnaire are included in the user's guides for the public use and restricted use data files. The survey questionnaire for 2000-01 is also available as HSC Technical Publication No. 37.

[19] Please note that when comparing these means to the codebooks for the public use and restricted use data files, these are weighted statistics while the public use and restricted use file codebook frequencies are unweighted.

TABLE 4.1

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Positional Order of VARNAME)

Value of VARNAME	Description of Summary File Estimate	Page
Survey Administration Variables		
GENDER	Percentage of physicians who are males	4-12
AGE	Average age of physicians	4-13
YRSGRAD	Average number of years since graduation from medical school	4-14
Questionnaire Section A: Introduction		
YRSPRAC	Average number of years in practice	4-15
SPECX1	Percentage of physicians who are internists	4-16
SPECX2	Percentage of physicians who are family or general practitioners	4-17
SPECX3	Percentage of physicians who are pediatricians	4-18
SPECX4	Percentage of physicians who are medical specialists	4-19
SPECX5	Percentage of physicians who are surgical specialists	4-20
PCPFLAG	Percentage of physicians who are primary care physicians	4-21
BDCERT	Percentage of physicians who are board certified in any specialty or subspecialty	4-22
CARSAT	Percentage of physicians who are either very or somewhat dissatisfied with their overall career in medicine	4-23
Questionnaire Section B: Utilization of Time		
WKSWRKC	Average weeks practiced medicine in 1999	4-24
HRSMED	Average hours during the previous week spent in medically-related activities	4-25
HRSPAT	Average hours during the previous week spent in direct patient care	4-26
HRFREE	Average hours during the previous month spent providing charity care	4-27
PATINFO	Average percentage of patients who talk about medical information from other sources	4-28
PATACT	Average percentage of patients for whom physician orders tests etc. suggested by patients	4-29
EFINFO2	Percentage of physicians reporting no effect of other medical information on high quality care	4-30
EFINFO3	Percentage of physicians reporting positive effect of other medical information on high quality care	4-31
EFEFF1	Percentage of physicians reporting negative effect of other medical information on efficiency	4-32
EFEFF2	Percentage of physicians reporting no effect of other medical information on efficiency	4-33
EFEFF3	Percentage of physicians reporting positive effect of other medical information on efficiency	4-34
Questionnaire Section C: Type and Size of Practice		
OWNPR	Percentage of physicians who are not full- or part- owners of the practice in which they work	4-35

TABLE 4.1

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Positional Order of VARNAME)

Value of VARNAME	Description of Summary File Estimate	Page
PRCTYPE1	Percentage of physicians who work in solo or two-physician practices	4-36
PRCTYPE2	Percentage of physicians who work in group practices with three or more physicians	4-37
CTL_WRK	Percentage of physicians reporting that control over working hours is very important	4-38
CTL_DEC	Percentage of physicians reporting that control over clinical decisions is very important	4-39
CTL_INC	Percentage of physicians reporting that control over potential income is very important	4-40
CTL_BUS	Percentage of physicians reporting that control over business decisions is very important	4-41
Questionnaire Section D: Medical Care Management		
IT_TRT	Percentage of physicians whose practices use computers to obtain information on treatments	4-42
IT_FORM	Percentage of physicians whose practices use computers to obtain information on formularies	4-43
ITRMNDR	Percentage of physicians whose practices use computers to generate reminders	4-44
ITNOTES	Percentage of physicians whose practices use computers to access patient notes	4-45
ITCLIN	Percentage of physicians whose practices use computers for clinical data and image exchanges	4-46
ITCOMM	Percentage of physicians whose practices use computers to communicate with patients	4-47
ACC_INT	Percentage of physicians with Internet access at place where providing patient care	4-48
FORMLRY	Average percentage of patients with formulary	4-49
EFGUIDE	Percentage of physicians indicating that the use of written guidelines had either no or a very small effect on their practice of medicine	4-50
EFPROFL	Percentage of physicians indicating that the results of practice profiles had either no or a very small effect on their practice of medicine	4-51
EFSURV	Percentage of physicians indicating that patient satisfaction surveys had either no or a very small effect on their practice of medicine	4-52
CMPPROV	Percentage of primary care physicians indicating increased complexity or severity of patient's conditions for which they provided care without referral in the last two years	4-53
CMPEXPC	Percentage of physicians indicating that the complexity or severity of patient's conditions for which they provide care without referral to specialists is either somewhat or much greater than it should be	4-54
PCTGATE	Average percentage of patients in their practice for whom the physician serves as a gatekeeper	4-55

TABLE 4.1

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Positional Order of VARNAME)

Value of VARNAME	Description of Summary File Estimate	Page
Questionnaire Section F – Physician/Patient Interactions		
ADQTIME	Percentage of physicians who either somewhat or strongly agree that they have adequate time to spend with their patients during typical office visits	4-56
CLNFREE	Percentage of physicians who either somewhat or strongly agree that they have the freedom to make clinical decisions that meet their patient's needs	4-57
HIGHCAR	Percentage of physicians who either somewhat or strongly agree that it is possible to provide high quality care to all of their patients	4-58
NEGINCN	Percentage of physicians who either somewhat or strongly agree that they can make clinical decisions in the best interests of their patients without the possibility of reducing their income	4-59
USESPCS	Percentage of primary care physicians who either somewhat or strongly agree that the level of communication they have with specialists about the patients they refer is sufficient to ensure high quality of care	4-60
COMMALL	Percentage of physicians who either somewhat or strongly agree that the level of communication they have with specialists (or primary care physicians) about the patients they refer (or who have been referred to them) is sufficient to ensure high quality of care	4-61
PATREL	Percentage of physicians who either somewhat or strongly agree that they can maintain continuing relationships with patients over time that promote the delivery of high quality care	4-62
OBREFS	Percentage of physicians who are either always or almost always able to obtain referrals to specialists when they think it is medically necessary	4-63
OBANCL	Percentage of physicians who are either always or almost always able to obtain ancillary services for their patients when medically necessary	4-64
OBHOSP	Percentage of physicians who are either always or almost always able to obtain non-emergency hospital admissions when they think it is medically necessary	4-65
OBINPAT	Percentage of physicians who are either always or almost always able to obtain an adequate number of inpatient days for their hospitalized patients when they think it is medically necessary	4-66
OBIMAG	Percentage of physicians who are either always or almost always able to obtain diagnostic imaging services for their patients when they think it is medically necessary	4-67
OBMENTL	Percentage of primary care physicians who are either always or almost always able to obtain inpatient mental care for their patients when they think it is medically necessary	4-68
OBOUTPT	Percentage of physicians who are either always or almost always able to obtain outpatient mental care for their patients when they think it is medically necessary	4-69
NWMCARE	Percentage of physicians whose practice is accepting either some or no new Medicare patients	4-70
NWMCAID	Percentage of physicians whose practice is accepting either some or no new Medicaid patients	4-71

TABLE 4.1

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Positional Order of VARNAME)

Value of VARNAME	Description of Summary File Estimate	Page
NWPRIV	Percentage of physicians whose practice is accepting either some or no new privately insured patients	4-72
NWNPAY	Percentage of physicians with limited acceptance of new patients unable to pay	4-73
ACC_CAP	Percentage of physicians accepting new patients under capitated contracts	4-74
Questionnaire Section G: Practice Revenue		
PMCARE	Average percentage of patient care practice revenue from Medicare	4-75
PMCAID	Average percentage of patient care practice revenue from Medicaid	4-76
PCAPREV	Average percentage of patient care practice revenue paid on a capitated or other prepaid basis	4-77
NMCCON	Percentage of physicians in practices who have more than 15 managed care contracts	4-78
PMC	Average percentage of patient care revenue from managed care	4-79
Questionnaire Section H - Physician Compensation Methods & Income Level		
SALPAID	Percentage of physicians who are salaried	4-80
SPROD	Percentage of physicians indicating that their compensation is affected by their own productivity	4-81
PCTINCC	Average percentage of a physician's 1999 practice income that was earned from bonuses, returned withdrawals, or other incentive payments	4-82
INCOMEX	Average 1999 net income received from the practice of medicine	4-83
INCENT2	Percentage of physicians whose financial incentives favor expanding services	4-84
INCENT3	Percentage of physicians whose financial incentives favor neither expanding nor reducing services	4-85
COMPETE1	Percentage of physicians reporting that competitive situation their practice faces is not competitive	4-86
COMPETE2	Percentage of physicians reporting that competitive situation their practice faces is somewhat competitive	4-87
COMPETE3	Percentage of physicians reporting that competitive situation their practice faces is very competitive	4-88
RACEWH	Percentage of physicians who are white	4-89

TABLE 4.2

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Alphabetical Order of VARNAME)

Value of VARNAME	Description of Summary File Estimates	Page
ACC_CAP	Percentage of physicians accepting new patients under capitated contracts	4-74
ACC_INT	Percentage of physicians with Internet access at place where providing patient care	4-48
ADQTIME	Percentage of physicians who either somewhat or strongly agree that they have adequate time to spend with their patients during typical office visits	4-56
AGE	Average age of physicians	4-13
BDCERT	Percentage of physicians who are board certified in any specialty or subspecialty	4-22
CARSAT	Percentage of physicians who are either very or somewhat dissatisfied with their overall career in medicine	4-23
CLNFREE	Percentage of physicians who either somewhat or strongly agree that they have the freedom to make clinical decisions that meet their patient's needs	4-57
CMPEXPC	Percentage of physicians indicating that the complexity or severity of patient's conditions for which they provide care without referral to specialists is either somewhat or much greater than it should be	4-54
CMPPROV	Percentage of primary care physicians indicating increased complexity or severity of patient's conditions for which they provided care without referral in the last two years	4-53
COMMALL	Percentage of physicians who either somewhat or strongly agree that the level of communication they have with specialists (or primary care physicians) about the patients they refer (or who have been referred to them) is sufficient to ensure high quality of care	4-61
COMPETE1	Percentage of physicians reporting that competitive situation their practice faces is not competitive	4-86
COMPETE2	Percentage of physicians reporting that competitive situation their practice faces is somewhat competitive	4-87
COMPETE3	Percentage of physicians reporting that competitive situation their practice faces is very competitive	4-88
CTL_BUS	Percentage of physicians reporting that control over business decisions is very important	4-41
CTL_DEC	Percentage of physicians reporting that control over clinical decisions is very important	4-39
CTL_INC	Percentage of physicians reporting that control over potential income is very important	4-40
CTL_WRK	Percentage of physicians reporting that control over working hours is very important	4-38
EFEFF1	Percentage of physicians reporting negative effect of other medical information on efficiency	4-32
EFEFF2	Percentage of physicians reporting no effect of other medical information on efficiency	4-33

TABLE 4.2

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Alphabetical Order of VARNAME)

Value of VARNAME	Description of Summary File Estimates	Page
EFEFF3	Percentage of physicians reporting positive effect of other medical information on efficiency	4-34
EFGUIDE	Percentage of physicians indicating that the use of written guidelines had either no or a very small effect on their practice of medicine	4-50
EFINFO2	Percentage of physicians reporting no effect of other medical information on high quality care	4-30
EFINFO3	Percentage of physicians reporting positive effect of other medical information on high quality care	4-31
EFPROFL	Percentage of physicians indicating that the results of practice profiles had either no or a very small effect on their practice of medicine	4-51
EFSURV	Percentage of physicians indicating that patient satisfaction surveys had either no or a very small effect on their practice of medicine	4-52
FORMLRY	Average percentage of patients with formulary	4-49
GENDER	Percentage of physicians who are males	4-12
HIGHCAR	Percentage of physicians who either somewhat or strongly agree that it is possible to provide high quality care to all of their patients	4-58
HRFREE	Average hours during the previous month spent providing charity care	4-27
HRSMED	Average hours during the previous week spent in medically-related activities	4-25
HRSPAT	Average hours during the previous week spent in direct patient care	4-26
INCENT2	Percentage of physicians whose financial incentives favor expanding services	4-84
INCENT3	Percentage of physicians whose financial incentives favor neither expanding nor reducing services	4-85
INCOMEX	Average 1999 net income received from the practice of medicine	4-83
IT_FORM	Percentage of physicians whose practices use computers to obtain information on formularies	4-43
IT_TRT	Percentage of physicians whose practices use computers to obtain information on treatments	4-42
ITCLIN	Percentage of physicians whose practices use computers for clinical data and image exchanges	4-46
ITCOMM	Percentage of physicians whose practices use computers to communicate with patients	4-47
ITNOTES	Percentage of physicians whose practices use computers to access patient notes	4-45
ITRMNDR	Percentage of physicians whose practices use computers to generate reminders	4-44
NEGINCN	Percentage of physicians who either somewhat or strongly agree that they can make clinical decisions in the best interests of their patients without the possibility of reducing their income	4-59
NMCCON	Percentage of physicians in practices who have more than 15 managed care contracts	4-78

TABLE 4.2

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Alphabetical Order of VARNAME)

Value of VARNAME	Description of Summary File Estimates	Page
NWMCAID	Percentage of physicians whose practice is accepting either some or no new Medicaid patients	4-71
NWMCARE	Percentage of physicians whose practice is accepting either some or no new Medicare patients	4-70
NWNPAY	Percentage of physicians with limited acceptance of new patients unable to pay	4-73
NWPRIV	Percentage of physicians whose practice is accepting either some or no new privately insured patients	4-72
OBANCL	Percentage of physicians who are either always or almost always able to obtain ancillary services for their patients when medically necessary	4-64
OBHOSP	Percentage of physicians who are either always or almost always able to obtain non-emergency hospital admissions when they think it is medically necessary	4-65
OBIMAG	Percentage of physicians who are either always or almost always able to obtain diagnostic imaging services for their patients when they think it is medically necessary	4-67
OBINPAT	Percentage of physicians who are either always or almost always able to obtain an adequate number of inpatient days for their hospitalized patients when they think it is medically necessary	4-66
OBMENTL	Percentage of primary care physicians who are either always or almost always able to obtain inpatient mental care for their patients when they think it is medically necessary	4-68
OBOUTPT	Percentage of physicians who are either always or almost always able to obtain outpatient mental care for their patients when they think it is medically necessary	4-69
OBREFS	Percentage of physicians who are either always or almost always able to obtain referrals to specialists when they think it is medically necessary	4-63
OWNPR	Percentage of physicians who are not full- or part- owners of the practice in which they work	4-35
PATACT	Average percentage of patients for whom physician orders tests etc. suggested by patients	4-29
PATINFO	Average percentage of patients who talk about medical information from other sources	4-28
PATREL	Percentage of physicians who either somewhat or strongly agree that they can maintain continuing relationships with patients over time that promote the delivery of high quality care	4-62
PCAPREV	Average percentage of patient care practice revenue paid on a capitated or other prepaid basis	4-77
PCPFLAG	Percentage of physicians who are primary care physicians	4-21
PCTGATE	Average percentage of patients in their practice for whom the physician serves as a gatekeeper	4-55
PCTINCC	Average percentage of a physician's 1999 practice income that was earned from bonuses, returned withdrawals, or other incentive payments	4-82

TABLE 4.2

ESTIMATES ON THE CTS 2000-01 PHYSICIAN SUMMARY FILE
(Alphabetical Order of VARNAME)

Value of VARNAME	Description of Summary File Estimates	Page
PMC	Average percentage of patient care revenue from managed care	4-79
PMCAID	Average percentage of patient care practice revenue from Medicaid	4-76
PMCARE	Average percentage of patient care practice revenue from Medicare	4-75
PRCTYPE1	Percentage of physicians who work in solo or two-physician practices	4-36
PRCTYPE2	Percentage of physicians who work in group practices with three or more physicians	4-37
RACEWH	Percentage of physicians who are white	4-89
SALPAID	Percentage of physicians who are salaried	4-80
SPECX1	Percentage of physicians who are internists	4-16
SPECX2	Percentage of physicians who are family or general practitioners	4-17
SPECX3	Percentage of physicians who are pediatricians	4-18
SPECX4	Percentage of physicians who are medical specialists	4-19
SPECX5	Percentage of physicians who are surgical specialists	4-20
SPROD	Percentage of physicians indicating that their compensation is affected by their own productivity	4-81
USESPCS	Percentage of primary care physicians who either somewhat or strongly agree that the level of communication they have with specialists about the patients they refer is sufficient to ensure high quality of care	4-60
WKSWRKC	Average weeks practiced medicine in 1999	4-24
YRSGRAD	Average number of years since graduation from medical school	4-14
YRSPRAC	Average number of years in practice	4-15

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

GENDER Gender

Description: The percentage of physicians who are male.

Derived from: This information was obtained from the AMA and AOA.

	PERCENT	STANDARD ERROR
National	76%	0.55
SITE		
Boston	67	3.05
Cleveland	75	2.81
Greenville	84	2.13
Indianapolis	75	3.00
Lansing	76	2.72
Little Rock	82	2.56
Miami	79	2.51
Newark	67	3.40
Orange County	79	3.30
Phoenix	80	2.33
Seattle	65	3.09
Syracuse	80	2.35

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

AGE Physician's age

Description: The average age of physicians. The age of the physician was derived by calculating the difference between the interview year and the year of birth.

Derived from: Based on year of birth obtained from the AMA and AOA.

	AVERAGE	STANDARD ERROR
National	48 years	0.17
SITE		
Boston	48	0.56
Cleveland	48	0.57
Greenville	47	0.63
Indianapolis	46	0.52
Lansing	49	0.52
Little Rock	48	0.56
Miami	50	0.63
Newark	51	0.70
Orange County	49	0.91
Phoenix	49	0.58
Seattle	47	0.45
Syracuse	48	0.53

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

YRSGRAD Number of years since graduation from medical school

Description: The average number of years since graduation from medical school, derived by calculating the difference between the year of the interview and the year the physician graduated from medical school.

Derived from: Based on year graduated from medical school, obtained from the AMA and AOA.

	AVERAGE	STANDARD ERROR
National	21 years	0.17
SITE		
Boston	21	0.58
Cleveland	21	0.61
Greenville	20	0.65
Indianapolis	19	0.54
Lansing	21	0.51
Little Rock	21	0.61
Miami	23	0.62
Newark	25	0.74
Orange County	23	0.93
Phoenix	21	0.51
Seattle	19	0.45
Syracuse	21	0.57

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

YRSPRAC Number of years in practice

Description: The average number of years in practice. Derived by calculating the difference between the interview year and the year the physician began to practice medicine.

Derived from: Questionnaire Section A, Question A6

	AVERAGE	STANDARD ERROR
National	15 years	0.12
SITE		
Boston	15	0.62
Cleveland	15	0.56
Greenville	15	0.67
Indianapolis	14	0.53
Lansing	16	0.54
Little Rock	15	0.65
Miami	16	0.61
Newark	19	0.75
Orange County	17	0.88
Phoenix	16	0.53
Seattle	14	0.45
Syracuse	15	0.55

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPECX1 Percentage of physicians who are internists

Description: The percentage of physicians who are internists (internal medicine). This includes physicians whose specialty and/or subspecialty are adolescent medicine/internal medicine, geriatrics/internal medicine, or internal medicine. It excludes family or general practitioners, pediatricians, and medical and surgical specialists (including psychiatry and obstetrics/gynecology).

Derived from: Based on responses to Questionnaire Section A, Questions A8 (physician's specialty) and A10 (physician's subspecialty). Refer to the description of the variable SPECX in the CTS Physician Survey Public Use File: User's Guide for more information concerning how physician specialties and sub-specialties are categorized.

	PERCENT	STANDARD ERROR
National	15%	0.57
SITE		
Boston	19	1.59
Cleveland	15	1.61
Greenville	12	1.65
Indianapolis	10	1.36
Lansing	8	1.48
Little Rock	10	1.53
Miami	15	1.75
Newark	20	2.14
Orange County	16	2.07
Phoenix	12	1.51
Seattle	12	1.42
Syracuse	10	1.30

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPECX2 Percentage of physicians who are family/general practitioners

Description: The percentage of physicians who are family or general practitioners. This includes physicians whose specialty and/or subspecialty are family/general practice, geriatrics-family/general practice, or adolescent medicine-general practice. It excludes internists, pediatricians, and medical and surgical specialists (including psychiatry and obstetrics/gynecology).

Derived from: Based on responses to Questionnaire Section A, Questions A8 (physician's specialty) and A10 (physician's subspecialty). Refer to the description of the variable SPECX in the CTS Physician Survey Public Use File: User's Guide for more information concerning how physician specialties and sub-specialties are categorized.

	PERCENT	STANDARD ERROR
National	17%	0.54
SITE		
Boston	5	0.81
Cleveland	11	1.23
Greenville	20	1.81
Indianapolis	18	1.48
Lansing	27	2.25
Little Rock	15	1.63
Miami	13	1.57
Newark	7	1.25
Orange County	15	1.81
Phoenix	18	1.49
Seattle	25	2.04
Syracuse	17	1.55

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPECX3 Percentage of physicians who are pediatricians

Description: The percentage of physicians who are pediatricians. This includes physicians whose specialty and/or subspecialty are pediatrics, adolescent medicine, or internal medicine-pediatrics. It excludes internists, medical and surgical specialists, and family or general practitioners. Psychiatry is categorized as a medical specialty, while obstetrics/gynecology is categorized as a surgical specialty.

Derived from: Based on responses to Questionnaire Section A, Questions A8 (physician's specialty) and A10 (physician's subspecialty). Refer to the description of the variable SPECX in the *CTS Physician Survey Public Use File: User's Guide* for more information concerning how physician specialties and sub-specialties are categorized.

	PERCENT	STANDARD ERROR
National	8%	0.28
SITE		
Boston	8	0.92
Cleveland	8	1.03
Greenville	5	0.72
Indianapolis	9	1.26
Lansing	6	0.99
Little Rock	7	0.96
Miami	12	1.46
Newark	10	1.39
Orange County	6	1.01
Phoenix	9	1.17
Seattle	5	0.83
Syracuse	10	1.53

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPECX4 Percentage of physicians who are medical specialists

Description: The percentage of physicians who are medical specialists. This category is based on 84 physician specialty and subspecialty classifications including allergy, immunology, cardiology, and diabetes, etc. It also includes psychiatry. This category excludes surgical specialists, internists, pediatricians, and family or general practitioners. Surgical specialties include obstetrics/gynecology.

Derived from: Based on responses to Questionnaire Section A, Questions A8 (physician's specialty) and A10 (physician's subspecialty). Refer to the description of the variable SPECX in the *CTS Physician Survey Public Use File: User's Guide* for more information concerning how physician specialties and sub-specialties are categorized.

	PERCENT	STANDARD ERROR
National	35%	0.67
SITE		
Boston	43	3.12
Cleveland	47	3.33
Greenville	29	3.24
Indianapolis	37	3.27
Lansing	32	3.04
Little Rock	40	3.56
Miami	36	3.14
Newark	40	3.76
Orange County	30	3.92
Phoenix	36	3.07
Seattle	36	3.16
Syracuse	39	3.15

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPECX5 Percentage of physicians who are surgical specialists

Description: The percentage of physicians who are surgical specialists. This category is based on 46 physician specialty and subspecialty surgical classifications. It also includes obstetrics/gynecology. This category excludes medical specialists, internists, pediatricians, and family or general practitioners. Medical specialties include psychiatry.

Derived from: Based on responses to Questionnaire Section A, Questions A8 (physician's specialty) and A10 (physician's subspecialty). Refer to the description of the variable SPECX in the *CTS Physician Survey Public Use File: User's Guide* for more information concerning how physician specialties and sub-specialties are categorized.

	PERCENT	STANDARD ERROR
National	25%	0.64
SITE		
Boston	25	2.98
Cleveland	19	3.00
Greenville	34	3.48
Indianapolis	26	3.22
Lansing	27	3.30
Little Rock	28	3.45
Miami	23	3.27
Newark	23	3.41
Orange County	32	4.28
Phoenix	26	3.16
Seattle	22	2.87
Syracuse	25	2.99

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PCPFLAG Percentage of physicians who are primary care physicians

Description: The percentage of physicians who are primary care physicians. Physicians are considered to be primary care if their specialty is one of the following: (1) family practice, geriatric medicine, general practice, or adolescent medicine; (2) internal medicine, pediatrics, internal medicine-pediatrics and spends the most time in this specialty; (3) an adult specialist that spends more time practicing general internal medicine than practicing a subspecialty; or (4) a pediatric specialist that spends more time practicing general pediatrics than practicing a subspecialty.

Derived from: Questionnaire Section A, Questions A8, A9, A9a, A9b, and A10.

	PERCENT	STANDARD ERROR
National	40%	0.71
SITE		
Boston	32	1.78
Cleveland	34	2.02
Greenville	37	2.23
Indianapolis	37	2.02
Lansing	41	2.28
Little Rock	32	2.07
Miami	41	2.42
Newark	37	2.67
Orange County	37	2.84
Phoenix	38	2.09
Seattle	42	2.36
Syracuse	37	1.88

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

BDCERT Board certification status

Description: The percentage of physicians who are board certified in any specialty or subspecialty.

Derived from: Questionnaire Section A, Questions A11, A13, A15, and A17.

	PERCENT	STANDARD ERROR
National	89%	0.65
SITE		
Boston	91	1.70
Cleveland	86	2.07
Greenville	98	0.68
Indianapolis	90	2.10
Lansing	90	1.51
Little Rock	90	1.66
Miami	79	2.34
Newark	88	2.11
Orange County	86	2.90
Phoenix	88	2.15
Seattle	93	1.36
Syracuse	91	1.79

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CARSAT Overall career satisfaction

Description: The percentage of physicians who are either very dissatisfied or somewhat dissatisfied with their overall career in medicine. Physicians could respond that they were generally very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied, or neither satisfied nor dissatisfied.

Derived from: Questionnaire Section A, Question A19.

	PERCENT	STANDARD ERROR
National	18%	0.47
SITE		
Boston	19	2.72
Cleveland	17	2.61
Greenville	12	2.34
Indianapolis	16	2.52
Lansing	12	2.35
Little Rock	15	2.59
Miami	23	2.64
Newark	17	2.37
Orange County	22	3.73
Phoenix	24	2.76
Seattle	15	2.05
Syracuse	19	3.05

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

WKSWRKC Weeks practicing medicine in 1999

Description: The average number of weeks that physicians practiced medicine in 1999. Physicians who began practicing medicine during 1999 or later were excluded.

Derived from: Questionnaire Section B, Question B1.

	AVERAGE	STANDARD ERROR
National	47 weeks	0.06
SITE		
Boston	46	0.40
Cleveland	47	0.37
Greenville	48	0.21
Indianapolis	47	0.40
Lansing	47	0.30
Little Rock	48	0.19
Miami	47	0.69
Newark	47	0.29
Orange County	48	0.32
Phoenix	46	0.45
Seattle	46	0.29
Syracuse	47	0.29

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

HRSMED Hours during previous week spent in medically-related activities

Description: The average number of hours during the last full week of work that each physician in the site spent in medically-related activities, including direct patient care.

Derived from: Questionnaire Section B, Questions B2, B3c, and B4.

	AVERAGE	STANDARD ERROR
National	54 hours	0.17
SITE		
Boston	54	1.07
Cleveland	56	1.08
Greenville	56	0.84
Indianapolis	56	0.93
Lansing	55	1.60
Little Rock	54	1.04
Miami	55	1.00
Newark	52	1.17
Orange County	56	1.78
Phoenix	56	1.07
Seattle	51	0.90
Syracuse	54	1.15

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

HRSPAT Hours during previous week spent in direct patient care activities

Description: The average number of hours during the last full week of work that each physician in the site spent in direct patient care activities.

Derived from: Questionnaire Section B, Questions B3, B3d, and B5.

	AVERAGE	STANDARD ERROR
National	47 hours	0.17
SITE		
Boston	44	1.06
Cleveland	48	1.03
Greenville	49	0.83
Indianapolis	47	0.97
Lansing	46	1.28
Little Rock	46	1.05
Miami	47	1.01
Newark	44	1.21
Orange County	47	1.42
Phoenix	49	1.04
Seattle	43	0.83
Syracuse	46	1.20

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

HRFREE Hours during previous month spent providing charity care

Description: The average number of hours during the last month that each physician in the site spent providing charity care.

Derived from: Questionnaire Section B, Question B6.

	AVERAGE	STANDARD ERROR
National	8 hours	0.26
SITE		
Boston	9	1.16
Cleveland	7	0.73
Greenville	10	1.23
Indianapolis	6	0.70
Lansing	6	0.98
Little Rock	7	0.87
Miami	13	1.53
Newark	13	2.07
Orange County	10	2.11
Phoenix	8	1.61
Seattle	7	0.73
Syracuse	6	0.62

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PATINFO Patients who talk about medical information from other sources

Description: Average percentage of physicians' patients who talked about medical conditions, tests, treatments, or drugs that they had read or heard about from sources other than the physicians. For physicians who indicated the percentage of patients was not zero but was less than one, a value of 0.5% was used in calculating the average percentage.

Derived from: Questionnaire Section B, Question B7.

	AVERAGE	STANDARD ERROR
National	18%	0.27
SITE		
Boston	19	1.27
Cleveland	18	1.34
Greenville	16	1.01
Indianapolis	18	1.42
Lansing	16	1.11
Little Rock	18	1.49
Miami	19	1.28
Newark	19	1.16
Orange County	18	1.31
Phoenix	20	1.60
Seattle	20	1.72
Syracuse	16	1.29

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PATACT Physician orders tests etc. suggested by patients

Description: Average percentage of physicians' patients for whom the physician ordered tests, procedures, or prescriptions suggested by patients that the physician would not otherwise have ordered. For physicians who indicated the percentage of patients was not zero but was less than one, a value of 0.5% was used in calculating the average percentage.

Derived from: Questionnaire Section B, Question B9.

	AVERAGE	STANDARD ERROR
National	4%	0.11
SITE		
Boston	3	0.28
Cleveland	4	0.54
Greenville	3	0.26
Indianapolis	3	0.40
Lansing	6	1.56
Little Rock	3	0.34
Miami	4	0.44
Newark	4	0.42
Orange County	5	0.44
Phoenix	4	0.56
Seattle	4	0.39
Syracuse	3	0.31

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFINFO2 No effect of other medical information on high quality care

Description: Percentage of physicians who think that there is neither a positive nor negative effect of medical information obtained by their patients from other sources (i.e., other than the physicians) on their (i.e., the physicians') ability to provide high quality care. Physicians could respond that the effect was generally positive, generally negative, or neither.

Derived from: Questionnaire Section B, Question B10.

	PERCENT	STANDARD ERROR
National	36%	0.60
SITE		
Boston	38	3.19
Cleveland	37	3.49
Greenville	38	3.29
Indianapolis	37	3.22
Lansing	35	3.33
Little Rock	34	3.42
Miami	35	3.28
Newark	36	3.60
Orange County	41	4.28
Phoenix	36	3.14
Seattle	40	3.24
Syracuse	32	2.87

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFINFO3 Positive effect of other medical information on high quality care

Description: Percentage of physicians who think that there is a generally positive effect of medical information obtained by their patients from other sources (i.e., other than the physicians) on their (i.e., the physicians') ability to provide high quality care. Physicians could respond that the effect was generally positive, generally negative, or neither.

Derived from: Questionnaire Section B, Question B10.

	PERCENT	STANDARD ERROR
National	49%	0.71
SITE		
Boston	45	3.23
Cleveland	49	3.53
Greenville	50	3.58
Indianapolis	52	3.40
Lansing	57	3.47
Little Rock	54	3.65
Miami	45	3.41
Newark	51	3.87
Orange County	48	4.24
Phoenix	49	3.26
Seattle	46	3.26
Syracuse	53	3.29

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFEFF1 Negative effect of other medical information on efficiency

Description: Percentage of physicians who think that there is a generally negative effect of medical information obtained by their patients from other sources (i.e., other than the physicians) on their (i.e., the physicians') efficiency. Physicians could respond that the effect was generally positive, generally negative, or neither.

Derived from: Questionnaire Section B, Question B11.

	PERCENT	STANDARD ERROR
National	30%	0.71
SITE		
Boston	32	3.01
Cleveland	30	3.30
Greenville	35	3.59
Indianapolis	39	3.33
Lansing	28	3.09
Little Rock	24	2.73
Miami	24	3.01
Newark	21	2.49
Orange County	25	3.55
Phoenix	33	2.98
Seattle	37	3.06
Syracuse	35	3.20

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFEFF2 No effect of other medical information on efficiency

Description: Percentage of physicians who think that there is neither a negative nor positive effect of medical information obtained by their patients from other sources (i.e., other than the physicians) on their (i.e., the physicians') efficiency. Physicians could respond that the effect was generally positive, generally negative, or neither.

Derived from: Questionnaire Section B, Question B11.

	PERCENT	STANDARD ERROR
National	43%	0.60
SITE		
Boston	47	3.17
Cleveland	41	3.50
Greenville	38	3.10
Indianapolis	35	3.10
Lansing	34	3.14
Little Rock	48	3.66
Miami	41	3.25
Newark	52	3.77
Orange County	43	4.19
Phoenix	42	3.18
Seattle	46	3.25
Syracuse	47	3.33

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFEFF3 Positive effect of other medical information on efficiency

Description: Percentage of physicians who think that there is a generally positive effect of medical information obtained by their patients from other sources (i.e., other than the physicians) on their (i.e., the physicians') efficiency. Physicians could respond that the effect was generally positive, generally negative, or neither.

Derived from: Questionnaire Section B, Question B11.

	PERCENT	STANDARD ERROR
National	27%	0.56
SITE		
Boston	21	2.61
Cleveland	30	3.17
Greenville	27	3.32
Indianapolis	26	3.09
Lansing	38	3.48
Little Rock	29	3.60
Miami	35	3.09
Newark	27	3.44
Orange County	32	3.94
Phoenix	25	2.72
Seattle	17	2.17
Syracuse	19	2.27

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OWNPR Ownership status of physician's practice

Description: The percentage of physicians who are not full or part-owners of the practice in which they work.

Derived from: Questionnaire Section C, Question C1.

	PERCENT	STANDARD ERROR
National	44%	0.87
SITE		
Boston	58	3.05
Cleveland	55	3.49
Greenville	49	3.48
Indianapolis	51	3.31
Lansing	48	3.28
Little Rock	45	3.52
Miami	37	3.13
Newark	33	3.52
Orange County	27	3.94
Phoenix	39	3.05
Seattle	49	3.17
Syracuse	40	2.96

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PRCTYPE1 Physician's practice type is solo or two physicians

Description: The percentage of physicians who work in solo or two physician practices. Physician's type of practice was categorized into one of six classifications: solo or two physicians, a group of three or more physicians, staff or group model HMO, medical school, hospital-based, or all other (other insurance, integrated health, freestanding clinic, physician practice management, community health center, management services organization (MSO), physician hospital organization (PHO), and locum tenens).

Derived from: Questionnaire Section C, Questions C2, C3, C3a, C3b, and C9. Refer to the description of the variable PRCTYPE in the *CTS Physician Survey Public Use File: User's Guide* for information about how the ownership and employment were combined to determine practice type.

	PERCENT	STANDARD ERROR
National	35%	0.79
SITE		
Boston	27	2.75
Cleveland	32	3.45
Greenville	23	3.02
Indianapolis	18	2.33
Lansing	28	3.28
Little Rock	29	3.29
Miami	54	3.28
Newark	56	3.72
Orange County	48	4.15
Phoenix	44	3.18
Seattle	26	2.79
Syracuse	32	3.13

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PRCTYPE2 Physician's practice type is a group of three or more physicians

Description: The percentage of physicians who work in group practices with three or more physicians. Physician's type of practice was categorized into one of six classifications: solo or two physicians, a group of three or more physicians, staff or group model HMO, medical school, hospital based, or all other (other insurance, integrated health, freestanding clinic, physician practice management, community health center, management services organization (MSO), physician hospital organization (PHO), and locum tenens).

Derived from: Questionnaire Section C, Questions C2, C3, C3a, C3b, and C9. Refer to the description of the variable PRCTYPE in the *CTS Physician Survey Public Use File: User's Guide* for information about how the ownership and employment were combined to determine practice type.

	PERCENT	STANDARD ERROR
National	30%	0.87
SITE		
Boston	27	2.80
Cleveland	22	2.81
Greenville	38	3.34
Indianapolis	45	3.39
Lansing	28	3.17
Little Rock	33	3.51
Miami	20	2.56
Newark	25	3.32
Orange County	31	3.79
Phoenix	31	3.03
Seattle	29	2.90
Syracuse	37	3.29

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CTL_WRK Control over working hours is very important

Description: Percentage of physicians who report that control over their working hours is very important, i.e., rated 10 on a scale from 1 (not important) to 10 (very important).

Derived from: Questionnaire Section C, Question C12A.

	PERCENT	STANDARD ERROR
National	49%	0.68
SITE		
Boston	43	3.19
Cleveland	44	3.50
Greenville	40	3.39
Indianapolis	38	3.24
Lansing	51	3.39
Little Rock	48	3.65
Miami	44	3.19
Newark	54	3.77
Orange County	48	4.17
Phoenix	51	3.20
Seattle	45	3.21
Syracuse	39	3.07

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CTL_DEC Control over clinical decisions is very important

Description: Percentage of physicians who report that control over their clinical decisions is very important, i.e., rated 10 on a scale from 1 (not important) to 10 (very important).

Derived from: Questionnaire Section C, Question C12B.

	PERCENT	STANDARD ERROR
National	76%	0.53
SITE		
Boston	73	2.85
Cleveland	80	2.30
Greenville	80	3.05
Indianapolis	72	2.98
Lansing	76	2.59
Little Rock	82	2.55
Miami	76	3.08
Newark	83	2.70
Orange County	71	3.82
Phoenix	77	2.77
Seattle	73	2.60
Syracuse	81	2.44

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CTL_INC Control over potential income is very important

Description: Percentage of physicians who report that control over their potential income is very important, i.e., rated 10 on a scale from 1 (not important) to 10 (very important).

Derived from: Questionnaire Section C, Question C12C.

	PERCENT	STANDARD ERROR
National	31%	0.61
SITE		
Boston	24	2.78
Cleveland	26	3.15
Greenville	25	2.57
Indianapolis	26	2.86
Lansing	27	3.21
Little Rock	32	3.52
Miami	42	3.25
Newark	42	3.77
Orange County	31	3.86
Phoenix	36	3.02
Seattle	20	2.83
Syracuse	25	2.65

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CTL_BUS Control over business decisions is very important

Description: Percentage of physicians who report that control over their practices' business decisions is very important, i.e., rated 10 on a scale from 1 (not important) to 10 (very important).

Derived from: Questionnaire Section C, Question C12D.

	PERCENT	STANDARD ERROR
National	36%	0.67
SITE		
Boston	24	2.45
Cleveland	32	3.49
Greenville	31	3.06
Indianapolis	27	3.22
Lansing	36	3.37
Little Rock	37	3.69
Miami	44	3.27
Newark	49	3.81
Orange County	43	4.14
Phoenix	38	3.13
Seattle	29	3.01
Syracuse	34	3.22

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

IT_TRT Use computers to obtain information on treatments

Description: Percentage of physicians whose practices use computers or other forms of information technology to obtain information about treatment alternatives or recommended guidelines.

Derived from: Questionnaire Section D, Question D1A.

	PERCENT	STANDARD ERROR
National	53%	0.72
SITE		
Boston	51	3.20
Cleveland	49	3.50
Greenville	52	3.49
Indianapolis	46	3.36
Lansing	51	3.43
Little Rock	50	3.61
Miami	51	3.28
Newark	41	3.72
Orange County	53	4.15
Phoenix	47	3.15
Seattle	64	3.09
Syracuse	52	3.29

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

IT_FORM Use computers to obtain information on formularies

Description: Percentage of physicians whose practices use computers or other forms of information technology to obtain information on formularies.

Derived from: Questionnaire Section D, Question D1B.

	PERCENT	STANDARD ERROR
National	32%	0.70
SITE		
Boston	43	3.17
Cleveland	36	3.34
Greenville	27	3.18
Indianapolis	20	2.89
Lansing	25	2.81
Little Rock	29	3.20
Miami	37	3.24
Newark	25	3.35
Orange County	38	4.29
Phoenix	27	2.94
Seattle	35	3.03
Syracuse	30	2.92

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ITRMNDR Use computers to generate reminders

Description: Percentage of physicians whose practices use computers or other forms of information technology to generate reminders for themselves about preventive services.

Derived from: Questionnaire Section D, Question D1C.

	PERCENT	STANDARD ERROR
National	24%	0.50
SITE		
Boston	24	2.84
Cleveland	21	2.61
Greenville	18	2.28
Indianapolis	20	2.81
Lansing	20	2.38
Little Rock	26	3.45
Miami	25	2.91
Newark	25	3.32
Orange County	27	3.49
Phoenix	22	2.61
Seattle	32	2.79
Syracuse	25	2.84

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ITNOTES Use computers to access patient notes

Description: Percentage of physicians whose practices use computers or other forms of information technology to access patient notes, medication lists, or problem lists.

Derived from: Questionnaire Section D, Question D1D.

	PERCENT	STANDARD ERROR
National	37%	0.66
SITE		
Boston	45	3.22
Cleveland	43	3.45
Greenville	32	3.14
Indianapolis	46	3.35
Lansing	15	2.08
Little Rock	49	3.68
Miami	35	3.18
Newark	23	3.13
Orange County	36	4.10
Phoenix	28	2.79
Seattle	42	3.13
Syracuse	37	3.26

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ITCLIN Use computers for clinical data and image exchanges

Description: Percentage of physicians whose practices use computers or other forms of information technology for clinical data and image exchanges with other physicians.

Derived from: Questionnaire Section D, Question D1F.

	PERCENT	STANDARD ERROR
National	41%	0.75
SITE		
Boston	55	3.17
Cleveland	50	3.51
Greenville	39	3.32
Indianapolis	47	3.38
Lansing	31	3.13
Little Rock	46	3.63
Miami	32	3.18
Newark	29	3.18
Orange County	39	4.16
Phoenix	30	3.00
Seattle	50	3.19
Syracuse	34	3.08

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ITCOMM Use computers to communicate with patients

Description: Percentage of physicians whose practices use computers or other forms of information technology to communicate about clinical issues with patients by e-mail.

Derived from: Questionnaire Section D, Question D1G.

	PERCENT	STANDARD ERROR
National	20%	0.52
SITE		
Boston	34	3.11
Cleveland	22	2.69
Greenville	14	2.48
Indianapolis	17	2.29
Lansing	18	2.39
Little Rock	25	3.46
Miami	18	2.55
Newark	16	2.74
Orange County	20	3.39
Phoenix	13	2.07
Seattle	33	3.03
Syracuse	17	2.16

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ACC_INT Internet access where providing patient care

Description: Percentage of physicians who have access to the Internet at the place where they provide most of their patient care.

Derived from: Questionnaire Section D, Question D2.

	PERCENT	STANDARD ERROR
National	77%	0.59
SITE		
Boston	83	2.08
Cleveland	77	2.64
Greenville	86	1.82
Indianapolis	82	2.18
Lansing	71	3.28
Little Rock	83	2.92
Miami	71	2.91
Newark	68	3.38
Orange County	81	3.14
Phoenix	75	2.82
Seattle	85	2.32
Syracuse	75	2.69

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

FORMLRY Percentage of patients with formulary

Description: Average percentage of physicians' patients who have prescription coverage that includes the use of a formulary. For physicians who indicated the percentage of patients was not zero but was less than one, a value of 0.5% was used in calculating the average percentage.

Derived from: Questionnaire Section D, Question D3.

	AVERAGE	STANDARD ERROR
National	57%	0.61
SITE		
Boston	63	1.61
Cleveland	57	1.58
Greenville	46	1.65
Indianapolis	56	1.75
Lansing	64	1.46
Little Rock	48	1.54
Miami	59	1.86
Newark	55	1.94
Orange County	70	1.83
Phoenix	70	1.44
Seattle	64	1.67
Syracuse	50	1.50

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFGUIDE Effect of formal written guidelines on the practice of medicine

Description: The percentage of physicians who indicated that their use of formal, written practice guidelines from physician organizations, insurance companies, HMOs, or government agencies, had either no effect or a very small effect on their practice of medicine. Physicians could respond that the effect was very large, large, moderate, small, very small, or had no effect on their medical practice.

Derived from: Questionnaire Section D, Question D4A.

	PERCENT	STANDARD ERROR
National	21%	0.56
SITE		
Boston	22	2.85
Cleveland	24	2.97
Greenville	27	3.45
Indianapolis	25	2.92
Lansing	17	2.39
Little Rock	26	3.19
Miami	25	3.14
Newark	23	3.34
Orange County	23	3.35
Phoenix	27	2.95
Seattle	16	2.03
Syracuse	18	2.46

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFPROFL Effect of practice profiles on the practice of medicine

Description: The percentage of physicians who indicated that the results of practice profiles, comparing their patterns of medical resources to treat patients with that of other physicians, had either no effect or a very small effect on their practice of medicine. Physicians could respond that the effect was very large, large, moderate, small, very small, or had no effect on their medical practice.

Derived from: Questionnaire Section D, Question D4B.

	PERCENT	STANDARD ERROR
National	39%	0.60
SITE		
Boston	45	3.19
Cleveland	47	3.55
Greenville	40	3.48
Indianapolis	38	3.27
Lansing	23	2.50
Little Rock	39	3.54
Miami	39	3.36
Newark	42	3.87
Orange County	36	3.90
Phoenix	43	3.22
Seattle	45	3.21
Syracuse	42	3.22

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

EFSURV Effect of patient satisfaction surveys on the practice of medicine

Description: The percentage of physicians who indicated that feedback from patient satisfaction surveys had either no effect or a very small effect on their practice of medicine. Physicians could respond that the effect was very large, large, moderate, small, very small, or had no effect on their medical practice.

Derived from: Questionnaire Section D, Question D4C.

	PERCENT	STANDARD ERROR
National	22%	0.51
SITE		
Boston	23	2.55
Cleveland	27	3.19
Greenville	26	3.47
Indianapolis	15	1.99
Lansing	17	2.50
Little Rock	20	2.85
Miami	22	2.46
Newark	26	3.49
Orange County	21	3.15
Phoenix	27	2.93
Seattle	21	2.40
Syracuse	22	2.56

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CMPPROV Change in complexity without referral to specialists

Description: The percentage of primary care physicians who indicated that the complexity or severity of patients' conditions for which they provided care without referral to specialists increased either a little or a lot over the last two years. Physicians could respond that the change increased a lot, increased a little, stayed the same, decreased a little, or decreased a lot.

Derived from: Questionnaire Section D, Question D7.

	PERCENT	STANDARD ERROR
National	36%	0.81
SITE		
Boston	43	3.44
Cleveland	33	3.29
Greenville	28	3.47
Indianapolis	39	3.52
Lansing	42	4.12
Little Rock	34	3.96
Miami	40	3.66
Newark	28	3.58
Orange County	33	3.90
Phoenix	47	3.39
Seattle	39	3.38
Syracuse	44	3.96

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CMPEXPC Appropriateness of expected care without referral

Description: The percentage of primary care physicians who indicated that the complexity or severity of patients' conditions for which they were expected to provide care without referral to specialists is either somewhat or much greater than it should be. Physicians could respond that the amount was much greater, somewhat greater, about right, somewhat less, or much less.

Derived from: Questionnaire Section D, Question D8.

	PERCENT	STANDARD ERROR
National	27%	0.94
SITE		
Boston	23	3.02
Cleveland	31	3.43
Greenville	13	2.17
Indianapolis	15	2.37
Lansing	20	3.28
Little Rock	28	3.89
Miami	33	3.56
Newark	26	3.55
Orange County	31	3.78
Phoenix	35	3.26
Seattle	24	2.95
Syracuse	26	3.62

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PCTGATE Percent of patients for whom physician acts as a gatekeeper

Description: The average percentage of patients in their practice for whom the primary care physician serves as a gatekeeper. A gatekeeper is described as a primary care physician whose patient's insurance plan (or medical group) requires that their enrollee obtain permission from a primary care physician before seeing a specialist.

Derived from: Questionnaire Section D, Question D10.

	AVERAGE	STANDARD ERROR
National	43%	0.63
SITE		
Boston	54	2.08
Cleveland	45	2.28
Greenville	34	2.34
Indianapolis	45	1.89
Lansing	49	2.02
Little Rock	41	2.61
Miami	47	2.36
Newark	51	2.45
Orange County	49	2.83
Phoenix	49	2.11
Seattle	47	1.98
Syracuse	41	1.97

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ADQTIME Adequacy of time to spend with patients

Description: The percentage of physicians who either somewhat or strongly agreed that they have adequate time to spend with their patients during typical office visits. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Questions F1A and F1B.

	PERCENT	STANDARD ERROR
National	64%	0.60
SITE		
Boston	51	3.21
Cleveland	65	3.30
Greenville	72	2.80
Indianapolis	60	3.41
Lansing	64	3.27
Little Rock	69	3.17
Miami	62	3.27
Newark	65	3.45
Orange County	61	4.01
Phoenix	61	2.92
Seattle	52	3.19
Syracuse	69	3.11

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

CLNFREE Freedom to make clinical decisions

Description: The percentage of physicians who somewhat or strongly agreed that they have the freedom to make clinical decisions that meet their patients' needs. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Question F1C.

	PERCENT	STANDARD ERROR
National	86%	0.50
SITE		
Boston	87	2.39
Cleveland	91	1.58
Greenville	88	2.82
Indianapolis	89	1.96
Lansing	91	1.90
Little Rock	92	1.44
Miami	79	2.80
Newark	82	3.12
Orange County	79	3.59
Phoenix	79	2.50
Seattle	85	2.42
Syracuse	89	2.26

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

HIGHCAR Possibility of high quality of patient care to all patients

Description: The percentage of physicians who either somewhat or strongly agreed that it is possible to provide high quality care to all of their patients. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Question F1D.

	PERCENT	STANDARD ERROR
National	78%	0.50
SITE		
Boston	83	2.01
Cleveland	86	2.10
Greenville	84	2.50
Indianapolis	78	2.78
Lansing	79	2.86
Little Rock	83	2.34
Miami	68	3.25
Newark	74	3.55
Orange County	77	3.23
Phoenix	68	2.95
Seattle	77	2.63
Syracuse	84	2.80

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NEGINCN Clinical decisions without possibility of reducing income

Description: The percentage of physicians who either somewhat or strongly agreed that they can make clinical decisions in the best interests of their patients without the possibility of reducing their income. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Question F1E.

	PERCENT	STANDARD ERROR
National	79%	0.48
SITE		
Boston	75	2.70
Cleveland	81	2.98
Greenville	88	1.80
Indianapolis	84	2.24
Lansing	75	3.07
Little Rock	77	3.10
Miami	71	3.19
Newark	75	3.25
Orange County	75	3.77
Phoenix	76	2.58
Seattle	77	2.57
Syracuse	80	2.84

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

USESPCS High communication level with specialists

Description: The percentage of primary care physicians who either somewhat or strongly agreed that the level of communication they have with specialists about the patients they refer is sufficient to ensure high quality care. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Question F1F.

	PERCENT	STANDARD ERROR
National	81%	0.55
SITE		
Boston	76	2.80
Cleveland	83	2.20
Greenville	83	3.08
Indianapolis	79	2.78
Lansing	86	3.05
Little Rock	81	3.51
Miami	72	3.31
Newark	80	3.08
Orange County	73	3.69
Phoenix	62	3.46
Seattle	78	3.25
Syracuse	86	2.65

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

COMMALL Level of communication among physicians

Description: The percentage of physicians who either somewhat or strongly agreed that the level of communication they have with specialists (or primary care physicians) about the patients they refer (or about the patients that have been referred to them) is sufficient to ensure high quality of care. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree.

Derived from: Questionnaire Section F, Questions F1F and F1G.

	PERCENT	STANDARD ERROR
National	79%	0.71
SITE		
Boston	77	2.62
Cleveland	85	2.47
Greenville	83	2.68
Indianapolis	74	3.12
Lansing	82	2.68
Little Rock	79	2.92
Miami	64	3.37
Newark	85	2.19
Orange County	73	3.66
Phoenix	65	3.10
Seattle	76	2.85
Syracuse	84	2.35

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PATREL Continuing patient relationships

Description: The percentage of physicians who either somewhat or strongly agreed that they can maintain continuing relationships with patients over time that promote the delivery of high quality care. Physicians could agree strongly, agree somewhat, disagree somewhat, disagree strongly, or neither agree nor disagree. Physicians who indicated that they don't normally have continuing relationships with patients were excluded.

Derived from: Questionnaire Section F, Question F1H.

	PERCENT	STANDARD ERROR
National	75%	0.62
SITE		
Boston	74	3.00
Cleveland	75	3.35
Greenville	80	3.16
Indianapolis	75	2.75
Lansing	79	2.54
Little Rock	79	2.96
Miami	64	3.21
Newark	71	3.52
Orange County	69	4.00
Phoenix	65	3.02
Seattle	71	2.86
Syracuse	83	2.86

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBREFS Referrals to specialists of high quality

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain referrals to specialists of high quality when they think it is medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain a referral. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8A.

	PERCENT	STANDARD ERROR
National	74%	0.72
SITE		
Boston	78	2.75
Cleveland	77	3.23
Greenville	81	3.04
Indianapolis	79	2.87
Lansing	71	3.23
Little Rock	78	3.12
Miami	56	3.40
Newark	69	3.65
Orange County	67	3.79
Phoenix	60	3.26
Seattle	74	2.94
Syracuse	84	2.07

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBANCL High quality ancillary services

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain high quality ancillary services for their patients when medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain these services. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8B.

	PERCENT	STANDARD ERROR
National	62%	0.91
SITE		
Boston	64	3.20
Cleveland	68	3.28
Greenville	70	3.46
Indianapolis	68	3.07
Lansing	63	3.33
Little Rock	72	3.03
Miami	39	3.14
Newark	51	3.89
Orange County	54	4.27
Phoenix	46	3.27
Seattle	60	3.34
Syracuse	68	3.20

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBHOSP Non-emergency hospital admission

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain non-emergency hospital admissions for their patients when medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain these services. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8C.

	PERCENT	STANDARD ERROR
National	60%	0.77
SITE		
Boston	59	3.43
Cleveland	61	3.94
Greenville	60	4.23
Indianapolis	70	3.14
Lansing	56	3.75
Little Rock	61	3.75
Miami	46	3.64
Newark	49	4.19
Orange County	61	4.31
Phoenix	49	3.66
Seattle	61	3.62
Syracuse	59	3.58

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBINPAT Adequate number of inpatient days

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain the adequate number of inpatient days for their hospitalized patients when they think it is medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain an adequate number of days. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8D.

	PERCENT	STANDARD ERROR
National	60%	0.80
SITE		
Boston	59	3.34
Cleveland	61	3.61
Greenville	58	4.18
Indianapolis	71	3.10
Lansing	60	3.81
Little Rock	55	4.02
Miami	55	3.57
Newark	37	3.72
Orange County	67	4.22
Phoenix	52	3.63
Seattle	67	3.27
Syracuse	69	3.26

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBIMAG High quality diagnostic imaging

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain high quality diagnostic imaging services for their patients when they think it is medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain these services. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8E.

	PERCENT	STANDARD ERROR
National	79%	0.65
SITE		
Boston	82	2.48
Cleveland	83	2.65
Greenville	82	2.95
Indianapolis	86	2.17
Lansing	76	3.17
Little Rock	85	2.70
Miami	67	3.20
Newark	74	3.23
Orange County	71	3.79
Phoenix	66	3.23
Seattle	84	2.50
Syracuse	86	2.34

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBMENTL High quality inpatient mental health care

Description: The percentage of primary care physicians and selected specialists who indicated that they are either always or almost always able to obtain high quality inpatient mental health care for their patients when they think it is medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain this type of care. This calculation includes responses from only primary care physicians and specialists in obstetrics/ gynecology and psychiatry. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8F.

	PERCENT	STANDARD ERROR
National	28%	0.93
SITE		
Boston	28	3.36
Cleveland	33	3.86
Greenville	31	3.75
Indianapolis	31	3.87
Lansing	24	3.43
Little Rock	23	3.64
Miami	32	4.02
Newark	34	4.12
Orange County	29	5.14
Phoenix	16	2.93
Seattle	22	2.83
Syracuse	26	4.12

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

OBOUTPT High quality outpatient mental health care

Description: The percentage of physicians who indicated that they are either always or almost always able to obtain high quality outpatient mental health care for their patients when they think it is medically necessary. Physicians could indicate that they are always, almost always, frequently, sometimes, rarely, or never able to obtain this type of care. This calculation includes responses from only primary care physicians and specialists in obstetrics/ gynecology and psychiatry. The calculation excludes physicians who indicated that this question does not apply to them.

Derived from: Questionnaire Section F, Question F8G.

	PERCENT	STANDARD ERROR
National	24%	0.90
SITE		
Boston	19	2.72
Cleveland	22	3.14
Greenville	21	2.84
Indianapolis	35	3.81
Lansing	17	2.71
Little Rock	24	3.81
Miami	30	3.69
Newark	30	4.09
Orange County	31	4.95
Phoenix	17	2.76
Seattle	16	2.98
Syracuse	21	3.40

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NWMCARE Limited acceptance of new Medicare patients

Description: The percentage of physicians whose practice is accepting either some or no new patients who are insured through Medicare. Physicians were asked if the practice was accepting all, most, some, or no new patients who were insured through Medicare, including Medicare managed care patients.

Derived from: Questionnaire Section F, Question F9A.

	PERCENT	STANDARD ERROR
National	20%	0.53
SITE		
Boston	17	2.43
Cleveland	14	1.78
Greenville	21	2.23
Indianapolis	18	2.00
Lansing	18	2.42
Little Rock	19	2.34
Miami	26	2.88
Newark	13	1.98
Orange County	24	3.33
Phoenix	24	2.72
Seattle	28	2.69
Syracuse	23	2.78

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NWMCAID Limited acceptance of new Medicaid patients

Description: The percentage of physicians whose practice is accepting either some or no new patients who are insured through Medicaid. Physicians were asked if the practice was accepting all, most, some, or no new patients who were insured through Medicaid, including Medicaid managed care patients.

Derived from: Questionnaire Section F, Question F9B.

	PERCENT	STANDARD ERROR
National	38%	0.82
SITE		
Boston	20	2.63
Cleveland	23	2.77
Greenville	37	3.14
Indianapolis	39	3.15
Lansing	41	3.29
Little Rock	23	2.65
Miami	42	3.26
Newark	56	3.71
Orange County	50	4.15
Phoenix	42	3.05
Seattle	44	3.15
Syracuse	41	3.23

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NWPRIV Limited acceptance of new privately-insured patients

Description: The percentage of physicians whose practice is accepting either some or no new patients who are insured through private or commercial insurance plans. Physicians were asked if the practice was accepting all, most, some, or no new patients who were insured through private or commercial insurance plans, including managed care plans and HMOs with whom the practice has contracts. Privately-insured patients included fee for service patients but excluded Medicaid or Medicare managed care patients.

Derived from: Questionnaire Section F, Question F9C.

	PERCENT	STANDARD ERROR
National	15%	0.48
SITE		
Boston	13	2.17
Cleveland	8	1.49
Greenville	9	1.31
Indianapolis	15	2.06
Lansing	12	1.60
Little Rock	11	2.40
Miami	20	2.71
Newark	13	2.15
Orange County	18	2.42
Phoenix	18	2.09
Seattle	18	2.16
Syracuse	15	2.57

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NWNPAY Limited acceptance of new patients unable to pay

Description: Percentage of physicians whose practice is accepting either some or no new uninsured patients who are unable to pay. Physicians were asked if the practice was accepting all, most, some, or no new uninsured patients who were unable to pay.

Derived from: Questionnaire Section F, Question F9G.

	PERCENT	STANDARD ERROR
National	43%	0.82
SITE		
Boston	35	3.15
Cleveland	32	3.21
Greenville	40	3.15
Indianapolis	38	3.18
Lansing	48	3.40
Little Rock	30	3.10
Miami	53	3.27
Newark	54	3.73
Orange County	58	4.22
Phoenix	47	3.17
Seattle	53	3.19
Syracuse	39	3.22

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

ACC_CAP Acceptance of new patients under capitated contracts

Description: Percentage of physicians whose practice is accepting any new patients under capitated contracts. For these calculations, physicians who indicated that the survey question did not apply to them because there were no capitated contracts in the area were considered to have responded that their practice was accepting no new patients under capitated contracts.

Derived from: Questionnaire Section F, Question F10.

	PERCENT	STANDARD ERROR
National	42%	0.97
SITE		
Boston	64	3.09
Cleveland	48	3.39
Greenville	22	3.09
Indianapolis	57	3.35
Lansing	42	3.07
Little Rock	28	2.94
Miami	43	2.99
Newark	41	3.33
Orange County	59	4.06
Phoenix	47	3.07
Seattle	42	3.09
Syracuse	30	2.71

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PMCARE Percentage of practice revenue from Medicare

Description: The average percentage of patient care practice revenue that comes from Medicare, including Medicare managed care.

Derived from: Questionnaire Section G, Questions G1 and G1a.

	PERCENT	STANDARD ERROR
National	32%	0.40
SITE		
Boston	31	1.58
Cleveland	38	1.52
Greenville	31	1.31
Indianapolis	28	1.62
Lansing	30	1.46
Little Rock	32	1.78
Miami	32	1.69
Newark	33	1.57
Orange County	27	1.78
Phoenix	32	1.74
Seattle	24	1.31
Syracuse	33	1.49

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PMCAID Percentage of practice revenue from Medicaid

Description: The average percentage of patient care practice revenue that comes from Medicaid, including Medicaid managed care.

Derived from: Questionnaire Section G, Questions G1 and G1a.

	AVERAGE	STANDARD ERROR
National	15%	0.28
SITE		
Boston	17	0.97
Cleveland	17	1.05
Greenville	15	1.16
Indianapolis	14	1.15
Lansing	14	1.14
Little Rock	17	1.32
Miami	18	1.31
Newark	10	1.11
Orange County	15	1.69
Phoenix	15	1.07
Seattle	14	1.00
Syracuse	14	0.92

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PCAPREV Percentage of practice revenue prepaid or capitated

Description: The average percentage of patient care practice revenue paid on a capitated or other prepaid basis.

Derived from: Questionnaire Section G, Questions G6 through G11.

	AVERAGE	STANDARD ERROR
National	13%	0.51
SITE		
Boston	17	1.53
Cleveland	12	1.12
Greenville	4	0.65
Indianapolis	11	0.76
Lansing	14	1.29
Little Rock	6	1.04
Miami	16	1.27
Newark	13	1.18
Orange County	27	2.60
Phoenix	16	1.44
Seattle	17	1.63
Syracuse	8	0.92

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

NMCCON Physicians with more than 15 managed care contracts

Description: The percentage of physicians who have more than 15 managed care contracts in the practice in which they work.

Derived from: Questionnaire Section G, Questions G6 through G6c.

	PERCENT	STANDARD ERROR
National	29%	0.76
SITE		
Boston	20	2.70
Cleveland	46	3.53
Greenville	35	3.32
Indianapolis	36	3.31
Lansing	7	1.39
Little Rock	32	3.40
Miami	30	3.16
Newark	42	3.76
Orange County	40	4.10
Phoenix	33	3.17
Seattle	26	3.01
Syracuse	23	2.90

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PMC Percentage of practice revenue from managed care

Description: The average percentage of patient care practice revenue from all managed care.

Derived from: Questionnaire Section G, Questions G6 through G11.

	AVERAGE	STANDARD ERROR
National	43%	0.66
SITE		
Boston	47	1.72
Cleveland	43	1.65
Greenville	39	1.45
Indianapolis	38	1.71
Lansing	45	1.52
Little Rock	38	1.33
Miami	45	1.76
Newark	42	1.57
Orange County	53	2.32
Phoenix	55	1.73
Seattle	45	1.88
Syracuse	35	1.23

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SALPAID Percentage of physicians who are salaried

Description: The percentage of physicians who are salaried. Physicians who are full owners of solo practices are assumed to be not salaried. Salaried physicians may be eligible to receive bonuses.

Derived from: Questionnaire Section H, Question H1.

	PERCENT	STANDARD ERROR
National	52%	0.82
SITE		
Boston	65	2.97
Cleveland	63	3.27
Greenville	54	3.47
Indianapolis	63	3.17
Lansing	55	3.43
Little Rock	58	3.51
Miami	42	3.21
Newark	49	3.74
Orange County	42	4.20
Phoenix	46	3.19
Seattle	52	3.17
Syracuse	60	3.27

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

SPROD Own productivity affects compensation

Description: The percentage of physicians indicating that their compensation is affected by their own productivity. Physicians who are full owners of solo practices are assumed to have their compensation affected by their own productivity.

Derived from: Questionnaire Section H, Questions H5A and H7A.

	PERCENT	STANDARD ERROR
National	78%	0.53
SITE		
Boston	75	2.81
Cleveland	82	2.22
Greenville	81	2.82
Indianapolis	74	3.07
Lansing	83	2.17
Little Rock	79	2.99
Miami	76	2.80
Newark	77	2.91
Orange County	75	3.97
Phoenix	79	2.59
Seattle	77	2.61
Syracuse	67	3.15

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

PCTINCC Percent of 1999 income from bonuses

Description: The average percentage of a physician's 1999 practice income that was earned from bonuses, returned withholds, or other incentive payments. Physicians who are not eligible for bonuses were not asked this question.

Derived from: Questionnaire Section H, Questions H9 and H9a.

	AVERAGE	STANDARD ERROR
National	6%	0.25
SITE		
Boston	4	0.63
Cleveland	4	0.62
Greenville	10	1.26
Indianapolis	6	0.83
Lansing	10	0.83
Little Rock	10	1.50
Miami	5	0.95
Newark	5	0.95
Orange County	7	1.44
Phoenix	5	0.85
Seattle	4	0.63
Syracuse	4	0.64

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

INCOMEX Net income in 1999

Description: Average 1999 net income received from the practice of medicine after expenses but before taxes.

Derived from: Questionnaire Section H, Question H10.

	AVERAGE	STANDARD ERROR
National	$184,038	$1,940
SITE		
Boston	152,801	4,258
Cleveland	180,587	12,296
Greenville	211,205	8,659
Indianapolis	198,798	7,348
Lansing	190,002	6,942
Little Rock	201,109	7,101
Miami	180,456	12,889
Newark	177,305	7,121
Orange County	197,073	15,365
Phoenix	183,127	10,375
Seattle	161,933	5,893
Syracuse	174,389	6,802

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

INCENT2 Financial incentives favor expanding services

Description: Percentage of physicians who report that their overall personal financial incentives in their practice favor expanding services to individual patients.

Derived from: Questionnaire Section H, Question 10b.

	PERCENT	STANDARD ERROR
National	23%	0.56
SITE		
Boston	19	2.62
Cleveland	18	2.71
Greenville	30	3.18
Indianapolis	26	2.87
Lansing	23	2.75
Little Rock	20	2.32
Miami	15	2.05
Newark	18	3.18
Orange County	22	3.44
Phoenix	21	2.84
Seattle	24	2.87
Syracuse	17	2.19

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

INCENT3 Financial incentives favor neither expanding nor reducing services

Description: Percentage of physicians who report that their overall personal financial incentives in their practice favor neither expanding nor reducing services to individual patients.

Derived from: Questionnaire Section H, Question 10b.

	PERCENT	STANDARD ERROR
National	69%	0.57
SITE		
Boston	73	2.84
Cleveland	78	2.86
Greenville	67	3.22
Indianapolis	67	3.11
Lansing	69	3.04
Little Rock	74	2.66
Miami	74	2.57
Newark	70	3.62
Orange County	69	3.86
Phoenix	69	3.07
Seattle	70	2.98
Syracuse	78	2.64

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

COMPETE1 Not competitive situation faced by practice

Description: Percentage of physicians who report that the competitive situation their practice faces is not competitive.

Derived from: Questionnaire Section H, Question 10c.

	PERCENT	STANDARD ERROR
National	31%	0.66
SITE		
Boston	36	3.14
Cleveland	28	2.87
Greenville	34	3.16
Indianapolis	30	3.00
Lansing	34	3.19
Little Rock	32	3.26
Miami	24	2.62
Newark	29	3.14
Orange County	26	3.69
Phoenix	35	2.90
Seattle	34	2.89
Syracuse	39	3.30

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

COMPETE2 Somewhat competitive situation faced by practice

Description: Percentage of physicians who report that the competitive situation their practice faces is somewhat competitive.

Derived from: Questionnaire Section H, Question 10c.

	PERCENT	STANDARD ERROR
National	45%	0.64
SITE		
Boston	42	3.11
Cleveland	44	3.51
Greenville	45	3.50
Indianapolis	51	3.39
Lansing	49	3.43
Little Rock	50	3.65
Miami	35	3.09
Newark	44	3.78
Orange County	39	3.95
Phoenix	42	3.24
Seattle	48	3.24
Syracuse	41	3.12

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

COMPETE3 Very competitive situation faced by practice

Description: Percentage of physicians who report that the competitive situation their practice faces is very competitive.

Derived from: Questionnaire Section H, Question 10c.

	PERCENT	STANDARD ERROR
National	23%	0.69
SITE		
Boston	22	2.69
Cleveland	27	3.18
Greenville	21	3.11
Indianapolis	19	2.73
Lansing	17	2.71
Little Rock	18	2.82
Miami	41	3.37
Newark	27	3.50
Orange County	35	4.12
Phoenix	23	2.73
Seattle	19	2.20
Syracuse	20	2.87

TABLE 4.3

DETAILED DESCRIPTIONS OF ESTIMATES
(Positional Order of VARNAME)

RACEWH Percentage of physicians who are white

Description: Percentage of physicians who are white, versus all others (African-American / Black, Hispanic, Native American or Alaska Native, and Asian or Pacific Islander).

Derived from: Questionnaire Section H, Questions H11 and H12.

	PERCENT	STANDARD ERROR
National	76%	1.34
SITE		
Boston	85	2.20
Cleveland	75	3.10
Greenville	88	2.48
Indianapolis	84	2.64
Lansing	78	3.08
Little Rock	85	2.58
Miami	47	3.30
Newark	69	3.43
Orange County	63	4.01
Phoenix	76	2.76
Seattle	83	2.43
Syracuse	84	2.36

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